

Prevention of Sexual Transmission of HIV in Zambian Prisons: An Ethical Perspective on the Provision of Condoms

By

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Fulfilment of the Requirements of the Degree of Master of Arts
in Applied Ethics**


The University of Zambia

2009

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APPROVAL

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ABSTRACT

There are high HIV prevalence rates among prisoners around the world and, in most cases, the levels of HIV infections among prisoners tend to be higher than in the general populations. In Zambian prisons, HIV prevalence is estimated to stand at 27% against a national HIV prevalence rate of 14%. This situation is described as being “grave”. It is grave because of other compounding factors such as poor environmental and prison conditions. A major risky behaviour associated with sexual transmission of HIV in Zambian male prisons is male-to-male sex (MMS). MMS is anal sex that is usually performed under coercive circumstances. The risk of sexual transmission of HIV is high because prisoners, in most cases, do not take precautionary measures when engaging in MMS. There is an urgent need to put in place workable preventive interventions that can reduce the high HIV prevalence rates in Zambian male prisons.

This study, *Prevention of Sexual Transmission of HIV in Zambian Prisons: An Ethical Perspective on the Provision of Condoms*, has two main objectives: First, to inquire into the main preventive interventions that are currently in place to prevent sexual transmission of HIV and second, to critically assess from an ethical point of view arguments for and against condom provision in Zambian prisons. It is divided in two parts: an empirical part and a philosophical part. The empirical part discussed current practices in prisons that are aimed at preventing sexual transmission of HIV. Data was collected through secondary sources and informal interviews. Secondary sources involved reading documents while informal interviews were done through a questionnaire and personal interviews with prison authorities. The philosophical part consisted of an ethical analysis of the arguments for and against the provision of condoms among prisoners. The Principle of the Lesser of Two Evils (PLE), which is an ethical principle that is widely used in literature on the prevention of sexually transmitted HIV, was employed.

It has been discovered that while there are a number of preventive interventions that have been put in place to reduce HIV infections through MMS, much more needs to be done in order to adapt these measures to a male prison environment. Prison environment is a peculiar environment that requires specifically tailored preventive measures suitable to that environment.

One such effective, though controversial, preventive intervention that should be introduced in Zambian prisons is the provision of male latex condoms. Using the PLE, it has been shown that the policy of condom provision can be seen as a lesser evil because the disadvantages of not providing condoms outweigh the disadvantages of condom provision.

To my second born daughter, Monica Mofya, for the love you have for me.

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Secondly, I would like to thank all the lecturers at the University of Zambia who shared with me their academic knowledge. It is often said that teaching is a noble profession and it is my humble prayer that these lecturers may continue to offer the best of their academic knowledge not only to the people of Zambia, but to every person who passes through the doors of the University of Zambia so that Africa may graduate from a continent of ignorance and poverty to a continent of hope, knowledge, and prosperity. Zambia, in particular, requires well informed, educated, and dedicated young men and women so that the dream of making her a middle income country by the year 2030 can be realised.

Thirdly, may I sincerely extend my heartfelt gratitude to my project supervisor, Dr.G. Spielthener, who ensured that this study meets the required academic standards. His guidance in the “know-hows” of how to write a research project of this magnitude is very much appreciated. I am also indebted to him for having permitted me to have access to his forthcoming work, *Lesser Evil Reasoning and its Pitfalls*, which I have referred to in Chapters 4 and 5 of this dissertation. I wish him all the best in life.

Lastly, I would like to thank Mr. Frederick Chilukutu, the Zambia Prisons Service HIV/AIDS focal point person, for having granted me permission to use his name in this dissertation. It is my sincere hope that this work may be of special help to him as he continues in his noble work of fighting HIV/AIDS among prisoners and prison staff.

TABLE OF CONTENTS

<i>Title of the thesis</i>	
<i>Declaration</i>	
<i>Copyright</i>	
<i>Approval</i>	
<i>Abstract</i>	<i>iv</i>
<i>Dedication</i>	<i>v</i>
<i>Acknowledgements</i>	<i>vi</i>
<i>Table of contents</i>	<i>vii</i>
<i>Acronyms</i>	<i>x</i>
CHAPTER 1: INTRODUCTION	1
Part 1: SEXUAL TRANSMISSION OF HIV IN MALE PRISONS AND PREVENTIVE INTERVENTIONS	6
CHAPTER 2: AN OVERVIEW OF MALE-TO-MALE SEX IN MALE PRISONS	7
2.1 <i>Preventive Interventions of Sexual Transmission of HIV</i>	<i>11</i>
2.1.1 HIV/AIDS awareness programmes.....	<i>11</i>

2.1.2	Voluntary HIV testing and counselling.....	12
2.1.3	Prevention of rape, sexual violence and coercion.....	14
2.1.4	Provision of post-exposure prophylaxis.....	15
2.1.5	Programmes for the detection and treatment of STIs.....	16
2.1.6	Condom provision.....	17

CHAPTER 3: MALE-TO-MALE SEX AND PREVENTION OF SEXUAL

TRANSMISSION OF HIV IN ZAMBIAN PRISONS..... 17

3.1	<i>Some suggested Preventive Interventions for Sexual Transmission of HIV in Zambian Prisons.....</i>	20
3.1.1	Conducting HIV/AIDS awareness programmes.....	20
3.1.2	Voluntary counselling and testing.....	21
3.1.3	Decongesting prisons.....	21
3.1.4	Provision of condoms.....	22

Part 2: ETHICAL ANALYSIS.....24

CHAPTER 4: THE PRINCIPLE OF THE LESSER OF TWO EVILS.....24

4.1	<i>Conditions for Applying the PLE.....</i>	26
4.2	<i>How to determine a Proportionate Reason.....</i>	29
4.2.1	The means do not cause more harm than necessary to achieve the value.....	29

4.2.2	No less harmful way exists at present to protect the value.....	30
4.2.3	The means used to achieve the value will not undermine it.....	30

CHAPTER 5: APPLICATION OF THE PRINCIPLE OF THE LESSER OF TWO

EVILS TO CONDOM PROVISION IN ZAMBIAN PRISONS.....32

5.1	<i>Arguments for and against Condom Provision in Zambian Prisons.....</i>	32
5.1.1	Arguments for condom provision.....	33
5.1.2	Arguments against condom provision.....	36
5.2	<i>Condom Provision in Zambian Prisons as a Lesser Evil.....</i>	39
5.2.1	Condom provision does not cause more harm than necessary in protecting the value of human life.....	40
5.2.2	Condom provision is not harmful to the protection of the value of human life.....	40
5.2.3	Condom provision does not undermine the value of human life.....	41

CHAPTER 6: GENERAL CONCLUSION AND RECOMMENDATIONS.....43

6.1	<i>General Conclusion.....</i>	43
6.2	<i>Recommendations.....</i>	46

REFERENCES.....49

APPENDICES.....52

<i>Appendix I: Questionnaire Schedule.....</i>	52
<i>Appendix II: Chapter 87 of the Laws of Zambia.....</i>	58

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
GRZ	Government of the Republic of Zambia
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication
NAC	National HIV/AIDS/STI/TB Council
LDC	Least Developed Country
MIPA	Meaningful Involvement of People Living with HIV/AIDS
MMS	Male-to-Male Sex
MOHA	Ministry of Home Affairs
PEP	Post-Exposure-Prophylaxis
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
ZPS	Zambia Prisons Service

Chapter 1

INTRODUCTION

The Human Immunodeficiency Virus (HIV) is a virus that causes Acquired Immunodeficiency Syndrome (AIDS). It weakens the natural ability of the body to fight diseases and people infected will eventually die from AIDS-related illnesses. There is no cure for AIDS and infected persons can only have their lives prolonged by the use of antiretroviral therapy (ART). In Zambia, just like in most Southern African countries, HIV prevalence is very high and currently it stands at 14% (Chakwe, 2008). This has become a source of concern and efforts are being made on how to lower this figure. One way of doing this is by preventing new infections from happening. In order to do this, transmission mechanisms must be well understood, and it is reported by NAC (2004), that there are two main transmission mechanisms in Zambia, and these are: heterosexual contact, and mother-to-child transmission. Equal attention also must be given towards certain sub-groups within the national population who are at risk of easily acquiring the virus. This is important because unless the risk factors of such groups are known, it would be extremely difficult to prevent further infections from happening. Knowing their vulnerable positions would result in putting up appropriate preventive measures specifically tailored to such groups.

Among the risk groups in Zambia where HIV prevalence is estimated to be high are prisoners. According to a study that was conducted by Simooya and Sanjobo (see GRZ/NAC, 2006) HIV prevalence rates stand at 27% in a prisoner population of 14,000. This represents almost twice the national HIV prevalence. While it can be argued that some convicts come into prisons already infected with HIV, it can also be said that this is the very reason why there is a high risk of the uninfected acquiring the virus from the infected due to the various factors found within the prison set up. Some of these risk factors according to Simooya and Sanjobo as quoted by GRZ/NAC (2006) include the following: unprotected sex between men; unprotected sex between male wardens and female inmates; unsafe tattooing and sharing of syringes and needles; congestion and overcrowding; poor hygiene and sanitation, and lack of appropriate information, education and communication (IEC) materials. Due to these, it is feared that if appropriate preventive interventions peculiar to prison life are not put in place, HIV prevalence among the prison population will continue to remain high.

One major concern is about sexual transmission of HIV in prisons. It is general knowledge that, though not permitted, sexual contacts do take place between male prison warders and female prisoners on one hand, and among male prisoners on the other. The latter is of major concern because in Zambia homosexuality is illegal. It is prohibited under Chapter 87 (CAP 87), Sections 155 and 158 of the Laws of Zambia (see Appendix II, p. 58). It is therefore discouraged in prisons. Despite this, it is a sexual practice that has continued to occur under cover. For example, the study by Simooya and Sanjobo (GRZ/NAC, 2006) has shown that 4-16% of the inmates who were sampled reported to have had practised homosexuality while in prison.

The fact that sex happens behind bars therefore raises an issue of what should be done to protect the uninfected from the infected. This high HIV prevalence in prisons is not just a mere figure; appropriate preventive interventions must be found. It will be the main focus of this study to find out what should be done to minimise incidences of HIV infections in prisons that could occur through sexual contacts.

For the purpose of this study, I have used the term “prison” to refer to all those places of detention that are managed by the Zambia Prisons Service and the term “prisoner” means male prisoner who is held in such places for the purpose of investigation of a crime; while awaiting trial; after conviction and before sentencing; and after sentencing. I am also aware that in the Zambian prison system, there are no prisons that are specifically referred to as “male prisons”; the set up which is there is that prisons have separate quarters for male and women prisoners. The term “male prisons”, therefore, denotes male prison quarters.

Statement of the Research Problem

The Zambia National HIV/AIDS/STI/TB Policy and the National HIV/AIDS Intervention Strategic Plan, 2002-2005, contain several preventive interventions. Most of them are primarily focused on preventing sexual transmission of the virus within the general Zambian population.

One strategy within these preventive interventions is to come up with programmes that are tailored towards the prevention of sexual transmission among the sub-groups involved in risk behaviours. The focus of this study will be on the prison population because this category of people is vulnerable to infection and, therefore, appropriate and effective strategies need to be put in place.

In preventing sexual transmission of HIV in prisons, the prison authorities have basically followed the national response strategies. These strategies include the following: peer education training and sessions; psychological counselling; distribution of information, communication, and education materials; setting up of anti-AIDS clubs and condom distribution to the members of staff only (GRZ/NAC, 2006). In view of the fact that the HIV prevalence rates among prisoners have consistently remained high, it is important that these strategies are re-assessed in line with the specific prison circumstances.

But, as already mentioned, the most contentious issue is condom provision. Provision of condoms in prisons is prohibited because, firstly, it is perceived to encourage the occurrence of homosexuality which, as I have already stated, is illegal under the Zambian laws. Secondly, most Zambians consider homosexuality as an immoral sexual act and, therefore, providing condoms in prisons is regarded as encouraging the occurrence of this immoral act. Accordingly, condoms are only provided to the prison staff. In light of what has been discussed concerning the occurrence of homosexuality among prisoners, it becomes a debatable issue of whether or not condoms should be made available to prisoners as well. The focus of the second part of this study will, therefore, be considering arguments for and against condom provision in Zambian prisons.

Research Objectives

This study has the following two main objectives:

- (a) to inquire about the main preventive interventions that have been put in place in Zambian male prisons in order to prevent sexual transmission of HIV, and
- (b) to evaluate arguments for and against the provision of condoms in Zambian male prisons in light of the Principle of the Lesser of Two Evils

Research Questions

In this study, two basic research questions will be pursued, and these are:

- (a) what are the main preventive interventions that have been put in place in Zambian male prisons to prevent sexual transmission of HIV?, and

- (b) is it ethically justifiable to provide condoms in Zambian prisons?

Significance of the Research

The National HIV/AIDS/STI/TB Policy provides the overall vision of the nation in terms of the response to the HIV/AIDS pandemic. It is envisaged to have “a nation free from Human Immunodeficiency Virus and Acquired Immunodeficiency Syndrome (HIV/AIDS)” (NAC, 2004: 30). To achieve this, a wider range of preventive interventions must be put in place.

This study is an attempt to contribute to the attainment of such a vision in the sense that it focuses on finding effective preventive interventions in as far as sexual transmission of HIV is concerned among the sub-group of the Zambian population that is at risk of acquiring HIV. As it has already been noted, some inmates come into prisons already infected, but what needs to be done is to prevent further infections and re-infections within the prison set up. Finding appropriate preventive interventions will be in line with the attainment of the national vision.

Preventing infections within the prison set up will be protecting the society in general because the inmates will come back and join their communities after serving the prison sentence. Zack and Flanigan (2000), for instance, report that 51% of the studied Latino inmates at a California prison had sex in the first 12 hours after release and that of these, most of them had “pure sex”(meaning, having sex without using condoms). Furthermore, 11% of these reported injecting drugs during the first day of their release. This fortifies the argument that preventing HIV transmission among prisoners is protecting public health.

How this is to be done depends on the applicability of the preventive interventions. Provision of condoms in prisons is a controversial issue but it is imperative that it is considered objectively and impartially. This study will discuss this issue from an ethical point of view and try to find out if condom provision in Zambian prisons is ethically acceptable. In the fight against HIV/AIDS, we need to find out what is and what is not working. Can the provision of condoms in prisons work?

Limitations

One limitation of this study is that it focuses its attention exclusively on Zambian male prisons. This is deliberate because the aim is to address the danger of HIV infections

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that would mainly result from male-to-male sexual contact. Homosexuality is a topic that people generally are not willing to talk about, but, given the fact that it does actually happen, it is important that infections that occur from such acts are prevented.

The other possible limitation concerns the generalisation of this research. This research is based on the measures that have been put in place in Zambian male prisons to prevent sexual transmission of HIV. However, due to time and financial constraints, it was not possible to visit all the 86 prisons in Zambia. Only 9 Central Prisons in the 9 Provincial Headquarters of Zambia have been included in the short interview questionnaire (see Appendix I, p. 52). However, Zambia prison administration is centralised and falls under one central command. For this reason, the findings from these 9 State Prisons can be generalised.

Research Methodology

As can be seen from the Research Objectives, this study is a Mixed Research that is both empirical and philosophical. In the empirical part, current policy practices that have been put in place to prevent sexual transmission of HIV in Zambian prisons will be discussed. Data have been gathered by the following two methods: (a) secondary sources and, (b) interviews.

(a) Secondary sources: This was done by collecting data from various documents. Places that were visited included the University of Zambia (UNZA) Library, offices of the National AIDS Council (NAC) of Zambia, offices of the Zambia Prisons Service (ZPS). The Internet was also accessed.

(b) Interviews: These basically involved personal interviews with Mr. Frederick Chilukutu, the Zambia Prisons Service HIV/AIDS focal point person. Permission was granted by Mr. Chilukutu to use his name in this dissertation. Prisoners could not be interviewed as this research focused mainly on policy practices rather than on prisoners' personal lives. A short interview questionnaire (see Appendix I, p. 52) was sent to the 9 Provincial Central State Prisons for the purpose of finding out incidences of morbidity and mortality. These are key indicators of the occurrence of HIV/AIDS.

The philosophical part consists of an ethical analysis of the arguments for and against the provision of condoms in prisons. These arguments have been discussed. The "Principal of the Lesser of Two Evils", which is often employed in conflicting situations, has been used to determine whether or not condom provision in Zambian

male prisons can be ethically justified. This is in view of the fact that on one hand, we are faced with the issue that if condoms are provided in prisons, homosexuality could be encouraged. But, homosexuality is illegal and it is considered to be immoral. On the other hand, if condoms are not provided, the risk of the infected transmitting the virus to the uninfected will still remain high thereby putting more people at risk of acquiring AIDS which eventually leads to death. Which, then, between the two options should be chosen?

Part 1

SEXUAL TRANSMISSION OF HIV IN PRISONS AND PREVENTIVE INTERVENTIONS

In the first part of this dissertation, I shall endeavour, in Chapter 2, to offer a general overview of MMS which is seen to be a risky behaviour for the sexual transmission of HIV in male prisons around the world. In addition, I shall briefly consider some of the preventive interventions recommended for the prevention of sexual transmission of HIV in prisons. As it will be shown later, it has been documented that there are outbreaks of HIV infections in a number of prison systems around the world posing a serious threat to the occurrence of intra-prison transmission of the virus. In this regard, there is an urgent need to find effective preventive interventions not only to prevent intra-prison HIV transmission, but also to protect the general population to which prisoners are likely to return upon their release from incarceration. The focus when discussing preventive interventions in this first part will be on those preventive interventions that are widely regarded to be effective in the prevention of sexual transmission of HIV in a male prison environment. Chapter 3 of this part will be limited to the debate in Zambia as it relates to the occurrence of MMS and the preventive interventions that are being suggested to prevent sexual transmission of HIV in Zambian male prisons.

It will be discovered in the discussions that follow that both globally and locally, the issue of prevention of sexual transmission of HIV in prisons has not extensively been dealt with. This could be as a result of the fact that most prison authorities deny the occurrence of MMS in their prisons. Much of the debate has been centred on the prevention of HIV transmission in prisons generally.

Chapter 2

AN OVERVIEW OF MALE-TO-MALE SEX IN PRISONS

According to Jürgens and Bijl (2001), sexual activities take place in most male prison systems around the world. These sexual activities, which take place between men, are usually collectively captured under the term male-to-male sex (MMS). MMS covers both anal and oral sex. Okie (2007) puts the estimate of occurrence of MMS in male prisons in the range of 2 to 65%. This wide range can, according to Jürgens and Bijl (2001), be attributed to the difficulties surrounding the collection of data related to sexual activities in most prison systems. Very often, prison authorities tend to deny the occurrence of MMS because in many countries, this type of sexual activity is legally prohibited. Furthermore, the WHO (2007) has noted that prisoners themselves tend not to report such sexual activities for fear of serious repercussions from fellow inmates and the prison staff authorities. Also, prisoners may fear to be labelled as homosexuals or gays, especially those prisoners found in countries where homosexuality is a cultural taboo and/or legally prohibited. In this case, there is a tendency to under-report incidences of MMS.

Yet, despite the above challenges, studies undertaken world wide so far show that MMS is a daily occurrence in a number of prisons. The two main kinds or types of MMS are consensual and coercive sex; the former being voluntary sex while the latter refers to forced sex and may include male rape. Voluntary MMS occurs when male sexual partners (male prisoners) mutually agree to engage in such acts. However, Okie (2007) has rightly argued that it is quite difficult to draw a clear distinction between

voluntary and forced MMS in a prison environment where personal choices are very rare. Similarly, WHO (2007) has alluded to the fact that there are numerous tensions in prisons which compromise prisoners' freedom of choice. As a result, prisoners tend to find ways by which they can release some of these tensions, including sexual tensions. In male prisons one way of releasing these tensions is by getting involved in MMS. It can be argued that most prisoners who engage in MMS are not homosexuals; they only do so temporarily in the prison environment. It can be said that the term "male-to-male sex" should be thought of more in terms of behaviour than denoting sexual preference. Other reasons that may force male prisoners to engage in MMS include sharing of affectionate comfort, cementing relationships, meeting needs for power and dominance, need for money, and bartering of otherwise unavailable commodities.

Consensual MMS is seen to be a less risky factor in sexual transmission of HIV than coercive MMS. The WHO (2007) has explained that this is because coercive MMS is generally forced unprotected anal MMS in which a receptive partner (that is, the one being penetrated) may suffer from damage or tearing in the membranes of the anus. This damage or tearing disrupts the integrity of the skin making it susceptible to HIV infection. Furthermore, the rectal mucous membranes appear to contain many receptors to bind HIV and when there is this damage to the membrane of the anus, the possibility of HIV infection is very high. Again, the active lining of the rectum of the receptive partner that is prone to infection is much larger than that found in the penetrating partner (that is, the head of the penis and exposed urethra). Moreover, the partner being penetrated receives a larger quantity of infectious fluid (that which is ejaculated) than the penetrating partner (who may be exposed to some cuts or tears). This problem is further aggravated if one partner or both partners has or have sexually transmitted infections (STIs). For instance, due to herpes simplex or syphilis, an individual can be carrying some genital ulcerations or blisters that easily become entry points or "doors" which can be used by HIV to penetrate the uninfected body. However, Ferris and Mizwa (2008) have rightly observed that HIV can even be transmitted in the absence of STIs especially if there are microscopic tears in the skin of the penis. It is also important to note that many STIs can be present with few or no symptoms and in such a situation, the risk of acquiring or transmitting HIV is very high.

In most male prison systems of the Least Developed Countries (LDCs), environmental or population conditions also become indirect causes of sexual transmission of HIV. These are conducive factors for the occurrence of MMS but do not become modes for sexual transmission of HIV. The environmental or population conditions vary and according to Jürgens (2004), they can be summarized to include the following: the prevailing culture; the size of the institution and system; whether accommodation is single cell or dormitory; the design of the institution; predictability of staff routines, the security classification of a prison; the extent to which conjugal visits are allowed; and the duration of the sentence. To this list, WHO (2007) has added the issue of whether or not commodities such as condoms, lubricants and dental dams are provided and are accessible to prisoners. As said, the above factors differ from prison to prison and from country to country. But, in most LDCs, prisons are overcrowded and have a low staff-to-prisoner ratio making it very easy for prisoners to engage in MMS. This is done, of course, out of sight of the prison authorities.

Poor environmental and prison conditions make prisoners vulnerable to HIV infection as well as to other infectious diseases. For instance, UNODC (2007) reports that when poor environmental and prison conditions are combined with inadequate means for personal hygiene, inadequate nutrition and lack of access to clean drinking water, the vulnerability of prisoners to HIV infection and other infectious diseases is greatly increased. This situation causes HIV-related morbidity and mortality in prisons.

Kantor (2006) says that there are very high HIV prevalence rates among prison populations around the world. In fact, these rates are in most cases higher among the prison populations than in the general populations. For example, Kantor has observed that in terms of AIDS prevalence in 2003 in the USA, the rates were more than three times higher in state and federal prisons (0.51%) than in the general USA population (0.15%). Similar observations have been made by Okie (2007) who says that in the USA in 2004, 1.8% of prison inmates were HIV positive, more than four times the estimated rate in the general population. It is also reported in HEPP news (2000) that there are HIV prevalence rates of 28% in the prisons of Cote D'Ivoire and of 2.7% in Senegalese prisons. UNODC (2007) has stated that there are also very high HIV prevalence rates in the prisons of southern Europe with Spain having the highest rate of 14%.

High HIV prevalence rates among prisoners raise the issue of intra-prison HIV transmission. Okie (2007) observes that while it can be argued that most prisoners come from those segments of society where HIV prevalence rates are already high, there is substantial evidence from various studies, which show that intra-prison HIV transmission does take place. She (Okie) has, for instance, shown that in a study that was done by the Georgia Department of Corrections between 1988 and 2005, it was discovered that a total of 88 male inmates of all the incarcerated people during that same period were found to be HIV positive from a subsequent HIV test that was performed on them while staying in prison. This seroconversion (that is, a change of status from HIV negative to HIV positive) was associated with either MMS or receiving a tattoo.

In another study, conducted in Florida and reported by the Minnesota AIDS Project (2004), 87 of the 556 prisoners who were incarcerated from 1977 to 1991 were tested for HIV. This HIV test was done at the end of 1991 and 21% of those who were tested were HIV positive. This showed that seroconversion took place within the prison environment rather than from outside. Kantor (2006) also notes that seroconversion within prison environments has been reported in other countries as well: Brazil (15% in 2001), South Africa (40% in 2003), Spain (16.4% in 2000), and Nigeria (9.0% in 2000). It can, therefore, be argued that intra-prison HIV transmission is a reality in many male prison systems around the world. Since this intra-prison HIV infection occurs, there is need for both prison authorities and public health managers to put in place effective preventive interventions so that those prisoners who are HIV negative are protected from acquiring HIV. It is worth noting that currently there is no cure for HIV, therefore, those prisoners who are infected and those who may get infected while in prison are likely to pass on the virus to the uninfected whenever they engage in MMS. HIV infection slowly progresses into AIDS, which despite the availability of ART, still results in death.

When one reads through the literature on the prevention of sexual transmission of HIV in prisons, one discovers that this issue is not adequately dealt with. What is rather discussed in detail is the general prevention of HIV in prisons. Despite this, it is generally agreed that MMS takes place in male prisons and that it is a risky behaviour for sexual transmission of HIV. Because MMS takes place in most male prison systems around the world despite lack of openness about it, there is need to find preventive

interventions that may curtail intra-prison sexual transmission of HIV. In what follows, I will consider some of the preventive interventions that have been suggested.

2.1 Preventive Interventions for Sexual Transmission of HIV

2.1.1 HIV/AIDS awareness programmes

A prison environment facilitates easy transmission of HIV and STIs. It has been argued above that MMS is a risky behaviour in a male prison environment and that it facilitates HIV transmission from the infected to the uninfected. In this regard, prisoners (especially the young and the recently incarcerated) need to be made aware of the danger of this risky behaviour through some form of HIV/AIDS awareness programmes. It is assumed that once prisoners are made aware of the fact that MMS is risky behaviour for sexual transmission of HIV, they would take necessary precautions in order to avoid contracting this deadly virus. Providing prisoners with knowledge is enabling them to protect themselves against HIV infection. The objective of HIV/AIDS awareness programmes is to bring about behavioural change. It is believed (see for instance, NAC, 2004) that since HIV is primarily transmitted through unsafe sexual behaviour, it can be prevented by changes of this behaviour by means of HIV/AIDS awareness programmes.

In order for HIV/AIDS awareness programmes to be effective, they must be adapted to the male prison environment. Kantor (2006) has observed that HIV/AIDS awareness programmes should be considerate of the level of education of most prisoners. She has, for instance, observed that 50% of the USA prisoners are functionally illiterate and many of them are not native English speakers. A similar observation is made by Norberry and Chappell (1989) who have noted that in Australia, it is very difficult to carry out effective HIV awareness programmes because most prisoners have little formal education and comprise a great variety of ethnic groups. Hence, as a tool for sensitization, HIV/AIDS awareness programmes must be conducted in languages understandable and applicable to the male prisoners. Furthermore, these programmes are not to be considered as a once-a-time programme whereby some outside HIV/AIDS experts come only once to present their prepared lectures and then leave at the end of the day. The approach which is being emphasized

here is that there must be a consistent and persistent use of HIV awareness programmes over time. Behavioural changes are unlikely to occur after a one-time-only intervention.

Important also to the success of these HIV/AIDS awareness programmes is the role that peer educators play in educating their fellow prisoners about the risky sexual behaviours found in male prisons. Because of the dynamics of prison set-ups, information provided by people from outside (that is, those who are not prisoners) is very often perceived negatively and not trusted because such information is viewed as information coming from the “outsiders”. Effective HIV/AIDS awareness requires that there is active involvement of prisoners (and prison staff) in learning, producing, and evaluating educational measures. This is to ensure that HIV/AIDS awareness programmes are relevant to the prisoners’ needs and concerns. In this regard, programmes that are being called for are those in which prisoners are involved in the development and design of such programmes. It is said that HIV/AIDS awareness programmes developed in such manner have been successful in a number of institutions and seem to be the best tools for HIV/AIDS awareness. Prisoners develop a sense of “ownership” of such programmes if they are involved from the beginning in the development of them. This is very important especially in those prison populations with a low literacy level and where face-to-face educational interventions are critical. For example, Kantor (2006) says that several gripping and effective videotapes have been made *by* and *for* prisoners.

However, UNODC (2007) has rightly observed that although HIV/AIDS awareness programmes are crucial in the fight against HIV, they are, however, not sufficient if prisoners are not empowered to act upon the information given to them. To be empowered, prisoners must have access to harm reduction programmes (such as the provision of condoms) that should be made available within the prison environment. It is also recommended that prisoners should be empowered to have access to the full range of prevention commodities that are available in the outside community. Because of the nature of the prison environment, these prevention measures should be accessible in a confidential and non-discriminatory manner.

2.1.2 Voluntary HIV testing and counselling

According to WHO (2007), voluntary HIV testing and counselling are vital to the prevention of sexual transmission of HIV in prison set-ups. Firstly, through counselling

those who wish to engage in MMS are given necessary information about the risks involved in engaging in such type of sexual behaviour. This information is imperative for behaviour change to occur. Kantor (2006) observes that behaviour change leads to reduced risk behaviour. Secondly, through HIV testing, those who are diagnosed as HIV positive and who have been counselled about their HIV status may take necessary precautions whenever they decide to take part in MMS. HIV testing is also important because a prisoner who is not aware that he is HIV positive can spread the virus to other prisoners even before he becomes ill. The risk of HIV transmission is greatest during both early and late stages of HIV infection because during these periods the viral load is very high. Furthermore, results from HIV testing may be helpful to prison authorities to monitor the trend of infection and if possible plan for the provision of antiretroviral (ARV) drugs.

HIV testing is a controversial issue: On the one hand, there are those people who advocate compulsory testing in order to control the spread of HIV, while on the other hand, there are those who emphasise the need to have an informed consent before performing any such test on an individual. This controversy is about public health versus individual autonomy. The WHO (2007) warns that compulsory testing of prisoners is unethical for it compromises with the individual prisoner's privacy and integrity. Studies elsewhere (see WHO, 2007) have also shown that mandatory HIV testing has resulted in the segregation of HIV-positive prisoners leading to negative health consequences for the segregated prisoners. Instead, prisons should routinely offer services for voluntary HIV counselling and testing to prisoners upon entry.

HIV testing may be part of routine testing. It may, for instance, be done when screening for other health conditions (such as syphilis) of any incoming inmate at prison admission. If this is done, it is recommended that testing should be carried out with strict confidentiality (if HIV specific medical care is to be provided) or absolute anonymity. Also, inmates should have the possibility to refuse to be tested, if they so wish. It should also be borne in mind that to many people, entry into a prison is a stressful time and many prisoners may not be willing to have an HIV test at that time. In this regard it is recommended that HIV testing should be made available to prisoners at any given time during imprisonment so that prisoners can know their HIV status and if possible, take the necessary precautions. It is also emphasised that HIV testing and counselling should be viewed as means to have access to other prevention measures

(such as the use of condoms). But, again, knowledge alone of a prisoner's HIV status is not sufficient to prevent the sexual transmission of HIV; the means to reduce further harm should be made available so that prisoners can protect themselves.

2.1.3 Prevention of rape, sexual violence and coercion

Reyes (2000) says that in prisons, the human environment is often one of violence and high-risk lifestyles. Sexual coercion and violence are common in all male prisons around the world and these are potential sources for sexual transmission of HIV. Because of this environment, some prisoners are forced to engage in MMS. In male prisons, MMS is very often performed through sexual assaults, rape, and common intimidation tactics. Kantor (2006) reports, for instance, that in the USA, there was one Federal Bureau of Prisons study which revealed that between 9 and 20% of federal inmates (especially the new inmates or homosexuals) were found to be victims of rape. WHO (2007) also documents a list of occurrence of rape and sexual violence in other countries (for instance, 2% in England, 3% in Canada, and 36% in Armenia).

The WHO (2007), has observed that there is no definition of rape in international human rights law, but it may be understood to mean a physical invasion of a sexual nature committed on a person under circumstances which are coercive. Circumstances which are coercive may include threats, intimidation, extortions and other forms of duress which prey on fear or desperation. In this dissertation, forceful insertion of a penis into a prisoner's mouth or anus is considered as rape.

The UNODC (2007) strongly advises that it is the duty of the prison authorities to prevent such aggressive sexual behaviours. Similarly, the WHO (2007) has noted that according to the International Guidelines on HIV/AIDS and Human Rights, which were issued in 1998, it is incumbent upon prison authorities to combat such aggressive sexual behaviours. Reyes (2000) has emphasised that prisoners have a right to be protected from these dangerous settings in prisons and that prison authorities are expected to protect them from physical and sexual violence. Commitment to preventing such aggressive sexual behaviours by the members of the prison staff can be shown by providing adequate staffing, effective surveillance, disciplinary sanctions, education, work and leisure programmes. In LDCs, this staff commitment is possible only to the extent that there is political will on the part of governments that have the mandate to improve the living conditions of prisoners.

Political commitment may also be demonstrated by acknowledging the fact that MMS takes place in prisons. Once this is done, necessary steps should be taken to fundamentally change the circumstances in prisons which perpetuate the occurrence of rape, sexual violence and coercion. According to WHO (2007), countries where the reality of the occurrence of MMS has been acknowledged have adopted appropriate methods to document incidents of prisoner sexual violence and have moved forward to put in place effective preventive interventions. For instance, prison authorities have provided staff training, undertaken investigations, and have responded to complaints related to sexual violence. This is in line with recommendations contained in the International Guidelines on HIV/AIDS and Human Rights released in 1998 by the Joint United Nations Programme on HIV/AIDS and Office of the United Nations High Commissioner for Human Rights (see UNODC, 2007).

Another further necessary step is to implement prison and penal reforms that must be targeted towards reducing prison populations. For instance, national governments should review criminal laws with a view to reducing the criminalisation of non-violent offences. This may lead to significant reductions in the use of incarceration for non-violent offences. When prison population is reduced it is envisaged that the few underpaid prison guards can effectively protect vulnerable prisoners from violence and sexual coercion. Some governments (especially those of the LDCs) usually have an excuse of lack of resources as a major reason for not instituting structural reforms in prisons. However, it has been noted by the UNODC (2007) that international law is clear that a lack of resources does not excuse a state from its obligations to provide proper and humane prison conditions. The political will can also further be strengthened by the passing of relevant parliamentary acts specifically targeting the elimination of sexual rape and violence in male prisons. WHO (2007), for instance, has given an example from the USA where there was an adoption of the Prison Rape Elimination Act in 2003.

2.1.4 Provision of post-exposure prophylaxis

Prisoners who have been victims of rape, sexual violence or coercion are at risk of being infected with HIV. To minimise this risk, the WHO (2007) has advised that prisoners who have had an unanticipated sexual exposure must have access to Post-Exposure Prophylaxis (PEP). PEP is medical care administered to persons within 72

hours after having been exposed to blood, genital secretions, or other potentially infectious body fluids of a person known or suspected to be HIV positive. Any exposure to blood or other infectious body fluids represents a substantial risk for HIV infection. It is important to note that this issue is of major concern in a prison environment where most of the inmates (particularly those in the LDCs) come from poor backgrounds bringing with them various untreated ailments into prisons. In these circumstances, the chances of acquiring HIV when they come into contact with blood or other infectious body fluids are very high, especially in view of the fact that the conditions in most prisons are pathetic.

PEP consists of a set of services aimed at preventing HIV infection from developing in the exposed body. These services usually include the following: first aid care, counselling and risk assessment, HIV testing following informed consent, and the provision of short term (for 28 days) antiretroviral drugs immediately after exposure. PEP administration to prisoners is possible. WHO (2007) gives an example where PEP was first offered to 46 prisoners in Australian prisons. Of these, 8 completed the full PEP course. From this experience it was realized that offering PEP in a prison set up is actually feasible. However, it is suggested that special consideration of prison circumstances must be taken into consideration when applying PEP in a prison set up. Such factors as accurate risk assessment, consideration of on-going risk behaviour, prompt initiation of the therapy, good compliance, and adequate follow up must also be taken into account.

2.1.5 Programmes for the detection and treatment of STIs

As mentioned earlier, STIs increase the risk of HIV transmission. Some STIs (such as chancroid) cause blisters or genital ulcerations which compromise the integrity of the skin. It is therefore recommended by the UNODC (2007) that prison systems in conjunction with public health authorities should develop comprehensive programmes to reduce the incidence and prevalence of STIs in prisons.

Health in prison is a right guaranteed by various international laws as well as by international rules, guidelines, and covenants. The right to health includes the right to medical treatment, the right to preventive measures as well as the right to standards of health care equivalent to those available in the general population. UNODC has referred to the 1993 WHO Guidelines on HIV infection and AIDS in prisons which

demand that prisoners should receive health care equivalent to that available in the community without discrimination. This is referred to as the *equivalent principle*. By this principle, prisoners ought to receive health care at least equivalent to that available for the outside population. For instance, UNODC refers to the United Nations Basic Principles for the Treatment of Prisoners which state that prisoners shall have access to the health services available in a particular country without discrimination on the grounds of their legal status. It is from this perspective that the proponents (for instance, the WHO) argue for the provision of condoms in prisons. Despite this strong recommendation, it has been observed by some (for instance, Agardh *et al.*, 2007) that most governments have not implemented adequate health services, including measures necessary to prevent HIV in their prisons.

2.1.6 Condom provision

This preventive intervention of sexually transmitted HIV will be extensively dealt with in Part 2 of this dissertation. It may, therefore, suffice here to say that condoms are now provided in most prison systems around the world (see WHO, 2007). According to UNODC (2007), the need to make condoms available to prisoners was actually recognized by the WHO as early as 1993 when through its Guidelines on HIV infection and AIDS in prisons, it strongly recommended making condoms available to prisoners throughout their period of stay in detention as well as before they are released from prison. But, as it will be explained later, the success of this preventive intervention depends largely on the implementation of the other preventive interventions that have already been discussed in this chapter.

Chapter 3

MALE-TO-MALE SEX AND PREVENTION OF SEXUAL TRANSMISSION OF HIV IN ZAMBIAN PRISONS

In terms of the occurrence of MMS in Zambian male prisons, the situation is not very different from what is found in other prison systems in the world. Simooya and Sanjobo

(2005) have observed that MMS takes place in Zambian prisons and it is estimated that the proportion of its occurrence ranges from 8 to 15%. This is despite MMS being legally prohibited under Sections 155 and 158 of the Zambia Penal Code, Chapter 87 of the Laws of Zambia (see Appendix II, p. 58). In addition, MMS is socially abhorred in most Zambian communities as this kind of sexual behaviour is perceived to be “indecent” and “against the order of nature”.

MMS in Zambian male prisons is considered by Simooya and Sanjobo (2005) to be the third major risk behaviour of HIV transmission in male prisons; the other two being the sharing of razor blades, and tattooing. Frederick Chilukutu, the focal point person for HIV/AIDS in the Zambia Prisons Service (ZPS) confided to me (personal communication, 15th July, 2008) that HIV/AIDS is a matter of worry in Zambian prisons. The trend, he said, is on the upswing. This is also acknowledged by MOHA/ZPS (2006) when they state that the major risk behaviours for HIV transmission identified in Zambian prisons include unprotected sex between men, tattooing, injecting drugs, and the sharing of shaving instruments. Although not being the major risky factor for HIV transmission in prisons, MMS still remains an issue of concern in so far as sexual transmission of HIV in Zambian prisons is concerned.

Kelly (2006) has observed that most Zambians who are prone to incarceration are those that are poor and those from vulnerable backgrounds (such as the unemployed, drug addicts, and women) where HIV prevalence rates are already high. According to him, these people are found in peculiar circumstances which put them at greater risk of acquiring HIV. Some of these peculiar circumstances that he alludes to include the following: untreated STIs, absence of information on their own HIV status and that of their sexual partners, the increased possibility of high-risk behaviour because of difficulties in accessing and storing condoms correctly as well as major constraints in using them properly, and economic pressures which lead them to the sale of sex to generate household income. These factors may explain why HIV prevalence rates are extremely high in Zambian prisons. It is also important to note the observation made by NAC (2004) which states that in Zambia, any form of unprotected sexual intercourse is risky behaviour due to the fact that there are very high proportion of untreated STIs among the general population. These high levels of untreated STIs are an important driver of HIV/AIDS epidemic in Zambia. Therefore, when there are a substantial

percentage of prisoners being involved in MMS, it is very likely that some of these have untreated STIs, a thriving condition for HIV transmission.

In the study that was conducted by Simooya and Sanjobo (2005), it was discovered that HIV prevalence rates in Zambian prisons stood at 27% against a national average at that time of 19 % (although now the national HIV prevalence rates have been reduced to 14%). High HIV prevalence rates in prisons raise the issue of intra-prison HIV transmission. The issue of intra-prison HIV transmission is of particular concern in Zambia because of poor prison conditions (poor sanitation, overcrowding, and a weak health care service). As it has been observed earlier, these prison conditions significantly contribute to HIV transmission in prisons and in Zambia, the issue of overcrowding in male prisons has been cited by Simooya and Sanjobo (2005) as one such factor that encourages the practice of MMS.

In Zambia, as it has been observed elsewhere around the world, the focus seems to have been directed more to the general prevention of HIV transmission in prisons rather than to the prevention of sexual transmission of HIV specifically. Although the national HIV prevention policy (see GRZ/NAC, 2006) has a component on the prevention of sexual transmission of HIV, it does not specifically deal with the problem of sexual transmission of HIV in a prison environment. Similarly, much of the debate in Zambia has been limited to finding those preventive interventions that address HIV prevention in prisons generally. There are very few studies that focus on the issue of sexual prevention of HIV in Zambian prisons. One such authoritative study that is nationally and internationally referred to is the one done by Simooya and Sanjobo (2005).

Several preventive interventions regarding sexual transmission of HIV in Zambian prisons have been proposed, and these have generally included the following: conducting HIV/AIDS awareness programmes, voluntary counselling and testing, decongesting prisons and, provision of condoms. Of course, several other preventive interventions have been proposed, but, much of the discussion is limited to these issues. In the section that follows, I consider some of the points that have been stressed in these preventive interventions.

3.1 Some suggested Preventive Interventions for Sexual Transmission of HIV in Zambian Prisons

3.1.1 Conducting HIV/AIDS awareness programmes

According to the Ministry of Home Affairs and the Zambia Prisons Service (MOHA/ZPS, 2006), prisoners must be informed about the basic facts of HIV and AIDS. This information must be tailored towards the circumstances affecting the spread of HIV within the Zambian prison environment. As mentioned earlier, one risky behaviour that encourages the sexual transmission of HIV in Zambian prisons is MMS. In this regard, therefore, prisoners need to know why and how this kind of sexual behaviour is risky and what they can do to protect themselves from acquiring HIV. Such information can be circulated to prisoners in form of leaflets, posters or mass media.

Simooya and Sanjobo (2005) have observed that for HIV/AIDS awareness programmes to be of use to prisoners, these programmes must be presented in a language and form that is attractive and in a clear manner. This is important in view of the fact that almost 40% of Zambians are illiterate and that the majority of prisoners are poor and lack the means to improve their educational levels.

Again, Simooya and Sanjobo have noted that in most cases, the information, education and communication (IEC) materials that are distributed outside prisons by the Ministry of Health do not touch on the specific problems of HIV/AIDS in prisons. In this regard, the “In-But-Free-Project”, which is run in partnership between the Copperbelt University Health Services Department and the Zambia Prisons Service, has developed its own IEC materials that have specific reference to the prison environment. The IEC materials are administered by peer educators chosen from prisoners themselves. Since January 2005, the “In-But-Free-Project” has managed to train 876 prisoners as peer educators who work within their respective prisons throughout the country to educate their fellow inmates about the risk of HIV and other STIs and also to promote a reduction of unsafe sexual practices. This approach to HIV/AIDS awareness programmes is well emphasised in the HIV and AIDS/STI/TB Workplace Policy of the Zambia Prisons Service of 2006 which states that some of the IEC materials can be developed by the prisoners within the concept of “Meaningful Involvement of People living with HIV/AIDS” (MIPA).

The MIPA concept emphasises the need for HIV positive people to be involved in the formulation of HIV/AIDS awareness programmes so that these messages are not seen as being alien (that is, being imposed on them by HIV negative people). Thus, HIV/AIDS awareness programmes as implemented in Zambian prisons by the “In-But-Free-Project” have closely followed the recommendations made by the WHO and the Joint United Nations Programme on HIV/AIDS which encourage prisoners to be actively involved in the whole process of formulating HIV/AIDS awareness and sensitisation programmes.

3.1.2 Voluntary counselling and testing

Just like in other prison systems around the world, voluntary counselling and testing (VCT) is also offered in Zambian prisons. This programme is being implemented by the “In-But-Free-Project”, which offers voluntary counselling and testing to both inmates and staff. VCT in Zambian prisons seems to be for the purpose of both monitoring the progress of HIV prevalence rates in prisons as well as for medication purposes (see Simooya and Sanjobo, 2005). The project offers VCT to prisoners on a monthly basis during medical examinations which are usually conducted in all the national prisons.

The HIV and AIDS/STI/TB Workplace Policy of the Zambia Prisons Service of 2006 has emphasized that VCT should be provided with special emphasis on counselling before and after testing and that counselling and confidential HIV testing must form the backbone of HIV and AIDS prevention. To ensure that VCT follows the MIPA approach, the “In-But-Free-Project” has also managed to train 248 prison officers as counsellors since January, 2005. Furthermore, an HIV/AIDS surveillance system has been set up from the data that have been generated by the monthly VCT programmes.

3.1.3 Decongesting prisons

The GRZ/NAC (2006) has reported that in 2006, there were 14,200 prisoners in the 86 Zambian prisons against an authorized capacity of 8,000. This is almost double above the capacity and this has resulted into overcrowding, a situation that is very conducive for prisoners to engage in MMS. Realizing this danger, there have been numerous calls to decongest prisons. For instance, Enoch Mulembe, the Director of the Zambia Human

Rights Commission, is quoted by *The Post* (Chansa, 2008: 11) as having said that sexual activities in prisons are mainly caused by congestion and to avoid this, prisons need to be rehabilitated to accommodate one or two people per prison cell. This view is shared by the then Permanent Secretary of Southern Province of Zambia, Darius Hakayobe, who attributed the high prevalence rates of HIV/AIDS in prison communities to congestion (see Times Reporter, 2005). Hakayobe further said that in a country that has limited and dilapidated prison infrastructure, HIV/AIDS is likely to spread at alarming rates.

As mentioned earlier, prison conditions encourage risk behaviours that perpetuate the spread of HIV in prisons. These become indirect causes of the spread of HIV and, therefore, tackling these problems means lessening the threat of intra-prison HIV transmission. However, it should be understood that Zambia is a poor country that lacks resources to improve the living conditions in prisons. It is, therefore, foreseen that the problems of overcrowding and other inhumane prison conditions are likely to continue. This scenario will continue to pose a threat to the sexual transmission of HIV in Zambia's male prisons.

3.1.4 Provision of condoms

This preventive intervention has been widely discussed in Zambia. Two opposing views have emerged: one view is in favour of providing condoms in prisons and is represented by Nkandu Luo (a consultant on health and HIV/AIDS issues and Professor of Immunology at the School of Medicine of the University of Zambia) and; the other one is against and this is represented by Enoch Mulembe, the Director of the Zambia Human Rights Commission (see Chansa, 2008).

According to Simooya and Sanjobo (2005), MMS occurs in Zambian male prisons. It has already been noted that MMS is a risky behaviour for sexual transmission of HIV. Because of this, it is being argued by some people (e.g. Nkandu Luo) that the risk of acquiring HIV can be minimised if prisoners have access to condoms. Furthermore, she (Nkandu Luo) has vehemently argued that the Zambian government should allow people who are willing to distribute condoms in prisons to do so (see Chansa, 2008). She has also said that there is no need to pretend that sexual relations were not taking place in prisons and that since people were confined, the chances of HIV cross-infection were high.

However, dissenting views as espoused by Enoch Mulembe (Chansa, 2008) contend that condom distribution in Zambia cannot be supported because it encourages sodomy, which is a crime in Zambia. He (Mulembe) has said that because of this the Human Rights Commission of Zambia cannot support condom distribution in Zambian prisons. He has further argued that the problem needs to be looked at beyond HIV and that he would be the first one to support condom distribution in prisons if the law was changed. What he proposes is rather that the government must embark on the long-term programme of prison expansion since MMS is, according to him, caused by congestion. He also alludes to the fact that in other African countries (like South Africa) where condoms are distributed, sodomy or homosexuality is legal. This is not the case in Zambia. Frederick Chilukutu, the ZPS HIV/AIDS focal point person, also mentioned to me (personal communication, 15th July, 2008) that condom provision in Zambian prisons is not encouraged because it is assumed that this encourages prisoners to engage in sodomy, which is a criminal offence in Zambia.

The above two opposing views are also captured by the divergent views found among prisoners themselves. According to Simooya (2000), a national health survey which was carried out at Kamfinsa State Prison revealed that of the 469 inmates that were interviewed about their views on condoms in prisons, 318 (68%) said “no” to condoms in prisons, 94 (20%) were in agreement, while 57 (12%) were undecided. Those who opposed said that condom provision in prisons would encourage homosexuality which is “unchristian”, “unZambian”, “against our tradition” and “a criminal activity”. Those who agreed said it would be for the protection against STIs and HIV. Generally, however, condom provision in Zambian prisons has not been welcome.

In Zambia, it becomes challenging to advocate for the provision of condoms in male prisons. This challenge has to be understood from the socio-cultural, legal, and religious perspectives that do not support the practise of homosexuality acts. Homosexuality is “unnatural” and most people are not in favour of it being practised either in the general population or in male prisons.

The above preventive interventions are basically the ones which generally form the bulk of discussions about the issue of preventing sexual transmission of HIV in Zambian prisons. But much of this discussion is on whether or not condoms should be provided. Very little is written about the prevention of sexual transmission of HIV in

Zambian male prisons. What has been discussed above will now form the basis of our ethical analysis in the next part, which is Part 2 of this dissertation.

Part 2

ETHICAL ANALYSIS

The second part of this dissertation has three chapters. The first chapter, which is Chapter 4, discusses the Principle of the Lesser of Two Evils which has been used by some authors (e.g., Ralf Jürgens) and international organisations (e.g., the UNAIDS and the WHO) to advocate for the provision of condoms in prisons in order to prevent sexual transmission of HIV. The second chapter, which is Chapter 5, discusses the application of the Principle of the Lesser of Two Evils to the issue of condom provision in Zambian male prisons; and the final chapter, Chapter 6, provides for the general conclusion and recommendations.

Chapter 4

THE PRINCIPLE OF THE LESSER OF TWO EVILS

In this chapter, my main objective is to state what the Principle of the Lesser of Two Evils says within the context of proportionalism, namely, an approach to moral thinking that emphasises an evaluation of the proportion of good and evil in actions. This is opposed to another approach to moral thinking called the “morality of principles” which emphasises the unfailing faithfulness to some absolute principles of morality, which is characteristic of Catholic moral teachings and tradition (see Lawler *et al.*, 2008). Whereas the morality of principles approach teaches that there cannot be any reason for violating specific norms or principles even for “good reasons”, proportionalism, on the other hand, states that due to “proportionate reasons”, fidelity to

these principles may sometimes be overridden if a particular action is likely to bring about more good or less evil. This is why it is said that, in proportionalism, the basic moral principle is the principle of the greater good or the principle of the lesser evil. In this chapter, my main preoccupation here is to explain the Principle of the Lesser of Two Evils (PLE).

Spielthener (forthcoming) has adequately dealt with the PLE by tracing its historical usage and has critically assessed the lesser evil reasoning. He has further showed some of the pitfalls commonly found under lesser evil reasoning which I feel are worth noting. What is also worth noting is the historical aspect of this principle which he traces to ancient Greece and says that since then, this principle has been applied in nearly all fields of human endeavour, including the fields of law and theology.

The PLE is referred to under various titles such as “the principle of a lesser evil” (Leies, 2008), the “principle of the lesser evil” (Lawler *et al.*, 2008) or the “Principle of the Counsel of the lesser of Two Evils” (Ferrer, 2002). These differences in titles have also led to variations in the correct formulation of the principle resulting into some controversies as to what this principle actually says (Spielthener, forthcoming).

In this dissertation, the version of the PLE which is referred to is that which requires that when one is faced with a practical moral conflict-situation where one has to choose between two available options (actions) both of which have evil consequences, one is advised or counselled to choose the lesser evil of the two evils. Spielthener (forthcoming) gives an example of a bank cashier who is caught up in such a moral conflict-situation during a bank robbery. In this situation, a bank cashier is faced with two alternatives; either to hand over the bank money or not to hand over the bank money. The former alternative may bring about a loss of money to the bank (which is one evil) while the latter action would endanger his life (the other evil). Depending on the circumstances that will influence his decision, the bank cashier will choose one option (between the two options that I have stated) and this can be referred to as the lesser evil. From this example, it can be noted that the PLE requires that one needs to make a choice *only* from two available options both of which have evil consequences. An option (act) with perceived lesser evil consequences is the lesser evil and, according to the PLE, it ought to be chosen.

The PLE has also been used in other moral conflict-situations particularly by some Catholic moral theologians (such as Italian Cardinal Carlo Maria Martini, Belgian Cardinal Godfried Danneels, and Mexican Cardinal Javier Lozano Barragan) to justify the use of condoms (especially within the marriage context) as “a lesser evil” in the fight against HIV. It has also been used in the Catholic moral tradition to counsel (that is why the PLE is sometimes referred to as the “Principle of the Counsel of the lesser of Two Evils) a lesser sin to a person who cannot reasonably be convinced to act morally right. St. Augustine and St. Thomas Aquinas have been credited to have used this principle in this context (Leies, 2008). Allen (2006) observes that it is generally accepted in moral theology that one may counsel a lesser evil if it is the only way to stop someone from doing a greater harm. This view is also held by Ferrer (2002).

4.1 Conditions for Applying the PLE

The question to be asked here is this: is the PLE applicable to any moral conflict situation where one ought to choose only between *action A* or *action B*? Spielthener (forthcoming) says that there are two important restrictions to the PLE, and these are: (a) moral absolutes and, (b) value incommensurability. Let me briefly consider the two here.

(a) Moral absolutes

I stated at the beginning of this chapter that there are two broad approaches in Catholic moral thinking, and these are: proportionalism and the morality of principles (see Lawler *et al.*, 2008). According to proportionalism, an act which otherwise could be considered immoral can be justified if it brings about less evil. The morality of principles, on the other hand, is concerned with the unfailing faithfulness to some moral principles (moral absolutes) which can never be overridden regardless of circumstances or consequences.

Actions based on moral absolutes should never be performed because they are considered to be intrinsically evil; this implies that there are some actions that are bad in themselves because they go against the order of nature or God. Spielthener (forthcoming) says that the lists of these moral absolutes vary; some moral absolutists favour a wider list while others demand only a more restrictive one. Some Catholic

theologians, for instance, teach that some actions like euthanasia, contraception, adultery, homosexuality, and abortion are intrinsically evil. These acts should never be done regardless of circumstances and consequences. Therefore, such acts do not qualify to be called lesser evils. Other absolutists favour a less demanding list of moral absolutes (see Spielthener, forthcoming).

Since intrinsically evil actions must not be performed, the PLE is not applicable to such acts. This, however, does not mean that those who advocate moral absolutism cannot use the PLE; they can do so as long as they apply this principle to those acts which are not intrinsically evil.

Proportionalists argue that each action has to be evaluated in terms of intention, circumstances, and consequences. If a particular action brings about a lesser proportion of evil, then, that action could be said to be morally right. In this case, secular proportionalists (e.g., consequentialists, who believe that consequences exclusively determine the moral rightness of actions) say that the PLE is applicable to all moral problems, including those “blacklisted” by the Catholic Church, and this is why this principle is regarded as a basic moral principle.

Proportionalists are cognisant of the fact that certain actions are morally bad. However, these acts are not morally bad because they are intrinsically evil *per se*; they are bad because they are likely to cause greater harm in all circumstances. This is to say that they bring about morally bad consequences. For example, Lawler *et al.*, (2008) say that it would be morally wrong to force a retarded child to have sexual relations because this has evil consequences. Such acts, according to proportionalists, are not intrinsically evil but are referred to as “practical absolutes”, “virtually exceptionless”, or “material norms”. Gula (1989: 294) says that practical absolutes “highlight values which, in the general course of events, will take precedence and, for all practical purposes, should be preferred.” This means that instead of transgressing a practical absolute, one should strive to promote the value at stake.

The above discussion leads to the issue of the difference between moral and premoral evils. Whereas moral evils are morally bad choices and acts, premoral evils refer to things like sickness and death which are natural deprivation of some good due to a person or a thing (see Lawler *et al.*, 2008). For example, death is a premoral evil that confronts human beings. It falls under those natural evils which are sometimes referred to as “physical evils”, “ontic evils”, “nonmoral evils”, or “premorale disvalue”

(see p. 269). As related to human actions, premoral evils are those regrettable human experiences which we sometimes have to go through (such as sickness) and which we cannot avoid. What is required is that they are limited to the minimum and that if they have to be permitted, there must be a *proportionate reason* for allowing them to occur. I shall deal with proportionate reason later.

(b) Value incommensurability

The other difficulty associated with the application of the PLE to moral problems is value ranking. For instance, Spielthener (forthcoming) correctly observes that if the PLE demands that one ought to choose a lesser evil from two bad options, it implies that there must be some form of value comparison. Meaning that if the value of *action A* has to be compared with the value of *action B*, one ought to have some scale or some form of measurement. If I take the dilemmatic situation of the bank cashier above, the cashier must presumably weigh financial loss against loss of life. But, what scale can the bank cashier use to rank the two in order to choose that action which is a lesser evil?

There is no consensus on this issue. Again, Spielthener (forthcoming) assists by saying that lesser evil reasoning only requires that the values at stake are ranked on an ordinal level of measurement. In our example of the bank cashier, it could mean that the action of financial loss is *better than* (although it still remains an evil) the action of loss of life. This comparison is on an ordinal scale. But how were the two values at stake evaluated to rank them as such? What process was taken to arrive at this ranking? Is it possible to compare a quantifiable value (financial loss) against a non-quantifiable value (loss of human life)? Spielthener (forthcoming) has noted that while some authors accept this difficulty involving value incommensurability, others say values on an ordinal scale are not incommensurable. Vacek (see Gula, 1989: 278) also admits that there is a problem of the ranking of values but advises that what is required in value comparison is “not the shrewd computations of a calculating mind, but the well-ordered heart sensitive to the breadth and depth of values.”

Indeed, the problem of value ranking exists and I fully concur with Spielthener (forthcoming) who has observed that the burden of proof is on those who use this form of reasoning to justify the preference of one value over the other. The PLE requires that values are ranked at the ordinal level of measurement. In this case, the PLE is not

applicable to those moral conflict-situations where the two values at stake are not comparable on an ordinal scale.

4.2 How to determine a Proportionate Reason

With the above two difficulties discussed, let me now deal with the issue of “proportionate reason” which is an important aspect of proportionalism and which Clark (2006: 9) says is the “linchpin for resolving which option is the lesser of two evils”. What, then, is a “proportionate reason”? Clark quotes G. Kelly who says that the term *proportionate reason* means that “according to a sound prudential estimate, the good to be obtained is of sufficient value to compensate for the evil that must be tolerated” (p. 9). As I have already alluded to above, proportionalism requires that there is some form of “weighing” (some prudential estimate) of the values at stake in order to permit the occurrence of the foreseeable evil consequences that may come about as a result of achieving some specific moral good or value. Gula (1989: 273) notes that proportionate reason refers, therefore, to “both a specific value and its relation to all the elements (including the premoral evils) in an action.” This implies that one must consider all the factors, both good and bad, and then decide whether or not a particular action is either morally good or bad.

But how does one determine this proportionate reason? Gula says that according to McCormick, there are three criteria that are necessary for deciding this relationship between the value and all the other elements involved in an act. These are that (1) the means do not cause more harm than necessary to achieve the value, (2) no less harmful way exists at present to protect the value, and (3) the means used to achieve the value will not undermine it. I will come back to these three criteria in Chapter 5 when I shall apply the PLE to the issue of condom provision in Zambian male prisons. Here, let me briefly try to explain these three criteria using an example from medical ethics as given by Gula (1989) of a surgeon who is seeking to protect the life of a patient by the surgical amputation of a diseased leg that is endangering the life of that patient.

4.2.1 The means do not cause more harm than necessary to achieve the value

The surgeon has to weigh the two sets of values at stake: bodily comfort (or bodily integrity) versus the total well-being (life). Since the surgeon has decided that the

patient's total well-being can only be preserved by amputating (action) the leg, it becomes inevitable, therefore, that the leg has to be amputated. However, the surgeon must ensure that the means he will use do no cause more harm than is necessary. The surgeon, according to this criterion, should not cut more than what is necessary (for example, the cutting-off of even the healthy part of the leg) since this will be tantamount to mutilation.

4.2.2 No less harmful way exists at present to protect the value

It is believed that the surgeon has considered the other option of not amputating the leg as not being viable. The option available to him, which is the amputation of the leg, will enable him to protect the value of the total-well being of his patient. In the process of amputating the leg, however, the patient has to suffer some pain (pre-moral evil). According to this criterion, such pain should be permitted because of the greater good that will be brought about by the action of leg amputation – the total-well being of the patient. This pain should be condoned because no other less harmful way exists that can enable the surgeon to protect the value of human life of his patient.

4.2.3 The means used to achieve the value will not undermine it

Under this criterion, Gula (1989; 274) has noted that “the way to reach a moral evaluation of an action is to consider the proportionate relationship of the material action and the intention in the total set of essential circumstances”. The choice of amputating the leg is proportionate to the realization of the intention (preservation of the total-well being of the patient). The objective in the assessment of which values to preserve should, therefore, be to consider those acts which foster the total well-being of human life. The amputation of the leg, in this case, preserves life and the surgeon is, therefore, right to take up this course of action after considering all the other factors in the two available options to him.

A question may arise here: does proportionalism advocate for relativism and subjectivism since the surgeon himself has to make this moral judgement? Gula (1989: 276) replies to this by saying that proportionalism is relative in the sense that the “intention and circumstances, or all the objectively given aspects which make up the total meaning of an action, are relevant to the morality of human action”. Against the objection of subjectivism, he says that an action does not become moral because one

thinks so, rather, “the material element of the action must be apt matter to sustain its intention, or form.” Hence, in this case, the surgeon thought of the *action of amputating the leg* as a lesser evil than the risk of destroying a human life. Meanwhile, the patient will have to endure some bodily pains as a result of the action of leg amputation.

Another question that arises from the Catholic moral point of view is this: does a person who counsels another person to perform a lesser evil participate in the commissioning of that evil? St. Alphonsus Ligouri as quoted by Ferrer (2002: 190) said that “he who counsels the lesser evil does not intend the evil but its reduction”. Ferrer stresses this point even further by saying that he who advises the actor to choose the lesser evil is not guilty himself, but “advises it *sub specie boni*, in order to reduce the harm or evil that the other is about to commit and the counsellor does not approve of”. Approval of a lesser evil, according to Ashley and O’Rourke (1996), would be tantamount to formal cooperation, and, therefore, this would be illicit. However, it is the duty of the counsellor to counsel one who is already determined to commit a greater evil to perform a lesser one. For instance, Ashley and O’Rourke state that a “physician who has failed to persuade a young patient from reckless sexual activity may point out that in his evil activities he still has the obligation to take precautions not to infect others or be infected with AIDS” (p. 193). Furthermore, Peschke (1993: 324) adds by saying that “it is even lawful to help the evildoer to perform the robbery, if he can thus successfully be restrained from killing his adversary”. Stealing, in terms of the ranking of values is of course *better than* killing.

It has been established from the discussions in this chapter that in this dissertation, the PLE requires that when one is faced with a moral conflict-situation that requires a choice from *only* two options both of which have some foreseeable evil consequences, one ought to choose that option (action) which is a lesser evil. Understood from this perspective, the PLE has limitations in terms of its practical applications particularly to those moral conflict-situations involving more than two bad options. Furthermore, the problems of value ranking and moral absolutism put a constraint on the wider practical application of this “time-honoured principle”.

Chapter 5

APPLICATION OF THE PRINCIPLE OF THE LESSER OF TWO EVILS TO CONDOM PROVISION IN ZAMBIAN PRISONS

Cardinal Carlo Maria Martini says that the use of condoms can constitute in certain situations a lesser evil (see Spielthener, forthcoming). I would believe that although this statement was made within the marriage context, many people are of the opinion that condoms should be provided in any human environment where there is a risk of sexual transmission of HIV. But to say that condom provision can be considered in certain situations as a lesser evil means that there ought to be a greater evil that should not be permitted to occur. As I have earlier mentioned, we need to consider all the circumstances surrounding a particular course of action in order to determine which action can be termed as a lesser evil. In this section, I consider the two options available; either the *act of condom provision* in Zambian male prisons or the *act of not providing* condoms. Which of the two acts can be considered as a lesser evil?

To pursue this question, I shall, firstly, try to consider the arguments both for and against condom provision in Zambian male prisons. Secondly, I will attempt to apply the PLE to the issue of condom provision in prisons and also to discuss whether or not the act of condom provision in Zambian male prisons can qualify to be called a lesser evil.

5.1 Arguments for and against Condom Provision in Zambian Prisons

The issue of condom provision in Zambian prisons has attracted some heated debate in Zambia as can be seen from some recent media publications (see, for instance, Chansa, 2008). The interest in this debate could be due to some concerns regarding the reported high rates of HIV prevalence in Zambian prisons which, if left unattended to, could result into a catastrophic situation where more prisoners would be infected with the deadly virus resulting into losses of more lives through AIDS. The other concern could be from the fact that since most prisoners are likely to be integrated into their communities sooner or later, they could potentially become a threat to the transmission

of HIV into the wider Zambian community thereby reversing all the gains that are currently being made in this regard.

In this section, I intend to consider the main arguments for and against condom provision in Zambian prisons. This section is important because the PLE requires that before one determines which evil is lesser to be permitted, one ought to consider all the prevailing circumstances of the two available options.

5.1.1 Arguments for condom provision

In general, the main arguments for condom provision in Zambian prisons are that (a) condoms are disease-control devices, (b) provision of ARVs is costly and unsustainable, and that there are (c) inadequate qualified medical personnel in the public health system.

(a) Condoms are disease-control devices

Proponents (e.g., Nkandu Luo, a consultant on health and HIV/AIDS issues and Professor of Immunology at the School of Medicine of the University of Zambia) argue that a condom must be seen as a disease-control device. If seen from this perspective, the obvious benefit of providing condoms in Zambian prisons is that this would result in the prevention of sexual transmission of HIV. Jürgens (2006) has observed that although studies done in other prison systems around the world have not conclusively determined whether infections have been prevented due to condom provision in prisons, they have, however, shown that condoms are effective means of preventing sexually transmitted infections. There is also evidence that prisoners actually use condoms.

To prevent disease in prisons is to reduce incidences of morbidity and mortality. There are many reported cases of diseases in Zambian prisons. The most common of these diseases are, according to Simooya and Sanjobo (2005), malaria, STIs, tuberculosis (TB), scabies, diarrhoeal diseases, and night blindness. The feedback from the questionnaire (see Appendix I, p. 52) that was sent to nine Provincial Central Prisons also show that malaria, TB, and diarrhoeal diseases are the most common illnesses in the six prisons that responded to question number 7 of the questionnaire. Most of these diseases are interlinked with HIV/AIDS. For instance, Chakwe (2009: 4) alludes to the 2009 Global Tuberculosis Report which observes that one out of four TB

deaths is HIV-related. Therefore, condom provision in Zambian prisons can be expected to result in the prevention of such diseases which currently are afflicting prisoners.

UNAIDS (2006) has observed that although there have been limited statistical data on the current HIV prevalence rates of HIV in Zambian prisons, the HIV situation is “grave”. This is reflected in the number of AIDS-related deaths that are said to occur in prisons. For example, it is reported by MOHA/ZPS (2006) that between the years of 1995 and 2000, 2,397 prisoners and 263 prison staff died from AIDS-related illnesses in Zambia. If these figures are to be relied upon, it means that almost 44 prison staff and 400 prisoners die from AIDS-related illnesses on average every year! This situation cannot be allowed to continue and it is in this line that proponents are arguing that these deaths can be reduced if condoms are allowed to be provided in prisons.

It is known that most HIV infected persons develop AIDS sooner or later. It is, for instance, stated by the US Centre for Disease Control (see, Norberry and Chappell, 1989) that after seven years of HIV infection, 30% of individuals develop AIDS and a further 49% develop AIDS-related complex (ARC). In Zambia, the average time (in the absence of ARVs) from AIDS to death is one year (see NAC, 2004). In between, there are huge expenses to be paid in terms of care and treatment for these ARC illnesses.

It is, then, argued based on the above reasons that preventing the occurrence of sexual transmission of HIV will ultimately lead to reduction in cases of morbidity and mortality. Evidence from other prison systems in the world where condoms are provided shows that condoms are effective in preventing STIs. It is being advocated, therefore, that condoms should be provided in Zambian male prisons as well.

(b) Provision of ARVs is costly and unsustainable

Prisoners in Zambia are supposed to access medical care and treatment through the general public health services either adjacent to or located within the prison compound (GRZ/NAC, 2006). By the year 2006, there were only 15 such medical clinics at prisons around the country. According to Frederick Chilukutu, the Zambia Prisons Service HIV/AIDS focal point person, prisoners have been treated depending on the availability of medicine, which of course, is very erratic (personal communication, 15th July, 2008).

In terms of AIDS treatment, the current policy of the Zambian government is to provide free ARVs to all HIV positive people (prisoners inclusive) who are clinically eligible. The number of prisoners on ARVs is not clearly known, but it has been observed that countrywide, the number of recipients for ARVs has been growing. For instance, from 2005 to 2006, the proportion of persons with advanced HIV requiring ARVs increased from 26% to 29% (GRZ/NAC, 2006). In 2006, 280,000 HIV positive persons were eligible for ARVs. Based on the assumption that most of the incarcerated people in Zambian prisons are from vulnerable backgrounds where the risk of HIV infection is very high, it is reasonable to assume that the number of prisoners who may be clinically eligible for ARVs must also be very high.

ARV medication is not cheap, and Kantor (2006) has observed that HIV requires health services that are expensive in terms of expertise and staff efforts, laboratory testing, and specific medication. In Zambia, it is calculated that the average cost per person per year for a course of ARV treatment is US\$480 – 490, of which 57% goes to drugs and 36% is for laboratory tests while the remaining 7% is in other hidden costs such as transport (Kaputo, 2007). This huge medical bill is borne by the Zambian government through a US\$ 254 million fund that was secured from the Global Fund in 2004. Further financial support for HIV/AIDS programmes and treatment comes from other cooperating partners such as UNAIDS and USAID.

Proponents argue that the cost of HIV/AIDS treatment is unsustainable in a poor country like Zambia that spends less than 10% of its annual national budget on public health. It is also not guaranteed that donors will continue funding ARV treatment in Zambia. If donors fail to fund ARV treatment, there could be erratic supply of drugs to AIDS patients. Once put on ARVs, a patient is expected to be on those drugs for the rest of his/her life. It is argued, therefore, that the best way is to prevent HIV infection from occurring in the first place. Condom provision in Zambian prisons is seen as one such effective preventive intervention.

(c) Inadequate qualified medical personnel in the public health system

Zambia has a shortage of medical personnel and technicians and ARV treatment requires specialised treatment and counselling. Prisoners are supposed to access this kind of treatment through public health services and their treatment largely depends on the availability of these skilled health workers. However, there has been a shortage of

skilled health workers in Zambia for some time now, due to the fact that a lot of medical personnel have left the country in search of the so-called “greener pastures” in other countries where there are better remuneration packages in terms of salaries and other working conditions. Kaputo (2007) alludes to the 2004 Report on global AIDS epidemic which states that Zambia has trained more than 600 doctors since independence (in 1964). Of these, only a paltry number of 50 doctors are available while the rest have migrated either to South Africa or to western countries where working conditions are much better. He further observes that it was estimated in 2003 that providing treatment to any HIV positive person eligible for ARV treatment, would require, after five years, twice the number of laboratory technicians and half of all the doctors that were available at that time in the public health system. This shortage of qualified medical officers is a constraint to the quality of medical care and treatment since the medical officers who remain behind are usually outnumbered by the number of patients seeking medical attention. The danger here again is that the majority of these medical officers who remain behind to attend to such patients may have limited skills in managing AIDS-related diseases.

Since prisoners require medical treatment through the public health services, it means that they too cannot receive adequate health care and treatment due to this shortage of qualified medical staff. It becomes prudent, therefore, to reduce incidences of HIV infections in prisons.

5.1.2 Arguments against condom provision

Opponents (e.g., Enoch Mulembe, the Director of the Zambia Human Rights Commission) seem to base their arguments on the fact that (a) homosexuality is illegal, (b) condoms are not effective, and (c) prisoners may not actually use condoms.

(a) Homosexuality is illegal

It has been argued that MMS is homosexuality and in the context of a male prison set up, this is sodomy. Homosexuality and sodomy are legally prohibited in Zambia (see Chapter Three). Due to this legal prohibition, all prisons that responded to the questionnaire schedule indicated that condoms are not provided in their prisons (see Appendix I, p. 52, questions 12 and 13). It is perceived that providing condoms in prisons encourages homosexuality, an illegality, and, therefore, opponents say it cannot

be supported. This abhorrence of homosexuality seems to come from the fact that most Zambians do not accept homosexuality as a normal sexual behaviour; it is considered as a sexual aberration. This is the reason why most Zambians perceive homosexuality to be “unZambian”, “a criminal activity”, and “unchristian”.

The “unchristian” aspect of homosexuality is likely to have been influenced by Christianity. Kaputo (2007) says that most Zambians (about 50-70%) consider themselves to be Christians. Christianity in Zambia consists mainly of Catholics, Protestant Churches (such as the Anglicans, Lutherans, and the Reformed) as well as other Pentecostal and Evangelical denominations. Generally, these churches perceive the sexual act as a conjugal act, meaning that it is an act that is supposed to happen only within the marriage context. Its purpose is for the procreation of children as well as for the nurturing of the marriage love. MMS is, therefore, an adulteration of sex and to provide condoms in prisons is to encourage the misuse of sex. The Catholic Church teaches, for instance, that anybody who excludes the begetting of children within the marriage context frustrates the natural power of sex and commits an offence against the law of God and of nature (Kaputo, 2007). Such a person commits a grave sin. One, therefore, must remain chaste if one is unmarried.

(b) Condoms are not effective

The other objection emanates from the technical aspect of the effectiveness of male condoms as a disease-control device. Opponents observe that there have been some concerns raised regarding the failure rates in the prevention of pregnancies and STIs (see WHO, 2007). They say that these failure rates occur in both *method effectiveness* and in *actual effectiveness*. The method effectiveness refers to the correct and consistent use of the condom while the actual effectiveness concerns the use of the device for the sole purpose of birth control (although now condoms are used for the prevention of sexual transmission of HIV and STIs). It is argued that in both cases, there have been failure rates.

While the failure rate in method effectiveness is estimated to be at 2% per year, actual effectiveness in pregnancy (depending on the population studied) range from 10-18% per year (see Kaputo, 2007). Various reasons have been advanced in order to explain these failure rates, particularly as related to physical damage and manufacturing defects. For instance, due to expiration or improper storage, male latex condoms can

easily be damaged. Condoms may also be spoiled by being exposed to sunlight, heat, and humidity. In MMS, there are very high chances that a condom can easily be damaged because of the high friction involved during that kind of sexual activity. Furthermore, Kaputo has indicated that experienced condom users are significantly less likely to have a condom slip or breakage compared to those who use them for the first time. This is of major importance in a prison environment where a majority of victims of MMS are young and newly incarcerated persons.

It is also said that there are naturally inherent occurring flaws in the natural rubber (latex) from which condoms are made. These flaws range from 5 to 70 microns in diameter (see Kaputo, 2007). The average sperm cell is estimated to be about 5 microns in diameter while that of the HIV-virus is about 0.1 micron. This means that the HIV-virus can easily pass through these natural flaws of the male latex condom. It is argued, therefore, from these observations that condoms are not effective in preventing sexual transmission of HIV.

(c) Prisoners may not actually use condoms

The other objection to condom provision in male prisons hinges on the belief that even if condoms were to be provided in prisons, there is no guarantee that prisoners can actually use them. It has been argued (Reyes, 2000) that sexual relations in prisons do not warrant the correct and consistent usage of condoms because most prisoners who engage in MMS are not homosexuals; they are forced into having these sexual acts because of the pressure of the prison environment. It is argued by the opponents of condom provision in male prisons that MMS is performed under duress. In such circumstances, those who engage in MMS are not likely to have the leisure of time to use a condom. This makes the argument of condom provision in prisons misplaced because condoms are not likely to be used.

From the above three observations, it has been concluded that condoms should not be provided in prisons. Condoms may be a protection but not a solution and that the only sure way of preventing sexual transmission of HIV is to abstain and, in a marriage context, to be faithful to one sexual partner. Furthermore, opponents propose that prison reforms should take place. For example, it is recommended that prisons should be decongested so that prison authorities can effectively police the few inmates under their

custody. Decongesting prisons also create adequate space in the prison sleeping quarters; overcrowding in the sleeping quarters perpetuates the occurrence of MMS.

The above two polarised arguments attest to the fact that there is no consensus in Zambia as to which method is best suited to deal with the issue of preventing sexual transmission of HIV in Zambian male prisons. It is, however, accepted in both camps that there are very high HIV prevalence rates in Zambian male prisons and that there is an urgent need to find workable preventive interventions in order to reduce such rates.

5.2 Condom Provision in Zambian Prisons as a Lesser Evil

It has been explained in Chapter 4 that one ought to have a proportionate reason for permitting a lesser evil. But, before I analyse the intentions, circumstances, and consequences of condom provision in Zambian male prisons in light of the PLE, I take cognisance of the observations made by Spielthener (forthcoming) concerning some common pitfalls involved in lesser evil reasoning. Of particular concern is the fact that most authors, when analysing the PLE involving those moral conflict-situations where it is required that all foreseeable outcomes are considered, tend to limit their conclusions on an analysis of only some negative outcomes. He argues that this is incorrect because all the outcomes, both negative and positive, need to be taken into consideration.

As I briefly alluded to earlier, proportionalism requires that all circumstances relating to a particular action need to be taken into consideration. Proportionalism does not limit itself only to consequences but to all the other factors that give an action its entire meaning. It is only after so doing that a particular action can be termed to be either morally bad, morally less bad or morally good. What gives a particular action its meaning is proportionate reason which I considered in Chapter 4 and this is important in evaluating that action.

In what follows below, I intend to analyse the policy of *condom provision* in Zambian prisons within McCormick's three criteria necessary for determining the presence of proportionate reason.

5.2.1 Condom provision does not cause more harm than necessary in protecting the value of human life

The proponents of condom provision in Zambian prisons are arguing that the object of condom provision is to protect the value of human life. If condoms are made available in prisons those prisoners who may engage in MMS (either by force or by consensus) could use condoms as a disease preventive mechanism. If this happens, it is argued that sexual transmission of HIV could be reduced. This will result into protection of human life.

A question of concern here is this: is the use of condoms harmful to the realisation of the value of the protection of human life? The WHO (2007) observes that studies done elsewhere in other prison systems of the world show that condom accessibility may help to reduce sexual transmission of HIV and other STIs in prisons. It was for instance shown by the study done in New South Wales that when condoms were introduced in prisons, there were high levels of condom usage by the prisoners, particularly by those who were engaging in anal sex.

Furthermore, WHO (2007) has stated that studies undertaken in the USA and Australia have shown that providing condoms in prisons has no adverse consequences. However, it is strongly advised that introducing condoms in the prisons of those countries where there are deeply held negative views about same-sex might prove to be difficult. This was seen, for instance, from the 1997 prison strike and riot by both the prison staff and the prisoners in Kingston (Jamaica) where six people died following the government's decision to introduce condoms in prisons. From this experience, it was realised that education (e.g., HIV/AIDS awareness programmes) should precede condom introduction in prisons.

Jürgens (2006) has also noted that provision of condoms in prisons does not lead to an increase in sexual activity. Only minor incidents of misuse such as water balloons, water fights and littering have been recorded. But these incidents are not harmful to the value of the protection of human life.

5.2.2 Condom provision is not harmful to the protection of human life

Opponents of condom provision in Zambian male prisons argue that condoms are not effective in the prevention of sexual transmission of HIV and therefore do not protect human life. Kaputo (2007) observes that condoms are ineffective in the prevention of

sexual transmission of HIV for a variety of reasons: they can allow the passage of the HIV, they can break during sexual intercourse, they can slip off, and they can be used incorrectly. But others (e.g., Norberry and Chappell, 1989) have replied that although condoms do not totally protect against HIV, they can, if used correctly, significantly reduce the risk of HIV transmission. A 2001 report by the US National Institute of Health (see Kaputo, 2007) says that correct and consistent use of the latex condom reduces the risk of acquiring HIV transmission by approximately 85% relative to the risk when unprotected. Surely, if this statistic is correct, it means that it is better to use condoms when engaging in any risky sexual activity than not to.

The above evidence testifies to the fact that despite condoms not being 100% effective in the prevention of HIV, they can, if correctly and consistently used, protect the value of human life. Correct and consistent use of a male latex condom can only be guaranteed if HIV/AIDS awareness programmes are frequently offered to prisoners. MMS occurs in prisons and prisoners need to be made aware of the danger of engaging in MMS. In this vein, it is being said by the proponents that condoms promote the value of human life.

To argue in favour of condom provision in prisons is not to say that this is *the only* best method of preventing sexual transmission of HIV in prisons. What is being advocated here is that condoms are necessary to the protection of human life in a prison environment where MMS occurs and studies elsewhere have shown that the male latex condom is the single most efficient available technology to reduce the sexual transmission of HIV and other sexually transmitted diseases (see WHO, 2007). But, in order for condoms to be effective and used for this purpose, other issues (such as explaining the reasons as to why condoms are being provided) ought to be taken into consideration.

5.2.3 Condom provision does not undermine the value of human life

The object of providing condoms in prisons is to preserve human life. Condoms are seen as disease-control devices and not as instruments to encourage prisoners to get involved in MMS. Some opponents to condom provision in Zambian male prisons argue that condoms demean human sexuality which is intended solely for procreation and for cementing the marriage union. MMS, therefore, is an infringement on human dignity. This is why homosexuality is considered evil. As an evil, it should never be

done. Spielthener (forthcoming) says that this view is held by some Catholic moral theologians who believe in the existence of some absolute moral norms. These absolute moral norms should never be violated or transgressed. This school of moral thought teaches that any act that is intrinsically evil is wrong in all circumstances and, therefore, should never be performed. In this regard, there are no circumstances in which homosexuality can be supported because it is intrinsically evil. This is why condoms cannot be justified under the PLE because MMS frustrates the nature and purpose of human sexuality and, as such, it undermines human dignity.

But proponents argue to the contrary. They say that what is at stake here is human life which the act of condom provision tends to protect. It is a fact that MMS takes place in prisons and it would, therefore, be irresponsible not to reduce the danger of acquiring HIV in these circumstances. Condoms reduce this risk of acquiring HIV through sexual intercourse and, so, they should be made available in prisons.

Providing condoms in prisons is not condoning the wrong use of sex; rather, it is intended to avoid committing another ethically wrong action by not protecting prisoners from acquiring a fatal disease. In this regard, Kelly (2006) says that the PLE is applicable in those circumstances where there are high-risk sexual activities. A male prison environment is one such place where there are high-risk sexual activities. If MMS is to occur, it should be performed in such a way that the danger of transmitting HIV is eliminated or at least reduced. Therefore, the provision of condoms in prisons is one such way of reducing the risk of transmitting a life-threatening infection. Kelly concludes by saying that in such a situation, the ethically wrong use of sex remains but without the use of condoms, there would be another ethical evil of putting other prisoners at risk of acquiring a life-threatening disease. This is in agreement with Ashley and O'Rourke (1996) who say that those infected have the obligation not to infect others even in their reckless sexual activity. MMS is such a reckless sexual activity that has a potential to transmit HIV. In this regard, the PLE is applicable to condom provision in Zambian prisons.

In this chapter, I have attempted to consider the main arguments for and against the issue of condom provision in Zambian prisons. It can be realised that condom provision has medical, health and economic benefits. The major disadvantage is that condoms may not be correctly used for the intended purpose of disease control. However, if provided and if used correctly and consistently, it can be expected that this

will result in the benefits that I have already discussed above. Overall, provision of condoms can be seen as a lesser evil as compared to the other option of not providing condoms. The policy of *providing condoms* may be seen as an evil because this may result in going against the value of chastity, in breaching the Zambian Laws, and in risking the lives of prisoners of acquiring HIV. The policy of not *providing condoms*, on the other hand, may result into another evil of high medical bills, increased cases of morbidity and mortality, and losses of prisoners' lives through HIV/AIDS infections. However, I have argued that since prisoners are likely to continue engaging in MMS, it is ethically justifiable to consider the policy of *condom provision* in Zambian male prisons as a *lesser evil* because it is established that condoms do actually protect the value of human life by preventing sexual transmission of HIV. Even if there are some doubts regarding the actual and method effectiveness of a male latex condom, it is ethically right to provide condoms in Zambian male prisons where the risk of sexual transmission of HIV is high. Furthermore, it is my view that the disadvantages of not providing condoms outweigh the disadvantages of condom provision and therefore condom provision in male prisons qualifies as the lesser of two evils.

Chapter 6

GENERAL CONCLUSION AND RECOMMENDATIONS

In this chapter, I intend to sum up this dissertation and also try to offer some recommendations to the Zambian government that can help to reduce sexual transmission of HIV in Zambian male prisons.

6.1 *General Conclusion*

In this dissertation, I have attempted to consider some of the preventive interventions that are being implemented to prevent sexual transmission of HIV in the prison systems around the world and specifically in Zambian male prisons. When discussing these preventive interventions, the focus was on those measures that have specifically been

put in place to prevent sexual transmission of HIV in male prisons. It has been discovered that there is quite a good number of these interventions that have been put in place although much more needs to be done in order to make them well adapted to the prison environment. Prison environment is a peculiar environment that requires specific and well targeted preventive interventions which, in certain cases, may be totally different from those being implemented in the general population.

It has been noted that there are no reliable current data on the trend of HIV/AIDS in Zambian male prisons although the situation has been described as being "grave". There are very high incidences of morbidity and mortality in Zambian prisons. To address this worrisome situation, there is an urgent need to institute appropriate and effective preventive interventions because those that are currently being implemented are either not appropriate or appear to be less vigorously pursued.

Due to the nature of the prison environment, HIV/AIDS should not be seen only as a prison health problem; it is more than just that and all efforts must be made to fight this scourge which has affected all sectors of the Zambian society. This calls for a broad-based multi-sectoral approach. Therefore, we need to vigorously pursue those measures that are likely to work in a prison environment so that sexual transmission of HIV can be reduced. By so doing, we will not only be protecting prisoners from acquiring HIV infections but we will also be protecting the general Zambian population from being infected from the same deadly virus. This is the reason why I have stated in this dissertation that prison health must be considered as a public health issue that requires public commitment. It is an undertaking that calls for massive political and civil will in terms of both human and financial resources.

I have discussed one controversial preventive intervention which is the issue of condom provision in Zambian male prisons. It is a controversial preventive intervention in Zambia because of the socio-cultural, religious and legal issues surrounding condom use. Using the PLE, the proponents of condom provision are arguing that condoms are necessary and effective in the protection of the value of human life. They are arguing that provision of condoms in Zambian male prisons should be seen as a disease-control measure, that provision of ARVs is costly and unsustainable, and that there are inadequate qualified medical personnel in the public health system. It is being argued, therefore, that what must be done is to prevent HIV infections from occurring and condom provision is seen as one such proven preventive intervention. This is not to say

that condoms are 100% effective; rather, the argument is that since MMS occurs in prisons, it would be morally right to empower prisoners with a sexual device that is likely to protect prisoners from acquiring this deadly virus. Condoms do just that.

It has been shown in this study that in other prison systems of the world, condoms are being distributed and indications are that prisoners actually use these condoms when they are made available and this has resulted in the prevention of STIs giving hope that HIV infections could also be reduced in Zambian prisons. But as it has been noted, doing so in those countries with negative views towards homosexuality may prove to be difficult unless this is done within the wider context of HIV/AIDS education awareness programmes.

In my view, the act of condom provision should be seen to be effective in as far as it is part of the wider efforts to scale up workable preventive interventions of sexual transmission of HIV in prisons. It is not the *only* best available option but it has been proven to be effective in preventing STIs in other prison systems where condom provision is allowed.

However, caution should be exercised if the act of condom provision is chosen. This is to be in agreement with Kelly (2006) who observes that condom provision should not be done anyhow as though one is handing out sweets. This is being irresponsible and unethical. It must be ensured that those who are likely to have access to condoms must have an opportunity to some understanding as to why this sexual safety device is being distributed. Of course, the safest way to prevent sexual transmission of HIV is to abstain but if this cannot be done, then, one should have access to the use of condoms. I have mentioned that in a male prison environment, there are numerous tensions which exist and prisoners tend to release these tensions in a variety of ways, one of them is by engaging in MMS. Therefore, MMS is likely to continue occurring in male prisons posing a threat to HIV transmission from the infected to the uninfected. Condoms reduce the chances of HIV infections.

In the section that follows , I make some recommendations that I feel are worth noting by the Zambian government when putting up policies necessary to fight sexual transmission of HIV in Zambian prisons.

6.2 *Recommendations*

From the discussions in this dissertation, it is clear that urgent action is needed in order to put in place appropriate and effective preventive interventions to curb sexual transmission of HIV in Zambian prisons. Based on my research, the following are my recommendations:

- (a) HIV/AIDS awareness programmes are essential to fighting sexual transmission of HIV in Zambian male prisons. To this effect, the Government needs to put in place a standing order in all prisons stating that HIV/AIDS awareness programmes are compulsory upon entry to all newly imprisoned persons. This will empower prisoners, at least in terms of awareness, with the knowledge about the risky behaviour involved in engaging in MMS. It is assumed that with this knowledge, prisoners would take precautionary measures when coerced into MMS. Furthermore, these same programmes should be offered to prisoners immediately before they are released from incarceration into society.
- (b) HIV/AIDS education must also be compulsory in the training schools of Zambia Prisons Service so that the newly recruited prison staff members can be equipped with such knowledge when policing prisoners. Currently, only selected prison officers are being sent to higher colleges (such as Chainama College of Health Sciences) to do specialised training in HIV/AIDS-related programmes. Such programmes must specifically focus on how to prevent the occurrence of sexual violence, intimidation and rape.
- (c) Sexual violence, rape, and intimidation occur in Zambian prisons. To this effect, it is recommended that an Act of Parliament be passed to criminalise these acts with specific punishments apart from what is provided for in the Penal Code.

(d) A deliberate working policy should be put in place to ensure that victims of sexual violence can immediately have access to PEP; there should also be specific guidelines for the use of these PEP services within the prison environment.

(e) Realising that MMS will continue to occur in Zambian male prisons despite putting in place other preventive interventions, it is strongly recommended that condoms be provided in prisons. Homosexuality and sodomy do not only take place in prisons; these acts also take place in the general Zambian population where condoms are easily distributed. Using the *equivalence principle*, prisoners should also have access to condoms.

Given the fact that most Zambians have negative views towards condom provision in prisons, condoms should be put in discreet places where the would-be users can easily access them without being seen by fellow inmates. Condoms can, for instance, be put in toilets, shower areas, or any other such area where they can be picked up without being seen or without asking for them. Realising the fact that condoms may break during MMS thereby increasing the risk of HIV transmission, water-based lubricants should also be made available. Providing water-lubricants is in conformity with the purpose of providing condoms in prisons.

(f) Urgent action is needed to implement the requirement of decongesting prisons. An ideal situation is to work towards having one or two prisoners in a cell that is well policed as well as well lit. I am aware of the fact that the Zambian government lacks the financial capacity to institute such a massive project at one go, but such a project can be spread out over years as long as there is political will to do so. Lack of resources is not an excuse under international law.

It is also strongly recommended that the use of non-incarcerating sentences on non-violent crimes be promoted. This could

significantly lead to reductions in the number of people being sent into *Zambian* prisons.

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APPENDICES

APPENDIX I QUESTIONNAIRE SCHEDULE

A QUESTIONNAIRE SCHEDULE ADMINISTERED TO NINE (9) PROVINCIAL STATE PRISONS ON **“THE PREVENTION OF SEXUAL TRANSMISSION OF HIV IN ZAMBIAN PRISONS: AN ETHICAL PERSPECTIVE ON THE PROVISION OF CONDOMS”**.

Dear Sir/Madam,

My name is Christopher Mofya Lukusu, a student at the University of Zambia, Great East Road Campus, Lusaka, Zambia. I am studying for M.A. in Applied Ethics. I am carrying out a research on the topic **“Prevention of Sexual Transmission of HIV in Zambian Prisons: An Ethical Perspective on the provision of condoms.”** It is my view that since you are the Officer-in-charge of the prison, you are in a better position to assist me in answering some of the questions here attached.

Please, be assured that the questions being asked here are general questions and meant for academic purposes only: neither your personal name nor that of your institution will be mentioned, unless, of course you so wish. Be assured that your responses will be treated in a very confidential manner and so, there is no need for you to feel afraid of any vindication whatsoever afterwards.

INSTRUCTIONS: Tick () against your answer.

1. What is your post? (a) Officer-in-charge ()
(b) Station Inspector ()
(c) Other ()

2. What is the classification of your prison?
(a) Main prison ()
(b) Open air prison ()
(c) Other ()



3. What is your prison population?
(a) 1 - 1,000 ()
(b) 1,001- 2,000 ()
(c) 2,001- 3,000 ()
(d) 3,001 and above ()

4. How would you describe the prison population as related to prison facilities?
(a) less population ()
(b) normal population ()
(c) overpopulation ()

5. In which age category do most of your prisoners fall?
(a) 15 -29yrs ()
(b) 30 -44yrs ()

(c) 45 - 51yrs ()

(d) 52yrs and above ()

6. Do most of your prisoners frequently fall sick?

(a) No ()

(b) Yes ()

7. If the answer to Q.6 is "Yes", which is the most frequent illness that most of your prisoners suffer from?

(a) TB ()

(b) Malaria ()

(c) Diarrhoea ()

(d) Syphilis ()

(e) Other ()

8. Where do your prisoners access medical treatment?

(a) Government-owned hospital/clinic ()

(b) Privately-owned hospital/clinic ()

(c) Prison-owned medical clinic ()

9. Are there cases of reported sexual intercourse in your prison?

(a) No ()

(b) Yes ()

10. If the answer is Yes to Q.9, which form of sexual intercourse is common among the reported cases?

(a) Heterosexual ()

(b) Homosexual ()

11. Have you had reported cases of sexual intercourse between prisoners and non-prisoners?

(a) No ()

(b) Yes ()

12. Does your institution provide condoms for personal use by prisoners in case they want to have sex?

(a) No ()

(b) Yes ()

13. If the answer is "No" to Q.12, what is the reason?

(a) It is against prison regulations ()

(b) It is illegal ()

(c) It is immoral ()

(d) Sexual intercourse does not occur ()

(e) No reason at all ()

14. Do you offer information, education and communication materials about safe sex and HIV/AIDS to your prisoners?

(a) No ()

(b) Yes ()

15. If the answer is Yes to Q.14, how would you describe the relevance of these materials to prison life?

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(a) Less relevant ()

(b) Relevant ()

(c) Very relevant ()

APPENDIX II CHAPTER 87 OF THE LAWS OF ZAMBIA

155. Any person who-

- (a) has carnal knowledge of any person against the order of nature; or
 - (b) has carnal knowledge of an animal; or
 - (c) permits a male person to have carnal knowledge of him or her against the order of nature;
- commits a felony and liable, upon conviction, to imprisonment for a term not less than fifteen years and may be liable to imprisonment for life:

Provided that where a person-

- (I) has carnal knowledge of a child against the order of nature;
- (ii) causes a child to have carnal knowledge of an animal; or
- (iii) permits a male person to have carnal knowledge of a male or female child against the order of nature;

that person commits an offence and is liable, upon conviction, to imprisonment for not less than twenty-five years and may be liable to imprisonment for life.

(As amended by No. 26 of 1933 and repealed and replaced by Act No. 15 of 2005)

158. (1) Any male who, whether in public or private, commits any act of gross indecency with a male child or person, or procures a male child or person to commit any act of gross indecency with him, or attempts to procure the commission of any such act by any male person with himself or with another male child or person, whether in public or private, commits a felony and is liable, upon conviction, to imprisonment for a term of not less than seven years and not exceeding fourteen years.

(2) Any female who, whether in public or private, commits any act of gross indecency with a female child or person, or procures a female child or person to commit any act of gross indecency with her, or attempts to procure the commission of any such act by any female person with himself or with another female child or person, whether in public or private, commits a felony and is liable, upon conviction, to imprisonment for a term of not less than seven years and not exceeding fourteen years.

(3) A child who, whether in public or private, commits any act of gross indecency with another child of the same sex or attempts to procure the commission of any such act by any person with the child's self or with another child or person of the same sex, whether in public or private, commits an offence and is liable, to such community service or counselling as the court may determine in the best interests of the child.

(As amended by No. 26 of 1933 and repealed and replaced by Act No. 15 of 2005)