An Assessment of the Impact of HIV/AIDS on Correctional System governance with Special Emphasis on Correctional Services Staff

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EXECUTIVE SUMMARY

1. The incidence of HIV/AIDS infection in South African prisons has been extensively documented in recent years. This research has focused variously on the geographic and demographic spread of the disease and on the rights of inmates to prophylactics and to appropriate treatment and care. In contrast, little research has been directed towards the incidence and impact of the pandemic amongst correctional officials.

2. From this research it is evident that whilst the Department of Correctional Services (DCS) has developed a fairly coherent (albeit unevenly implemented) programme for the prevention and treatment of HIV/AIDS amongst inmates, and notwithstanding the recent launch of a "Framework for the Implementation of a Comprehensive HIV and AIDS Programme" it has yet to develop and implement systematic measures to manage the disease amongst its own staff.

3. At the time of this research the Department had yet to formulate a comprehensive HIV/AIDS strategy and was largely reliant on national HIV/AIDS programmes and on the policies which emanate from them. At the same time, correctional centre managers had not adapted national HIV/AIDS programmes to their own realities and HIV/AIDS initiatives had, in effect, become an 'add on" to the normal activities of correctional centres.

4. An HIV Prevalence Survey conducted on behalf of the Department and released in 2007, found that the national HIV infection rate amongst all staff was 9.8%, lower than the national estimate of 16.25%. However, disaggregated, the DCS survey reveals patterns which are similar to national norms. Thus, the KwaZulu Natal region recorded an infection rate of 22.7%, indicating that roughly one out of every four officials in the correctional system are HIV positive. The survey found that the bulk of those infected (87.2%) were in the age cohort of 26 to 45 years. It further found that 93.6% of HIV positive staff was employed at the 'production level', meaning that they were involved either in the direct management of offenders or in providing support services.

5. Whilst there is no published record of the causes of death amongst prison officials, it is noteworthy

that the national mortality rate of officials who died in office, increased from 3.0 per 1000 in 1993 to 6.1 in 2001/2 in 2001, and to 7.8 per 1000 in 2006/7 - more than doubling the mortality rate in 14 years.

6. Officials are encouraged to undergo voluntary testing and counselling, but not all prisons visited offered this facility. However, it is unlikely that even if they had, this would have influenced officials to undergo testing. This is because it was reported that in prisons which offered Voluntary Counselling and Testing (VCT) the take-up rate was extremely low even amongst managerial staff.

7. It was reported that as a consequence of low levels of VCT and equally low levels of participation in HIV/AIDS prevention programmes, many officials knew very little about the disease, its modes of transmission and the potentially lifesaving effects of Anti-retroviral Therapy (ART). In this context, many officials still viewed HIV/AIDS infection as a death sentence.

8. Officials in all correctional centres visited reported that their medical staff presented lectures on how to avoid contracting the disease, but stated that there was no policy available on how to manage officials who had already contracted the disease. Moreover, still less attention was being paid to succession planning and to anticipating the full impact of the pandemic on the running of correctional centres.

9. It was readily apparent in all the correctional centres visited, that fear of stigmatisation is the single greatest constraint to any programme introduced to prevent and manage the impact of the disease. It is evident that the stigma attached to the disease is of such gravity that the majority of officials would rather die than risk disclosure and many, indeed, do.

10. Notwithstanding the launch of the new Framework policy, the findings of this investigation suggest that at the operational level, the extent of the challenge facing the DCS has yet to be fully recognised whilst it is steadily growing in magnitude. It also points to a situation which, if left unchecked, will unquestionably compromise the operations of many correctional institutions across the country and will materially affect the goals and strategic plans of the Department due to staff attrition.

11. Officials in all centres visited reported the attrition of staff due to HIV/AIDS and it is likely (given trends elsewhere in the regions visited), that the incidence of the disease is on an upward curve and that its fullest impacts have yet to be felt.

12. The illness and death of officials has an adverse effect on their healthy colleagues. The absence of sick staff, and the death of others, inevitably adds to the work load of those who remain in office by lengthening shifts and lessening days off. It also serves to aggravate already existing staff shortages and compounds the threat to staff and inmate security.

13. Inmates interviewed complained that when correctional officers were clearly at an advanced stage of the disease they were frequently on sick leave and this led to staff shortages in a unit, and, consequently longer periods of lock-up for themselves by healthy staff concerned about safety issues.

14. Succession planning for those who have contracted full-blown AIDS is reported to be constrained by the fact that extremely few infected officials disclose their status. In this context, steps to recruit new staff can only be initiated once an official is medically boarded or die in office.

15. In the centres visited, there were no officials who were specifically trained and assigned to support staff with HIV/AIDS. Responsibility for the general welfare of staff currently falls to Employee Assistance Practitioners (EAPs).

16. In the absence of formal policy guidelines to direct them, prison managers reported that they resorted to ad hoc measures in their attempts to manage staff members that appear to be suffering from HIV/AIDS. These included the reassignment of staff from operational to administrative duties and the reduction of their working days to a four hour shift.

17. Correctional centre health officials reported that, with notable exceptions, correctional centre managers displayed little direct interest in the HIV/AIDS programmes presented to staff and none were willing to undergo voluntary testing as an example to others; this acted as a disincentive to junior staff members.

18. It was reported that while some inmates took advantage of the illness of custodial staff, it was generally felt that this served to disadvantage inmates through diminished opportunities for extra-unit activities and through longer lock-up periods. Recreational activities, in particular, were curtailed in this way.

19. The newly launched Framework represents an important starting point for the Department in its efforts to contain and manage the HIV/AIDS pandemic. As a framework, however, it merely sets out the parameters within which policy might be formulated and programmes developed.

20. Many of the Framework's proposed interventions are derived directly from the National Strategic Plan. As generic interventions, however, they appear not to have been adapted to the particular circumstances and challenges of a prison environment. The proposals are also short on the specifics of how different interventions might be introduced.

21. A weakness of the Framework lies in the fact that it is silent on the crucial question on how the impact of HIV/AIDS on the DCS workforce might be managed. Beyond the need to identify (unspecified) risks, the Framework says nothing about how to manage officials infected with (and sometimes dying of) AIDS or how to implement succession plans so that there is minimal impact on the daily operations of correctional centres and correctional programmes are not compromised.

22. The Framework will need to be developed into a fully fledged programme of action with clearly defined outputs, time frames, resource implications and budgets.

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INTRODUCTION

This incidence of HIV/AIDS infection in the South African correctional system has been extensively documented in recent years. This research has focused variously on the geographic and demographic spread of the disease and on the rights of inmates to prophylactics and to appropriate treatment and care. In contrast, little research has been directed towards the incidence of the virus amongst correctional officials. The DCS commissioned HIV Prevalence Sample Survey, conducted in 2006 and released in 2007, represents the first official investigation on the extent to which the disease has spread amongst inmates and correctional officials alike.[1] Whilst the sample derived for the survey was too small to disaggregate beyond regional level, the findings indicate that a sizeable number of DCS officials have contracted the HIV virus. From this it can be inferred that a proportion of those infected are already living with AIDS.

Whilst the Prevalence Survey represents an important step in determining the scale of the HIV/AIDS challenge confronting the DCS, it does not provide any indication of the likely impact of the disease on the operations of correctional centres. This investigation, thus, represents an attempt to address a lacuna in the research on HIV/AIDS in prisons in South Africa. Its focus, however, is not on the incidence of HIV/AIDS *per se* but rather on the ways in which the disease impacts on the health of DCS officials and on the ways in which this, in turn, impacts on the governance of correctional institutions across the country. It also considers the extent to which the prevalence of HIV/AIDS in correctional centres is compromising the goals set by the 1998 *Correctional Services Act*, the 2005 *White Paper on Corrections in South Africa* and the Department of Correctional Services' (DCS) *Strategic Plan 2006-2011*.

For the purposes of this study, good prison governance is understood to be determined, to a large extent, by the existence of an enabling policy framework, necessary resources and the extent to which prison management has the ability to implement these policies on a day-to-day basis in a transparent, accountable and ethical manner. In the context of this research, however, the notion of governance is understood to encompass not only issues of administrative efficiency and probity, but

[1] Lim'ivume Consulting, (2007), p.17

also the extent to which the basic human and constitutional rights of offenders are recognised and respected. This relates both to the manner in which offenders are treated in the prison system and the opportunities which they are afforded to re-orientate their lives towards a more constructive future in society.[2]

Objectives of the Research

The objectives of this research were threefold:

- to ascertain whether the incidence of HIV/AIDS amongst DCS officials was at a level which might constitute a threat to correctional centre governance;
- to assess the existence and effectiveness of DCS policies in place to manage the disease; and
- to make recommendations on measures that might be pursued to mitigate the impact of HIV/AIDS on correctional centre governance.

Methodology of the Investigation

Fieldwork for this investigation entailed a series of visits to six correctional centres located in regions in which there is a high prevalence of HIV/AIDS amongst the general population. The correctional centres visited were Qalakabushe (Empangeni), Westville Youth (near Durban), and Pietermaritzburg (all in KwaZulu-Natal), St Albans (in the Eastern Cape) and Johannesburg and Leeuwkop (in Gauteng). During the visits, interviews (guided by an interview schedule) were conducted with senior correctional centre staff, with officials in human resource management as well as with those staff involved in the management of HIV/AIDS programmes (where these existed). Interviews were also conducted with focus groups comprising between five and seven inmates. Further interviews were conducted with officials at the DCS headquarters in Pretoria.

The empirical information gathered through the fieldwork was augmented by a range of supporting documents, including the findings of the DCS HIV/AIDs prevalence survey, government policies and reports, and other secondary material. As there are currently no data on the numbers of officials

[2] Tapscott C (2005) *A study of best practice in prison governance*, CSPRI Research Paper No. 9, CSPRI, Cape Town, p. 3.

who have died from the disease, the findings of this research are unavoidable qualitative in nature. Where possible, corroborative data is presented to support the qualitative findings presented.

THE LITERATURE ON HIV/AIDS IN PRISONS

A review of the literature on HIV/AIDS in prisons[3] reveals that whilst much has been written on this issue, virtually all of the discussion has focused on the incidence of the disease amongst inmates, on effective prevention programmes, and on inmates' rights to appropriate treatment and care.[4] Extremely little research has been directed towards the incidence of HIV/AIDS among prison officials and the impact which this might have on prison governance.[5]

Thus, the comprehensive 1993 World Health Organisation guidelines on HIV/AIDS management in prisons state merely that: "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."[6] With regard to how this should be achieved, the guidelines maintain simply that "Prison staff should receive HIV/AIDS prevention information during their initial training and thereafter on a regular basis."[7] The 2004 Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia, likewise, focuses on the risk of staff contracting the virus from inmates and asserts that "improving health care and prevention programmes for prisoners is an integral part of enhancing workplace health and safety for prison staff."[8] The more recent United Nations Office on Drugs and Crime framework report on "HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings"[9],

[3] The term 'prison' is used here as the internationally common term and full recognition is given to the nomenclature of the DCS.
[4] See Jürgens, R,, and Betteridge, G., "HIV Prevention for Prisoners: A Public Health and Human Rights Imperative", *Interights Bulletin*, Vol. 15, No.2 2004, p.55-59.
[5] The recent DCS "HIV Prevalence Survey 2006" is an exception to this trend.
[6] World Health Organisation, (1993),"WHO guidelines on HIV infection and AIDS in prisons", UNAIDS, Geneva, p. 4. Accessed on 17 January 2006 at http://data.unaids.org/Publications/IRC-pub01/JC277 Ibid. p.5
[7] Ibid. p.5
[8] Lines, R., et al., (2004), "Dublin Declaration on HIV/AIDS in Prisons in Europe and Central Asia", Dublin Ireland,
[9] United Nations Office on Drugs and Crime, (2006), *HIV/AIDS Prevention, Care, Treatment and Support in Prison Settings – A Framework for an Effective National Response,* Co-published with the World Health

once more stresses the need to improve training of prison officials to restrict the spread of HIV/AIDS amongst offenders and to better care for those infected, but fails to mention the fact that prison officials themselves might contract the disease. Similar omissions are to be found in the 2007 UNAIDS report on the "Effectiveness of Interventions to Manage HIV in Prisons".[10] These omissions are also to be found in the literature on HIV/AIDS in South African prisons, where the emphasis of research has been on the high incidence of the disease amongst inmates and on the inadequacy of treatment and care afforded to them.[11]

Where attention has been directed towards prison officials, this has focused on their lack of knowledge and awareness of HIV/AIDS[12] and on ways to prevent spread of the disease. Somewhat surprisingly, this writing, for the most part, assumes that prison officials have escaped infection by a disease which is ravaging the communities in which they live. This omission in the research on correctional institutions is a serious one. Research on other large public institutions in Africa, such as the military[13] and the police[14], have illustrated both the extent to which their members have contracted the disease as well as its deleterious effects on the operational efficiency of these bodies. Underscoring the effects on the epidemic on the public sector at large, Pharoah and Schönteich assert that "HIV/AIDS on an epidemic scale could detrimentally affect the capacity of governments as

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Organisation and the Joint United Nations Programme on HIV/AIDS, Vienna, Accessed on 30 September 2006 at data.unaids.org/pub/Report/2006/20060701_hiv-aids_prisons_en.pdf

[10] UNAIDS, (2007), *Effectiveness of Interventions to Manage HIV in Prisons – HIV Care, Treatment and Support*, Geneva, Accessed on 30 September 2007 at http://www.who.int/hiv/idu/

[11] See Goyer, K., (2003), "HIV/AIDS in Prison, Problems, Policies and Potential", Institute for Security Studies, Discussion Paper, Pretoria, and and Goyer, K., Saloojee, Y., Richter, M., Hardy, C., (2004), "HIV/AIDS in Prison: Treatment, Intervention and Reform", A submission to the Jali Commission on behalf of the AIDS Law Project and the Treatment Action Campaign, Accessed on 25 September at www.ceehrn.org/EasyCEE/sys/files/PrisonSatellite-background.pdf

[12]See Rotily, M. al, "Conaissance et attitudes du Personnel de surveillance pénitentiare face au HIV et/ou sida: une enquête européene", (Knowledge and attitudes of prison staff towards HIV/AIDS : a European Survey), *Santé Publique*, Vol. 13 No. 4. and Dursin, R., "Indonesia: Prison Officials' Ignorance Hampers Drive vs HIV/AIDS", *Inter Press Service*, 3 May 2004. Accessed on 10 September 2007, at http://www.aegis.com/news/ips/2004/IP040501.html

[13] See Rupiya, M.(ed), *The Enemy Within*, Institute for Strategic Studies, Pretoria, Accessed on 5 October 2007 at http://www.iss.co.za/dynamic/administration/file_manager/file_links/CHAP4EW.PDF?link_id=27&slink_id=3703&link_type=12&slink_type=13&tmpl_id=3

[14] Masuku, T, (2007), "Impact of HIV/AIDS on National Police", Working Paper, Clingendael and Social Science Research Council, Accessed on 5 October 2007 at http://asci.researchhub.ssrc.org/impact-of-hiv-aids-on-national-police/resource_view

civil servants experience illness and death, resulting not only in labour and productivity losses but also the loss of institutional memory. AIDS may decimate the ranks of skilled administrators and other government employees and diminish the reach or responsiveness of governmental institutions, or reduce their resilience."[15]

LEGISLATION AND POLICY TO ADDRESS HIV/AIDS IN SOUTH AFRICA

During the past decade a number of pieces of legislation have been promulgated to address the issue of HIV/AIDS in the work place, both directly and indirectly. These are the Compensation for Occupational Injuries Act, No. 130 of 1993, the Occupational Health and Safety Act, No. 29 of 1996, the Employment Equity Act, No. 55 of 1988, the Medical Schemes Act, No. 131 of 1998 and the Promotion of Equality and Unfair Discrimination Act, No.4 of 2000. Much of this legislation, however, deals with HIV/AIDS indirectly, placing emphasis on the legal rights of those affected to fair treatment and non-discrimination. Successive HIV/AIDS Strategic Plans (2000-05 and 2007-11 respectively) formulated by the South African National Council on AIDS (SANAC), provide an elaborate outline for minimising the spread of the disease and for treating those affected, but say little about the implications for management resulting from the epidemic. More recently, as shall be discussed below, the DCS has established a framework for the implementation of its own HIV/AIDS programme.[16]

The Department of Labour's "Code of Good Practice: Key Aspects of HIV/AIDS and Employment" published in 2000, provides an important framework for addressing HIV/AIDS in the workplace. Significantly, it stresses the need for an integrated approach to managing the disease, "(s)ince the HIV/AIDS epidemic impacts upon the workplace and individuals at a number of levels, it requires a

[15] Pharoah, R., and Schönteich, M., "AIDS, Security and Governance in Southern Africa – Exploring the Impact, ISS Paper 65, Institute for Security Studies, January 2003, p. 6.
[16] Department of Correctional Services (2007), "Framework for the Implementation of Comprehensive HIV and AIDS Programmes and Services for Offenders and Personnel 2007-2011", Pretoria.

holistic response which takes all of these factors into account."[17] The areas which the Department of Labour Code addresses are as follows:

- "creating a safe working environment for all employers and employees;
- developing procedures to manage occupational incidents and claims for compensation;
- introducing measures to prevent the spread of HIV;
- developing strategies to assess and reduce the impact of the epidemic upon the workplace; and
- supporting those individuals who are infected or affected by HIV/AIDS so that they may continue to work productively as long as possible."[18]

The Code proposes the development of workplace policies aimed at preventing the spread of the disease amongst employees and their communities; the management of HIV positive employees so that they are able to work productively for as long as possible; and management of the direct and indirect costs of HIV/AIDS in the workplace.[19] It also advocates for the development of risk profiles and assessments of the direct and indirect costs of HIV/AIDS.

Department of Correctional Services Policy on HIV/AIDS

This research revealed that whilst the Department of Correctional Services had developed a relatively coherent (albeit unevenly implemented) programme for the prevention and treatment of HIV/AIDS amongst inmates,[20] its Framework policy had yet to be released and it had yet to implement systematic measures to manage the disease amongst its own staff. In practice, the investigation found that correctional centres appeared to treat programmes to prevent the spread of the disease and to manage its impacts as additional, rather than integral, to their normal responsibilities. In other words, at the Department was largely reliant on national HIV/AIDS programmes and on the policies which emanate from them. As a consequence of this, correctional centre managers did not appear to

[17] Department of Labour, (2000), "Code of Good Practice: Key Aspects of HIV/AIDS and Employment", *Government Gazette*, Vol. 426, No. 21815, Pretoria. p.5
[18] Ibid.
[19] Department of Labour, (2000), op. cit., p 12.
[20] This is evident in the DCS Strategic Plan and in various in-house policy documents.

have adapted national HIV/AIDS programmes to their own realities and such initiatives had, in effect, become an 'add on" to the normal activities of correctional institutions. This was evident from the fact that in the correctional centres visited limited, or no, staff had been assigned specifically to run HIV/AIDS prevention programmes amongst DCS officials or specifically to support those who might be suffering from the disease.

Officials in all correctional centres visited reported that training courses and lectures were extended to correctional centre staff several times a year. These courses were offered by external organisations (NGOs) as well as by officials from DCS regional and national offices. Staff attendance of HIV/AIDS training programmes is voluntary and it was reported in one correctional centre that, except when lunch was included, attendance was very low. However, whilst all correctional centre officials reported that their medical staff presented lectures on how to avoid contracting the disease, there was no policy available on how to manage officials who had already contracted the disease, still less attention was being paid to succession planning and to anticipating the full impact of the pandemic on the running of correctional centres. To that extent, at the time of this research, the DCS appeared to be focussing its attention on its client community (inmates) and had yet to address the needs of its own staff.

THE INCIDENCE OF HIV/AIDS IN SOUTH AFRICA

It is widely accepted that HIV infection rates within the general population of South Africa are amongst the highest in the world. Whilst there is disagreement over the precise numbers of those infected and the rate at which the disease is spreading, the Government's own statistics suggest that the problem is a severe one. In 2005 the Department of Health's estimated an overall infection rate of 16.25%, whilst 18.7%, or 4.9 million, of those aged 15 to 49 years (the principle working cohorts) were estimated to be HIV positive.[21] The highest incidence of the disease was reported to be in KwaZulu-Natal, Mpumalanga, Gauteng, and the North West provinces respectively. At the same time, the Actuarial Society of South Africa estimated that in 2003 26% of adults in KwaZulu-Natal,

[21] Department of Health (DOH), (2006), *National HIV and Syphilis Ante-Natal Sero-prevalence Survey in South Africa', 2005,* Pretoria, Accessed on 5 October 2007 at http://www.doh.gov.za/docs/hiv-syphilis-f.html p.17.

22% in Gauteng, 21% in Mpumalanga and 20% in the North West provinces were HIV positive.[22] These statistics suggest that between 1 in 4 and 1 in 5 adults in the primary working age cohorts in these provinces are currently HIV positive, with an unknown, but likely significant, proportion of them living with AIDS.

Of particular concern, is the fact that so many people are still in the asymptomatic phase of HIV and, in the absence of widespread voluntary testing, most of these are unaware of their status and are continuing to engage in risk behaviour. As the 2007-2011 HIV/AIDS and STI Strategy Plan affirms, "(a)lthough the rate of the increase in HIV prevalence has slowed down in the past five years, the country is still to experience a reversal in trends. There are still too many being newly infected with HIV."[23] For risk managers in the South African public service the message is clear: the threat posed by the epidemic is likely to become worse before it becomes better.

The Incidence of HIV/AIDS among Correctional Staff

An HIV Prevalence Survey conducted on behalf of the Department and released in late 2007, found that the national HIV infection rate amongst all staff was 9.8%, lower than the national estimate of 16.25%.[24] However, disaggregated, the DCS survey reveals patterns which are similar to national norms. Thus, the KwaZulu-Natal region recorded an infection rate of 22.7%, indicating that roughly one out of every four individuals in the correctional system is HIV positive. This prevalence rate is also similar to estimates of infection rates amongst the general population. The table below provides prevalence rates across the different correctional regions.

[22] Actuarial Society of South Africa. 2005. *ASSA 2003 Summary Statistics*. Accessed on 5 October 2007 at http://www.assa.org.za/aids/content.asp?id=1000000449

[23] South African National AIDS Council (SANAC), (2007), *HIV/AIDS and STI Strategy for South African 2007-2011*, Pretoria, Accessed on 30 September 2007 at http://data.unaids.org/pub/ExternalDocument/2007/20070604_sa_nsp_final_en.pdf p.8.

[24] It must be noted that the DCS prevalence survey was not without flaws, as only 37/1% of those selected in the sample agreed to participate. This amounted to 3.4% of the total number of officials in the Department. No indication is provided in the survey report as to how this might have influenced the validity of the sample. It is also not clear whether non-participation occurred evenly across all categories of employees, for example at production level, middle management or top management.

Table 1: Provincial HIV Prevalence Rates amongst DCS Officials 2006

Region	HIV Prevalence
KwaZulu-Natal	22.7%
Limpopo/North West/Mpumalanga	14.4%
Eastern Cape	12.1%
Gauteng	4.5%[25]
Free State/Northern Cape	4.0%
Western Cape	2.6%

The survey found that the bulk of those infected (87.2%) were in the age cohort of 26 to 45 years. It further found that 93.6% of HIV positive staff was employed at the 'production level', meaning that they were involved either in the direct management of offenders or in providing support services. No statistics were provided on prevalence rates by age cohort. Middle managers comprised 5.5% of those infected, while senior managers made up just 0.9% of the number. However, the data on prevalence rates amongst managers must be questioned in that, in the words of the report, "senior managers (not a majority but still a sizeable number) would not make themselves available at the testing stations on the day of the survey."[26] Whilst the possibility of under-reporting exists in the prevalence survey, the findings as they are confirm the seriousness of the challenge facing the correctional services in South Africa.

At the level of the individual correctional centres visited, none of the managers or health officials could provide an estimate of the number of their staff who might be HIV positive. This, as will be discussed, was a consequence of a general reluctance amongst members to undergo voluntary counselling and testing (VCT). Furthermore, it was reported, in those instances where individuals did

[25] It is important to note that the Gauteng region was used in the survey pilot and only 8.7% of those sampled participated in the survey. As a consequence, the prevalence rates recorded have to be treated with some circumspection, given the estimated rates prevailing in the general population (22%).
[26] Lim'Uvune Consulting (2007) p. 5

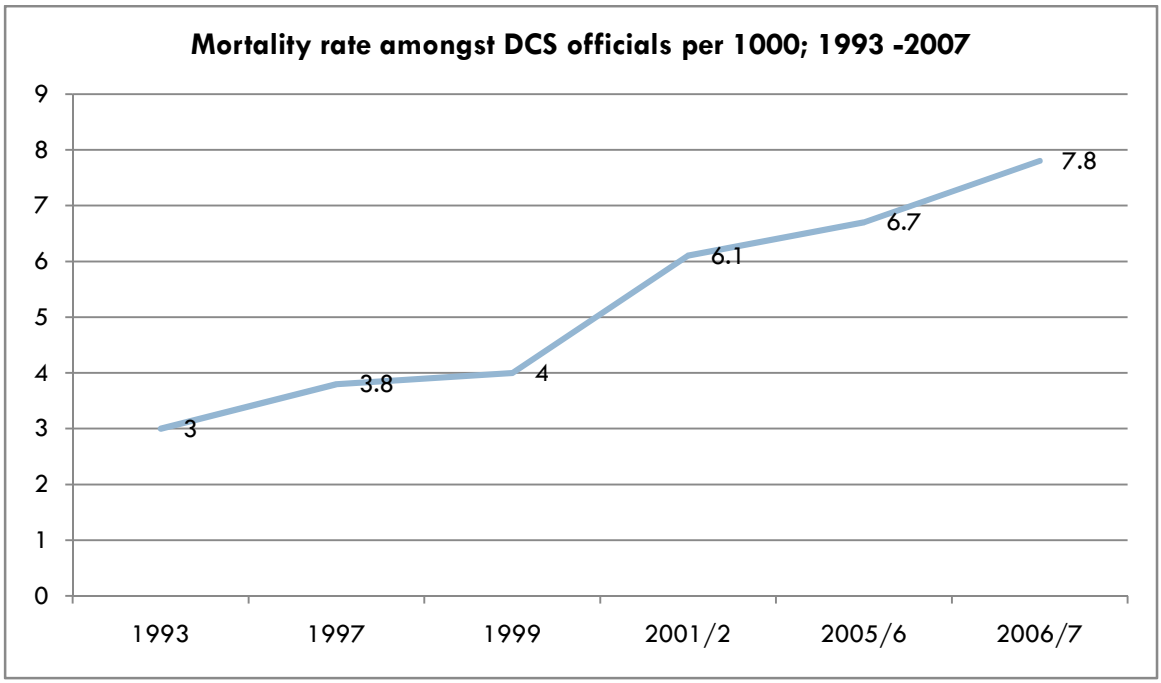
undergo testing at private clinics, for reasons of confidentiality, the outcome was never communicated to them. Sick and death certificates submitted to the Department by or, on behalf of, staff seldom if ever record the fact that the ailment or death is AIDS related.

Despite the lack of data, it would not be unreasonably to assume that infection rates in individual centres will bear some relationship to those found in the communities from whence members were recruited, even assuming that HIV/AIDS awareness programmes have had some success in reducing seroprevalence rates amongst staff. Indeed, the evidence of senior correctional officials, medical and human resources staff and from inmates alike, suggests that the incidence of the disease is wide-spread and that significant numbers of officials are suffering from the disease and that others have died from its effects.

Whilst there is no published record of the causes of death amongst correctional officials, it is noteworthy that the mortality rate of officials nationally who died in office, increased from 3 per 1000 in 1993 [27] to 6.1/1000 in 2001[28], and to 7.8/1000 in 2007[29] - more than doubling over the 14-year period. To an extent, this increase follows the growth in the mortality rate of inmates, which has increased from 1.65 deaths per 1000 in 1995 to 9.2 per 1000 per thousand in 2005,[30] and which is generally accepted to be related to the AIDS epidemic.

[27] Department of Correctional Services, (1994), *Annual Report 1993,* Table 16.
[28] Department of Correctional Services, (2002), *Annual Report 2001/02*, Pretoria, p. 25. Accessed on 5 October 2007 at http://www.dcs.gov.za/Annualreport/DCS%20Annual%20Report%202002.pdf
[29] Department of Correctional Services, (2007), *Annual Report 2006/07*, Pretoria, p.144. Accessed on 18 October 2007 at http://www.dcs.gov.za/Annualreport/DCS%20Annual%20Report%202007.pdf
[30] Judicial Inspectorate of Prison, (2006), *Annual Report for the period 1 April 2005 to 31 March 2006*, Cape Town. Accessed on 18 August 2007 at http://judicialinsp.pwv.gov.za/Annualreports/ANNUAL%20REPORT%202006.pdf p.34.

Figure 1



Further, indirect, evidence of the impact of HIV/AIDS on mortality rates is to be found in the Pietermaritzburg Management Area, where it was reported that out of a staff compliment of 1 131 there had been 17 deaths (1.5% of the total) during the period from February to July 2006 alone. Although the causes of death were never disclosed[31] to have been AIDS-related, the fact that the majority of those who had died were young and had suffered symptoms characteristic of the disease, was seen by officials as evidence of the fact that they contracted the virus. Officials in all correctional centres visited, reported that they both had colleagues who had died of AIDS as well as colleagues currently suffering from the disease. According to one official interviewed "we are facing a catastrophe here".

[31] It was reported that death certificates typically reflected that an individual had died from a symptomatic disease such as pneumonia or tuberculosis.

Voluntary Counselling and Testing

Correctional officials are encouraged to undergo voluntary counselling and testing (VCT), but not all correctional centres visited offered this service. However, it is unlikely, under the circumstances prevailing, that even if VCT was available that this would have influenced officials to undergo testing. It was reported that in correctional centres which offered VCT, the take-up rate was extremely low, even amongst managerial staff. As the 2006 DCS Annual Report confirms, "VCT is encouraged but officials are referred to external service providers. As it is voluntary very few present themselves for testing."[32] At the Qalakabushe Correctional Centre, which is a designated ARV roll-out centre, it was reported that no more than three officials out of a staff complement of some 600, had undergone VCT when it was offered at the centre.

The reasons cited for the reluctance to undergo testing were principally that the process was too public and, linked to this, the very fact that an individual had decided to undergo a test raised suspicions that he or she might have contracted the virus. A second factor cited was that there was a strong socio-cultural resistance to discuss any matters related to sexual practice. A third factor mentioned was that individuals were afraid to know their status, even when symptoms of the disease were evident. This state of denial, it was maintained, frequently persisted throughout an official's illness. A further dimension of the fear of disclosure relates to an unfounded belief that individuals might lose their jobs should their status become known to centre managers. In that respect, the DCS prevalence study report noted that many "personnel simply refused to participate" in the survey because they believed that the Department will medically board all those found to be HIV positive.[33]

In the centres visited it was reported that as a consequence of low levels of VCT and equally low levels of participation in HIV/AIDS prevention programmes, many officials knew very little about the disease, its modes of transmission and the potentially life-saving effects of ART. In this context, many officials still viewed HIV/AIDS infection as a death sentence. Partly as a consequence of this lack of knowledge and partly as a consequence of a fear of stigmatisation, the use of ARTs amongst officials was reported to be extremely low.

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[32] Department of Correctional Services, (2006), *Annual Report for the 2005/06 Financial Year*, Pretoria, Accessed on 5 October 2007 at http://www.dcs.gov.za/Annualreport/DCS%20Annual%20Report%202006.pdf

[33] Invume (2007) p. 27

Aggravating the fear of voluntary testing is the fact that the principle of confidentiality appears not always to be adhered to in its strictest form. Thus, for example, in a meeting with health and human resources officials conducted during the course of this investigation, the names of those staff members known to be HIV positive were openly discussed with the researcher, and there was speculation about the status of others who were known to be frequently ill.

The Impacts of Stress

It is generally recognised that most frontline officials in the correctional system, that is those working directly with inmates, operate under conditions of stress. This stress arises primarily through fear of violent assault by inmates, a state of anxiety which is heightened by high levels of overcrowding (which compromises effective control of inmates) as well as by staff shortages. This pressure, which is aggravated by long hours, is known to affect all staff to a greater or lesser extent and in extreme cases it has been known to lead a variety of nervous disorders. Health officials in the centres visited suggested that stress adversely affects the immune system and accelerates the progression from asymptomatic HIV to full-blown AIDS. Whilst there is no scientific research to corroborate this view, it was reported that staff not infrequently die within 18 to 24 months of becoming ill.

Fear of Stigmatisation

It was readily apparent in all the centres visited, that fear of stigmatisation is the single greatest constraint to any programme introduced to prevent and manage the impact of the disease. The factors that give rise to stigmatisation, or fear of stigmatisation, are complex and deeply rooted in the social and psycho-cultural fabric of a society. Furthermore, as Deacon et al point out, "(s)tygmatisation is.. a social process that is constantly changing and being reformulated in different social contexts."[34] Thus, they maintain, the content of HIV/AIDS stigma varies:

> *"..according to who is doing the stigmatising. Different cultural, biological, situational, social or political contexts also influence the content of and intensity of stigmatising beliefs. These include perceptions about the cause and origins of the disease, the extent of individual responsibility for contracting it, the nature of the disease biology, the course of the epidemic or*

[34] Deacon, H., Stephey, I., and Prosalendis, S., (2005), *Understanding HIV/AIDS Stigma: A Theoretical and Methodological Analysis*, HSRC Monograph Series, Research Programmes on Social Cohesion and Identity and the Social Aspects of HIV/AIDS and Health, Cape Town, p. 50.

the disease in a specific individual, the level of uncertainty in lay and medical knowledge, the situational context of an interaction, and broader legal, social and economic factors."[35]

The factors which give rise to this fear of stigmatisation, discussed briefly below, are complex and have multiple determinants. The fear, nevertheless, is pervasive and reaches all levels of a centre's administrative hierarchy to the extent that there was, in the centres visited, a palpable conspiracy of silence on the issue.

It is evident that the stigma attached to the disease is of such gravity that the majority of officials would rather die than risk disclosure and many, indeed, do. It was reported that even in instances where officials were clearly suffering from the disease, they refused to access to available anti-retroviral therapy (ART) because this would provide concrete evidence to others that they were suffering from AIDS.

Correctional officials generally live in relatively closed communities, whether within the precincts of a correctional centre itself or in close proximity to it. Furthermore, the nature of correctional work is such that staff, and particularly those in operational positions, tends to socialise more frequently with each other than with outsiders. Under such circumstances, the fear of ostracisation is acute. Like any popularly conceived plague, those living with an infected person suffer stigmatisation by association. Officials spoke of the fear of isolation which staff believed they would confront should it be known that they were HIV positive. This isolation, it was stated, would extend to an individual's entire family, such that their neighbours would instruct their children to avoid all contact with their own children. Whether or not stigmatisation ever truly occurred to the degree suggested is uncertain. However, it is certain that the fear of stigmatisation is at a high level in all of the centres visited and that this shapes officials' decision-making and behaviour.

In general, it was reported, so great is the stigma associated with the disease, that officials who actively and enthusiastically promote the practice of safe sex and the importance of testing, are themselves sometimes suspected of having contracted HIV. Why else, it was suggested, would they be so concerned about fighting the disease. Whilst this perception is unlikely to be widespread, it is reflective of the challenges faced in managing the disease amongst DCS staff.

[35] Deacon, H., Stephey, I., and Prosalendis, S., (2005), ibid.

It is evident that there is likely to be a multiplicity of factors that act as triggers to the stigmatisation of HIV/AIDS sufferers amongst DCS officials. For example, the ethic espoused in the White Paper's assertion that "a correctional official must be willing to account for his or her behaviour and in the process be correctable … (because) (t)his value also sets a good example for offenders."[36] could, inadvertently, further contribute to the fear of stigmatisation following disclosure. Since the high incidence of the disease amongst inmates is widely known, the disclosure that correctional officials have themselves contracted the disease could be seen as tantamount to having lowered their status to the level of offenders.

A further manifestation of the stigmatisation process, it was reported, was evident in the manner in which officials made fun of HIV/AIDS and derided those who were believed to have contracted it. Labelling someone an AIDS sufferer, whether or not they had contracted the disease, it was stated, was intended as a means of denigration. This practice, furthermore served to reinforce a sense of denial amongst officials. By joking about the disease in this way, they were, effectively, attempting to distance themselves from the prospect that they might themselves have contracted the disease. It was reported that this pattern of denial was evident even amongst those whose health suggested they might be suffering from HIV and AIDS.

It was also reported that it is considered taboo, and highly disrespectful to a deceased's family, to mention AIDS at the funeral of someone who had likely died as a result of the disease. This sense of denial, as indicated, is further reinforced by the fact that death certificates typically record the proximate causes of death and make no mention of the HIV/AIDS virus.

THE IMPACTS OF HIV/AIDS ON PRISON GOVERNANCE

The Department's policy Framework acknowledges the threat to correctional services by the HIV virus and spells out a range of measures to combat the spread of the disease. Derived from the National Strategic Plan 2007-2017 for HIV/AIDS and STDs, the overall objectives of the Framework are stated to be as follows:

[36] DCS (2005) p. 8

- to communicate HIV and AIDS programmes and services to all offenders and personnel;
- to implement comprehensive HIV and AIDS programmes and services for all offenders and personnel;
- to review, align and develop new policies;
- to capacitate offenders and personnel;
- to monitor the implementation of HIV and AIDS programmes;
- to monitor the impact of HIV and AIDS programmes and services among offenders and personnel;
- to facilitate and initiate research on activities relevant to HIV and AIDS.[37]

Correctly, the Framework focuses on preventing the spread of HIV/AIDS by raising awareness, encouraging VCT and by promoting measures to protect the human rights of those infected with the HIV and AIDS and to provide for their needs. However, the Framework is noticeably silent on the impact which HIV/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 on running of these institutions.

Whilst some headway has undoubtedly been made in addressing the disease amongst inmates, there is little evidence that serious consideration has been given to its existence amongst prison officials. Thus, whilst the Department's 2006/07 Annual Report (the most recent available) records that a "Draft Employee Health and Wellness Policy and procedure manual has been formulated which includes HIV/AIDS"[38], it is noteworthy that the "categories of employees identified to be at high risk of contracting HIV and related diseases", are stated to be "nurses and officials working in sections in correctional centres"[39], rather than the staff complement as a whole.[40] Indeed, it would appear that

[37] Department of Correctional Services (2007), "Framework for the Implementation of Comprehensive HIV and AIDS Programmes and Services for Offenders and Personnel 2007-2011", Pretoria.
[38] Department of Correctional Services (2007) *Annual Report for the 2006/07*, op. cit, p.157.
[39] Ibid. p.157.

that the disease is still considered to be largely an occupational hazard rather than a pandemic that threatens all people living in South Africa.

The findings of this investigation suggest a major problem in human resource management, the extent of which is yet to be fully recognised by DCS officials while it is steadily growing in magnitude. It also points to a situation which, if left unchecked, will unquestionably compromise the operations of many correctional institutions across the country and will materially affect the goals and strategic plans of the Department due to staff attrition, and full or partial incapacitation.

It would appear that the full extent of the impact of HIV/AIDS on the governance of correctional centres has yet to be fully recognised by the Department of Correctional Services. As a consequence, specific measures to mitigate the impact of the disease on the management of the Department are still to be instituted.

Staff Attrition

The DCS prevalence study revealed that infection rates amongst DCS officials roughly track those in the surrounding population, implying that at least a proportion of staff have full blown AIDS. Indeed, officials in all centres visited reported the attrition of staff due to HIV/AIDS and it is likely (given trends elsewhere in the regions visited), that the incidence of the disease is on an upward curve and that its fullest impacts have yet to be felt. Staff attrition, furthermore, does not only occur due to deaths, but also to illness and a general inability to fulfil work responsibilities. Although the death of staff has yet to reach levels which significantly affect the day-to-day running of the centres visited, such losses are not insignificant.

Typically, officials who are ill rapidly exhaust the 36-sick leave days available to them over a three-year cycle. In such circumstances they are obliged to apply for Temporary Incapacity Leave (TIL) until such time as they are able to recover sufficiently to resume work. At the centres visited it was reported that there had been an increase in TILs during the course of the past five years. At Leeuwkop Correctional Centre it was reported that there had been 14 long term TILs (out of a staff

[40] Somewhat paradoxically, nurses with their training and detailed knowledge of HIV/AIDS are probably the least likely staff to contract the disease.

complement of 1200) in a 20 month period during 2004 and 2006. This was in addition to numerous TILs of one month's duration or less.

Whilst the loss of staff through medical boarding or death adversely affects the operations of all correctional centres, these losses are most acutely felt when officials with special skills or experience are involved. Such losses aggravate an already acute shortage, which is evident in the vacancy rate amongst professional staff which nationally stood at 24.5% in 2007.[41] For example, it was reported in the Pietermaritzburg prison, that the death of an official responsible for the management of the prison farm had led to the termination of a number of rehabilitation programmes. The impact of staff attrition, consequently, cannot be considered purely in numerical terms. The seniority of the officials concerned and their span of control are equally important factors in assessing the impact which the loss of staff might have on prison governance. It was reported that most of those who appear to have contracted or to have succumbed to HIV/AIDS have been from the junior ranks of officials, a fact confirmed by the prevalence study. However, it was stated that the loss of even junior members of staff resulted in a loss of skills and experience, in that it took three to five years for officials to reach optimal efficiency even at these levels.

Impacts on Remaining Staff

The illness and death of officials has an adverse effect on their surviving colleagues. The absence of sick staff, and the death of others, inevitably adds to the work load of those who remain in office by lengthening shifts and lessening days off. It also serves to aggravate already existing staff shortages and compounds the threat to staff security. The 'buddy system', set in place to promote greater staff security, in particular, is compromised if one partner is ill or has passed away and is not replaced or is not replaced with a person of similar or higher skill and ability. It was also reported that the illness and death of officials adversely affects the morale of all staff, and this was accentuated by the frequent attendance of funerals of deceased colleagues.

The illness and death of staff also compromise the system of Unit Management. Officials who are sick but on duty lack the energy to conduct their duties in the manner expected of them. This, for

[41] Department of Correctional Services, (2007), op.cit. p.138

example, can lead to delays in the preparation of reports for the Case Management Committee and the Correctional Supervision and Parole Board. Inmates interviewed complained that when warders were clearly at an advanced stage of the disease they were frequently off sick and this led to staff shortages in a unit, and, consequently longer periods of lock-up for themselves by the staff on duty, concerned about security issues. It is also evident that increasing numbers of sick officials pose a threat to rehabilitation programmes, which constitute a central component of the White Paper on Corrections.

The loss of officials to the HIV/AIDS epidemic threatens to undermine the Department's commitment to address already existing staff shortages. Both the White Paper and the Strategic Plan emphasise the need to recruit new staff, both to support the introduction of the seven-day establishment and to improve inmate/member ratios.

Succession Planning

At present, succession planning for those who have contracted full-blown AIDS is reported to be constrained by the fact that extremely few infected officials disclose their status. As infected officials, in general, are either unaware of their status of else refuse to consider using ART, there is a progressive onset of the disease and as they become weaker and weaker they become increasingly incapable of carrying out their responsibilities. They are also repeatedly booked off sick and for longer and longer periods until they ultimately die. However, as they are never officially diagnosed as suffering from HIV/AIDS, it is not possible for centre managers to embark on any form of succession planning. In this context, steps to recruit new staff can only be initiated once an official is medically boarded or dies in office. Centre managers stated that whilst they generally knew when an official had AIDS (from repeated and increasingly prolonged illness), in the absence of voluntary disclosure, there was nothing that could be done to anticipate and plan for the employee's replacement. It was reported that many of those who were believed to be suffering from AIDS were young and that they feared losing their medical benefits and pensions if they were medically boarded and this acted as a further disincentive to disclosure.

It is evident, furthermore, that staff recruitment practices vary from region to region. Whilst some centres reported relatively quick recruitment procedures of three months or less, others maintained

that it could take up to 12 months to replace an official who had been medically boarded or who had died. Aggravating this state of affairs, it was reported that in some instances it had occurred that the replacement recruit, in turn, became ill and rapidly became incapacitated. In regions were there is a significant incidence of HIV/AIDS amongst the general population, the likelihood of this occurring is high, particularly as there is no formal process for VCT which would encourage new recruits towards voluntary disclosure and, hence, towards the possibility of succession planning.

Official Assistance to Staff who are HIV positive

In the centres visited, there were no officials who were specifically trained and assigned to support staff with HIV/AIDS, although this is an area targeted for improvement by the Framework. Responsibility for the general welfare of staff currently fell to Employee Assistance Practitioners (EAPs), who provided assistance to employees who had disclosed their HIV status. However, two of the six centres visited had no EAPs, whilst those that did, generally had too few to offer meaningful support to the entire workforce. In the Pietermaritzberg Management Area there was just one EAP for some 1 400 employees. When it is borne in mind that EAPs carry a broad range of responsibilities relating to employees' conditions of service (pensions, leave etc.), it was evident that they had relatively little time available to support HIV/AIDS infected officials, even in the limited number of cases where their status was disclosed. At best, staff members were alerted to the dangers of contracting the disease whilst on duty, either through needle-stick injuries incurred whilst treating HIV positive inmates, from stab wounds inflicted by gang members, or by any way coming into contact with contaminated blood.

During the preceding two years, six HIV and AIDS Management Area Coordinators were appointed as part of a pilot programme funded by USAID. Their brief is to ensure effective implementation of HIV/AIDS programmes amongst staff and offenders in the prisons under their jurisdiction. Amongst staff, the activities which they oversee include HIV and AIDS awareness programme and promotion of VCT. Whilst this initiative represents an important step in addressing the disease amongst staff, it is noteworthy that the individuals were appointed on 12-month contracts and did not form part of the permanent staff establishment. Their number is also too few to impact significantly on the administrative practice of individual centres. Recognising this shortcoming, the Framework

underlines the need to "train health care professional in the Comprehensive Management of HIV and AIDS and related diseases." [42] It further stresses the need to establish wellness centres for DCS staff.

In the absence of formal policy guidelines to direct them, centre managers reported that they resorted to ad hoc measures in their attempt to manage staff who appear to be suffering from HIV/AIDS. These included the reassignment of staff from operational to administrative duties and reduction of their working days to a four hour shift. Such decisions are taken after consultation with the health risk manager when an employee has suffered from repeated and prolonged periods of illness.
Centre managers interviewed stated that they were at a loss as to what to do with colleagues who appeared to be suffering from AIDS. It was stated that there were no procedures or standing orders to follow and each manager was left to his or her own devices in managing colleagues too weak to perform their duties.

Although ART is not available to DCS officials through the DCS health structures, it was reported that ART are readily available through the officials' medical aid schemes. The decision to forgo VCT and possible ART, as a consequence, appears not to be determined by the availability of these services, but is attributable to fear of stigmatisation and other socio-cultural and socio-psychological factors. In that respect, it was noteworthy that, unlike the situation which pertained amongst inmates in several of the centres visited, there were no peer support groups for officials living with HIV and AIDS and infected individuals were left to manage their illness on their own. Again, the Framework proposes training "personnel to establish, facilitate and sustain support groups for both infected and/or affected offenders and personnel."[43]

The Role of Leadership in Combating HIV/AIDS

In any large institution, it is axiomatic that the leadership has a critical role to play in advancing any new policy and in ensuring its effective take-up by subordinate officials. In that respect it was reported by correctional centre health officials that, with notable exceptions, centre managers displayed little direct interest in the HIV/AIDS programmes presented to DCS officials and none were willing to undergo voluntary testing as an example to others. In one centre it was reported that even during an 'off campus' leadership retreat, only three out the twenty senior officials present were

[42] DCS, (2007), op. cit. p. 10
[43] DCS, 2007, Ibid, p. 12

willing to undergo the voluntary testing that was made available. The evident lack of interest in VCT displayed by the leadership of correctional centres, it was stated, acted as a disincentive to more junior members of staff. In a similar vein, as indicated, the report of the DCS HIV surveillance survey noted that senior managers avoided the testing stations on the day of the survey."[44]

Secondary Impacts

Whilst the infection of staff members impacts directly on their health and operational ability, it is also evident that the infection of family members of officials adversely affects their performance. It was reported that some officials were responsible for nursing sick partners or family members and that this contributed to absenteeism. It was also stated that sick family members add to a member's financial burdens and aggravate their stress levels. It was mentioned, for example, that officials sometimes had to take care of the orphans of family members who had died. In this context, it is clear that the presence of the disease in the custodial community has a multiplier effect which extends beyond individual members and their families, to extended family networks which entail an array of socio-economic obligations and reciprocities. As the group Development Works observes that "(t)he impacts of HIV and AIDS cannot be reduced to impacts on an individual infected or household affected. The spread of HIV and AIDS are systematic and fundamentally transform the local development and governance context."[45] The impacts of the disease on an institution, they suggest, are generally far reaching and are frequently subtle and indirect.

Impacts on Inmates

Inmates interviewed during the course of this investigation reported that they were generally aware when a member of staff was suffering from AIDS. This was evident, it was stated, in their protracted sick leave and increasing lethargy. Whilst it was reported that some inmates took advantage of these situations, it was generally felt that they served to disadvantage inmates through diminished opportunities for extra-unit activities and, as indicated earlier, through longer lock-up periods. Recreational activities, in particular, could be curtailed in this way.

[44] Lim'uvune Consulting (2007), p.5.
[45] Development Works; 2005:11

Inmates also reported that the loss of an official frequently set back the rehabilitation elements of Unit Management. Implicitly, this approach depends on the development of a trusting relationship between an inmate and an official. Such relationships, which are built up over time, end summarily when an official dies or is medically boarded, often leaving inmates disillusioned and frustrated, particularly if they fail to establish the same rapport with his or her replacement.

Experiences of the Military

The experiences of the South African National Defence Force (SANDF) in combating HIV/AIDS are instructive. Confronted with an estimated HIV infection rate of 23% amongst staff, the SANDF embarked upon a number of proactive measures to stem the tide of the disease. These include a concerted programme to promote VCT, which resulted in some 80% of staff undergoing testing. It must, however, be noted that the SANDF was assisted in this process by the fact that all staff volunteering for international peacekeeping missions are obliged to undergo testing. This requirement has helped to promote the practice of voluntary testing, which, in turn, has assisted the SANDF in promoting ART and other forms of support to infected officials.[46]

In the Zambian Defence Force members are encouraged, after counselling, to disclose their status to health workers and to their superiors.[47] Integral to this process is strict adherence to a policy of confidentiality, as well as a concerted initiative to de-stigmatise the disease. In addition to disclosure in the workplace, members are strongly encouraged to disclose their status to their spouses and partners. By emphasising the possibility of effective management of the disease, and thereby prolonged life, by early disclosure, and by stressing the government's commitment to supply ART to HIV positive members both during and after their service in the defence force, the programme has succeeded in significantly increasing the proportion of staff who undergo VCT.[48]

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[46] It must be noted, however, that the SANDF has been challenged in court for infringing the human rights of personnel who were reportedly coerced to undergo testing.

[47] Phiri, A., and Simapuka, L., "HIV/AIDS in the armed forces: Policy and mitigating strategies in Zambia", in Institute for Strategic Studies, *The Enemy Within*, Pretoria, p.114, Accessed on 5 October 2007 at http://www.iss.co.za/dynamic/administration/file_manager/file_links/CHAP4EW.PDF?link_id=27&slink_id=3703&link_type=12&slink_type=13&tmpl_id=3

[48] Ibid. p. 119

REMEDIAL MEASURES

The launch of the Department's Framework policy, as indicated earlier, represents an important initiative in addressing the impact of HIV/AIDS on the correctional system. In addressing the challenges posed by HIV/AIDS, nevertheless, it is clear that the DCS will need to embark upon a multi-dimensional programme to mitigate the impact of the disease on the governance of correctional centres. In particular, it is evident that the management of HIV/AIDS amongst correctional officials cannot continue to be considered as an "add on", which merely forms another component of human resource management. The challenge, as Pharoah, succinctly states, is to develop an integrated approach:

> *"(A)n effective workplace response to HIV/AIDS requires understanding the nature of the threat, acknowledging the problem, and mainstreaming HIV/AIDS into the organisation's core functions. It also requires putting into place measures to prevent new HIV infections, treating and caring for employees living with HIV/AIDS, and mitigating the effects of AIDS related attrition on the institution itself. Successful execution of these strategies, in turn, requires committed leadership; a clear well thought out policy framework; and dedicated staff to guide and co-ordinate implementation, as well as sufficient resources, capacity building; and communication strategies to translate plans into action."*[49]

At the same time, it is important that HIV/AIDS is not dealt with purely as a health problem or an occupational hazard. As Strode and Grant make explicit in arguing for a multi-sectoral and inter-sectoral response to the disease:

> *"HIV and AIDS is not simply a health issue, but it is a developmental problem with profound socio-economic implications. A purely health-based approach is unable to deal adequately with the problem at hand, as simply treating the physical symptoms of HIV/AIDS will not reduce the incidence of the disease. The social conditions that make people vulnerable to infection must be addressed as well. Furthermore, bringing in new sectors increases resources available to deal*

[49] Pharaoh, R, (2005), "Not Business as Usual, Public Sector Responses to HIV/AIDS in Southern Africa", Institute for Security Studies, Pretoria, p.109

with HIV and AIDS and allows for the impacts on individuals, families and communities to be managed."[50]

In similar vein, albeit speaking in the context of local government, the group Development Works stresses the importance of seeing "HIV and AIDS through a development and governance lens; as a phenomenon which includes biomedical and behaviour characteristics, but which is greatly influenced by development and governance conditions." [51]

Formulation of an HIV/AIDS Strategy

Whilst the Framework represents an important departure point in the battle against HIV/AIDS, it is important to note that as a policy document it merely provides an outline of the documents to be followed. Details on the content of these programmes and their resource implications have yet to be made public. Whilst an implementation strategy will need to be closely informed by existing national policy, it will also need to be formulated to meet the particular needs of correctional institutions. In that respect, the Department of Public Service and Administration's guide on *Managing HIV/AIDS in the Workplace* provides a number of important measures which will be of assistance in both preventing and combating the spread of HIV in correctional institutions

"Key questions need to be answered as a first step to preparing a department's strategic plans, such as:
What are the HIV/AIDS goals/objectives of the department?
Is there a high degree of alignment between government HIV/AIDS priorities and departmental goals/objectives?
Are departmental strategic HIV/AIDS objectives and planned outputs aligned with the core functions and mandates of the department?
What is the current and future impact of HIV/AIDS on the department?
How is the impact of HIV/AIDS going to affect the overall goals/objectives of the department?
What programmes can be put in place to mitigate the impact of HIV/AIDS on the department?
Are the planned HIV/AIDS outputs and deliverables relevant?
Have commitments and targets been met?

[50] Strode, A., and Grant, K., (2004), Understanding the Institutional Dynamics of South Africa's response to the HIV/AIDS Pandemic, IDASA, Pretoria, p.10.
[51] Development Works; 2005: 13

> What resources (human and financial) are needed to operationalise the department's HIV/AIDS programme?"[52]

It is important furthermore, that implementation of the Framework should be based on a process of broad consultation, both to elicit the views of officials at all levels and to build support for the initiative. Such an approach will require an implementation plan at the level of individual centres and it will also require appropriate budgetary provision to ensure that officials are appointed to oversee its implementation.

Conducting a Risk Assessment

The Framework identifies a need to "receive and review comprehensive reports on the implementation of the HIV and AIDS programmes and services for offenders and personnel and (to) develop effective Risk Management reports indicating the level of adherence to identified risks."[53] This risk analysis, however, will need to be incorporated into a more comprehensive risk management strategy, and in that respect, the steps outlined in the Department of Public and Administration guidelines on HIV/AIDS in the workplace are instructive.

> In many instances, a department may not have all the necessary data, yet it is often possible to use the data that is available to estimate the current position (i.e. the prevalence of HIV in a department), and to model the data to create a picture of the epidemic in the department in the future. These projections can provide useful information for the Public Service on: the HIV prevalence by department and province currently and in 5 and 10 years; the number of new HIV infections by department and province currently and in 5 and 10 years; the AIDS cases by department and province currently and in 5 and 10 years; the number of AIDS deaths by department and province currently and in 5 and 10 years; HIV infection levels by age groups up to 2012; HIV infections by skill level up to 2012; HIV infection levels by selected occupational categories compared to overall Public Service levels up to 2012."[54]

[52] Department of Public Service and Administration (2002) p. 62.

[53] DCS (2007) p. 15.

[54] Department of Public Service and Administration, (2002) p. 58.

The recent seroprevalence survey conducted by the DCS represents an important basis for the development of such a risk assessment, but it will need to be augmented by an assessment of the projected impact which current and future staff illness will have on the operations of individual centres.

Need for a Knowledge, Appreciation, Practice and Behaviour Study

The Framework rightly addresses the need to "(d)evelop and implement an assessment too to determine the Knowledge, Appreciation, Practice and Behaviour (KAPB) of offenders and personnel on HIV and AIDS."[55] It also commits the Department a national KAPB survey amongst personnel. Such a study will provide useful knowledge of the extent to which officials understand the pathology of the disease and the manner in which it is transmitted. It will also reveal details of the extent to which they comprehend the ways in which the disease is contracted, how this might be avoided and, most importantly, what steps can be taken to manage the disease once contracted. Of concern, however, is the fact that a KAPB is only scheduled to take place in the third year of the Framework's implementation. Ideally, the input from such a survey would be used to inform the design of programmes implemented under the Framework.

The Role of Correctional Centre Leadership

The sensitisation of centre managers, at all levels of the management echelon is vital to the success of any programme to manage HIV/AIDS amongst staff. Where managers treat HIV/AIDS programmes perfunctorily or even dismissively, there is little chance that their subordinates will respond to these initiatives with any conviction. It is essential that levels of awareness are raised amongst managers and that they play a leading role in championing VCT and promoting the value of ART.

Addressing Stigma

The impact of stigma, as indicated, represents a major constraint to the promotion of VCT, in the first instance, and to the support of HIV positive officials in the second. This, in turn, hinders efforts to manage the disease in the workplace and to prepare recruitment and succession plans. The national 2007-2011 HIV and AIDS Strategic Plan notes that "Stigma and discrimination continues to present challenges in the management of HIV and AIDS", and emphasises the need

[55] DCS, (2007), p.16

"to mainstream programmes to mitigate these fundamental human rights challenges."[56] The strategy lays out a number of measures to be followed in order to minimise discrimination against people living with HIV and AIDS, including reinforcement of legislative measures which protect their human rights and better provision of social services. Whilst the Strategy mentions the need to mobilise society to mitigate stigma and discrimination, it makes no mention as to the steps to be followed in achieving this objective. The Framework similarly stresses the need to develop guidelines and to raise awareness on the human rights of those infected with HIV/AIDS, and, in particular, their right to confidentiality. Significantly, however, the Framework provides no details on how the complex issue of stigma is to be addressed in practice. In view of this, it is recommended that consideration should be given to the preparation of a specific strategy to address the problem of the HIV/AIDS stigma amongst officials. This will need to be supported by appropriate research and extensive consultation with staff.

Establishing Best Practices

Whilst the need for a coherent policy remains paramount, it is also certain that in any organisational system as large as the network of correctional institutions in South Africa, some entities will have established more effective management practices than others. In that respect, it will be important to establish what best practices there are with the respect to the management of HIV/AIDS amongst correctional staff. This knowledge will need to be shared amongst all prison managers.

CONCLUSION

The data generated by the DCS prevalence survey reveal that sero-prevalence rates amongst DCS officials broadly reflect those found in the communities from whence correctional officials were recruited, and that in some centres as many as one in four members have contracted HIV/AIDS. Furthermore, the evidence generated in this investigation suggests that HIV/AIDS infection rates

[56] South African National AIDS Council (SANAC), (2007), *HIV/AIDS and STI Strategy for South African 2007-2011*, Pretoria, Accessed on 30 September 2007 at http://data.unaids.org/pub/ExternalDocument/2007/20070604_sa_nsp_final_en.pdf p.14.

amongst members are still growing and that the impact of the disease is increasingly being felt in the day-to-day operations of correctional centres.

The Department's new policy Framework represents an important starting point in its efforts to contain and manage the HIV/AIDS pandemic. As a framework, however, it merely sets out the parameters within which policy might be formulated and programmes developed. The challenge of articulating a fully fledged programme of action with clearly defined outputs, time frames, resource implications and budgets, remains ahead. At present, many of the proposed interventions are derived directly from the National Strategic Plan. As generic interventions, however, they appear not to have been adapted to the particular circumstances and challenges of a prison environment. Of further significance is the fact that the proposals are noticeably short on the specifics of how different interventions might be introduced. Thus, for example, the critical challenge of overcoming stigma and its impact on voluntary testing is addressed in terms of a need to "conduct campaigns to increase uptake of personnel in VCT services"[57] as if this process was in some way self-evident and unproblematic. Similarly, most of the proposed interventions group personnel and inmates together and treat them as undifferentiated group. Thus, the Framework proposes establishing "support groups for HIV and AIDS infected and/or affected offenders and personnel."[58] and the conducting of "awareness raising events for special categories of offenders and personnel.'[59]

The most significant weakness of the Framework, however, lies in the fact that it is silent on the crucial question of how the impact of HIV/AIDS on the DCS workforce might be managed. The report emphasizes the need to "Receive and review comprehensive reports on the implementation of HIV and AIDS programmes and services for offenders and personnel and develop effective Risk Management reports indicating the level of adherence to identified risks."[60] Beyond the need to identify (unspecified) risks, the Framework says nothing about how to manage officials infected with (and sometimes dying of) AIDS or how to implement succession plans so that there is minimal impact on the daily operations of correctional centres and correctional programmes are not compromised.

[57] DCS (2007) p.10
[58] DCS (2007) p.11
[59] DCS (2007) p.13
[60] DCS (2007) p.15

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