



PRISONS IN SOUTHERN AFRICA

A DISCUSSION PAPER

June 2015

Presented by:



Knowledge for action: The power to make a difference!



AIDSAccountability
International

WWW.AIDSACCOUNTABILITY.ORG

AIDS Accountability International's vision is a world where strong and accountable leadership permeates all levels of society to ensure effective responses to health challenges.

We do this by increasing transparency, promoting dialogue and supporting action for an improved response.

Cover photo - UN Photo/Christopher Herwig.

ACKNOWLEDGEMENTS

Phillipa Tucker, Co-Founder and Research and Communications Director at AIDS Accountability International (a SAfAIDS strategic partner), is the principal author of this report, working with and through SAfAIDS Head of Technical Services, Katrina Wallace-Karenga. Additional peer review and oversight was received from Rouzeh Eghtessadi, SAfAIDS Deputy Director and Lois Chingandu, Executive Director.

- **Cover photo credit:** A Nimba county prison inmate looks through the window of a cell during a tour of the overcrowded facility by Henrietta Mensa-Bonsu, Deputy Special Representative of the Secretary-General for the United Nations Mission in Liberia (UNMIL) for Rule of Law. Photo ID 234114. 02/12/2008. Sanniquellie, Liberia. UN Photo/Christopher Herwig. www.unmultimedia.org/photo/

FEEDBACK

Every attempt has been made to ensure the accuracy of this report but any errors or omissions are our own. SAfAIDS welcomes any feedback, comments, and/or corrections on the content.



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“No one truly knows a nation until one has been inside its jails. A nation should not be judged by how it treats its highest citizens, but its lowest ones.”

Nelson Mandela

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ABOUT SAFAIDS

Established in 1994, SAfAIDS is a regional non-profit organisation based in Harare, (Zimbabwe), with country offices in Pretoria (South Africa), Lusaka (Zambia) and Manzini (Swaziland). Over the last 20 years, SAfAIDS has implemented programmes in Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia, and Zimbabwe. SAfAIDS is recognised for its capacity to bring national lessons and experiences to regional advocacy and knowledge-sharing platforms.

Through its work, SAfAIDS uses advocacy, communication and social mobilisation (ACSM) strategies to influence change in policy and social practices. In recognition of the role that stigma and discrimination, gender inequality and related social structures and norms play in driving the HIV epidemic and creating barriers to access to services in southern Africa, SAfAIDS works to address gender equality and the rights of women, girls and key population groups to access sexual and reproductive health services and rights by confronting complex issues like culture, human rights and stigma.

ABOUT AIDS ACCOUNTABILITY INTERNATIONAL

Stronger leadership is required in order to ensure that universal health rights and services are provided that are accessible, affordable, acceptable and quality in nature. This also requires impact mitigation programmes to the people who need them, and rights and services that are catered to the needs of those who are most marginalised by society, policy or otherwise.

AIDS Accountability International (AAI) was established in 2005, with the mission to follow up on commitments made by governments to the AIDS. Our work has since expanded into sexual and reproductive health and rights, malaria, tuberculosis, and non-communicable diseases; we work on holding all leaders accountable, such as business, civil society, funding partners and bi and multi-lateral development organisations.

We are an independent research and advocacy thinktank holding leaders accountable for the commitments they have made to respond to health needs. AAI uses research to develop various tools for stakeholders for them to use in their campaigns to advocate for better health.

CONTEXTUAL INTRODUCTION

THE SCORE PROGRAMME

The SCORE programme is a five-year regional initiative being implemented by SAfAIDS through strategic regional and national partners in six countries to address HIV, TB, GBV and SRH needs of young people, women and key populations (LGBTI, sex workers, and prisoners).

Funded by Sweden, SAfAIDS is implementing in Lesotho, Malawi, South Africa, Swaziland, Zambia, and Zimbabwe. The programme seeks to address HIV, TB, Gender-based violence (GBV) and sexual reproductive health and rights (SRHR) needs of young people, women and key populations (, sex workers, prisoners and lesbian, gay, bisexual, transgender and intersex people (LGBTI) in high transmission/ high population regions, within the stated six countries. Through SAfAIDS platforms for learning and sharing – lessons, working models and best practices from the six countries - will be shared within and between all 10 southern African countries, including those countries that are outside the primary focus of the programme.

90-90-90

In 2014, UNAIDS launched its new five-year strategy to drive the end of the global HIV and AIDS epidemic: 90-90-90. Its aim is a “healthier, more just and equitable world for future generations”. (UNAIDS, 2014) The three basic pillars of the strategy are:

- By 2020, 90% of all people living with HIV will know their HIV status.
- By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy.
- By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.



diagnosed



on treatment



virally suppressed

Source: (UNAIDS, 2014)

THE OBJECTIVE OF THIS REPORT

In the context of the **SCORE Programme**, and the **90-90-90** Strategy, the objective of this report is to **create dialogue** around the implementation that has taken place to date on the **SADC Minimum Standards** for HIV & AIDS, TB, Hepatitis B & C and STIs Prevention, Treatment, Care and Support in Prisons, using a lens of **accountability**.

This Discussion Paper highlights strengths and weaknesses in the existing **enabling environment**.

The **Country Status Reports** inform us of the current state of prisons in SADC; the **mapping of stakeholders** directs us on what is currently being done on **awareness raising**.

This information guides us in the **key findings** and **recommendations** as a starting point for the development of a **strategic roadmap** for the future.

ABOUT THE MINIMUM STANDARDS

The Minimum Standards for HIV & AIDS, TB, Hepatitis B & C and STIs Prevention, Treatment, Care and Support in Prisons in the SADC Region (Minimum Standards) were developed in 2009, as a response to various drivers. Article 3 of the SADC Protocol on Health demands that member states “identify promote, coordinate and support activities which have the potential to improve the health of the SADC population” and that they “coordinate regional efforts on epidemic preparedness, mapping, prevention, control and the eradication, where possible, of communicable and non-communicable diseases.” (SADC Secretariat, 2009)

Given the UNAIDS 90-90-90 strategy referred to above, working to ensure prisons become safer health settings seems an obvious necessity within SADC. Article 9 of the same protocol also requires member states to “cooperate, harmonise and where appropriate standardise policies...” and Articles 10 and 12 focus on harmonisation of HIV, AIDS, STIs and TB policies in particular. (SADC Secretariat, 2009) As a result of these commitments, and advocacy from key stakeholders, the SADC Ministers of Health, in 2009, tasked the SADC Secretariat with evaluating the HIV situation in SADC prisons. (SADC Secretariat, 2009)

The Minimum Standards set minimum requirements for SADC prisons to treat, care and support the five disease areas. They are based on six guiding principles: the need for high level political commitment, universal access to public health, adherence to the ethics of confidentiality, need to respect all human rights of prisoners and those in detention, equity of distribution of services across prison and the general population and finally the need to treat prisoners with compassion and solidarity.

Below is a synopsis of the Minimum Standards.

| | |
|------------------------------|---|
| Enabling Environment | Basic necessities, such as shelter, water, food, sanitation, medical care and human rights are a necessity. |
| Legal Framework: | Remove impeding laws that hinder access for vulnerable populations |
| Policy Development: | Policy to address disease control |
| Reducing Prison Populations: | Reduce pre-trial detention times and increased non-custodial sentencing |
| Awareness Raising | Social mobilisation for prison health |
| Admission | At admission, all new prisoners should be evaluated |
| Prevention: | A comprehensive health assessment |
| Treatment: | Treatment must be continued or offered |
| Care and Support: | Prisoners must be provided with information |
| During prison term | Prevention, treatment, care and support must be available to all |
| Prevention: | Prisoners must be offered a spectrum of prevention interventions |
| Treatment: | Prisoners must be offered a spectrum of treatment interventions |
| Care and Support: | Information and education on health issues |
| Release | On release or transfer, prevention, treatment, care and support must be available to all |
| Prevention: | A comprehensive health assessment |
| Treatment: | Continuity of treatment must be a priority |
| Care and Support | Co-operation and co-ordination between prisons and public health |

| | |
|--|--|
| Groups with Special Needs | 'Circumstantial' children, children in conflict with the law, women, physically and mentally challenged people, LGBT and elderly people all require special arrangements and must be provided with the requirements to ensure their human rights are respected in every way. |
| Workplace Wellness Programme for Prison Staff | Prison staff must be provided with: adequate training on health issues; on the needs of groups with special needs; appropriate workloads and adequate time off and support staff; protective clothing and equipment, post-exposure prophylaxis, and voluntary testing and counselling (VTC) for HIV. |
| Monitoring and Evaluation and research | Periodic surveys, monitoring of monitoring and evaluation (M&E) commitments at member state level, and monitoring of M&E commitments at SADC Secretariat must be prioritised. |

ADDITIONAL RELEVANT INTERNATIONAL INSTRUMENTS INCLUDE:

- The International Guidelines on HIV/AIDS and Human Rights (OCHR and UNAIDS).
- WHO Guidelines on HIV Infection and AIDS in Prison.
- UNODC Comprehensive Package of HIV Prevention, Treatment, and Care in Prisons.
- UNODC's Guidelines for HIV and TB Treatment in Prison Settings in Southern Africa
- United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)
- Southern African Development Community (SADC) Standard Minimum Guidelines for the Treatment and Management of Detainees
- The Mandela Rules (which include extensive revisions and additions to the UN's Standard Minimum Rules for the Treatment of Prisoners.)

WHAT IS ACCOUNTABILITY?

Accountability is a general principle that refers to the relationship between the government and the governed in a democracy.

Accountability is a governance principle that is fundamental to representative democracy, i.e. where politicians are elected into government to take collectively binding decisions on behalf of citizens. It is a fundamental principle because it gives meaning to the notion of 'limited government'. We elect government to take binding decisions, but it is not allowed to take any kind of decisions in whatever way it chooses, because the constitution restricts the scope of its power, as well as defines the process for taking legitimate decisions.

But there is also a more political approach to accountability. This is when government is held accountable for not following and realising the political programme on which it was elected. Since we elect government by choosing between parties on the basis of how they promise to improve our society – and we pay them taxes to do so – we have a right to hold them accountable for corruption of those resources and/or for spending them differently. This is the approach to accountability that is most relevant to AAI, since, as we say, we identify gaps between commitment and performance and hold them accountable to poor performance.

THE ORIGINS OF ACCOUNTABILITY

The notion of accountability stems from the argument that government power is legitimate only if it is limited and conditional. The terms of those limitations and conditions will be detailed in a 'social contract' between the 'sovereign' and the 'subjects'. If government abuses the powers given to it by the 'contract', it should be held accountable and sanctioned.

The notion of accountability is thus not unique to democracy. Also dictators and even the King of Swaziland have stakeholders and constituents whose demands and expectations need to be reflected in political decisions, or the rulers will be sanctioned in one way or another. But here we focus this discussion on countries that are more or less democratic.

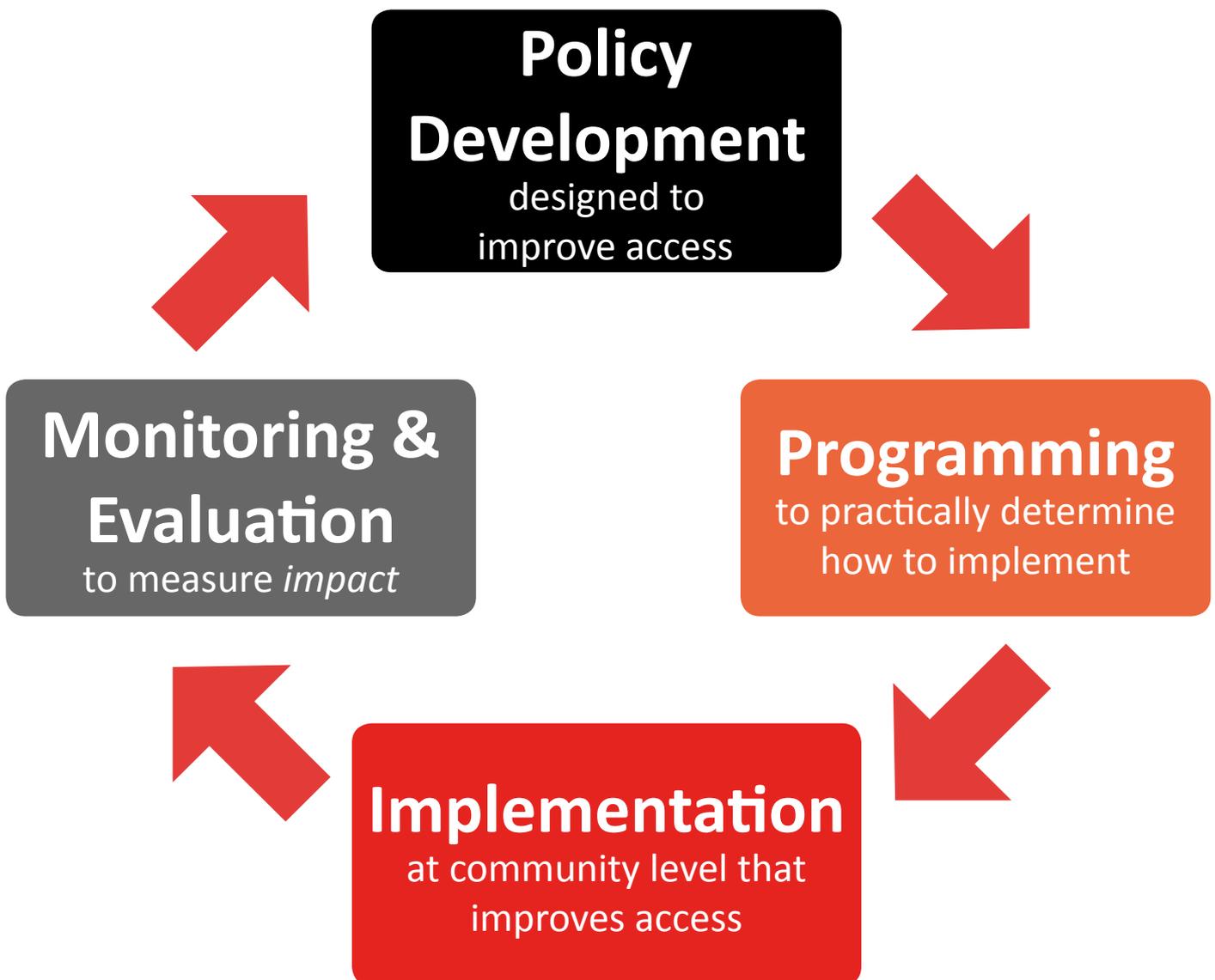
ACCOUNTABILITY IN DEMOCRATIC GOVERNANCE

Democracy adds three central components to the discussion.

1. Firstly, in a democracy each citizen is party to the 'contract' with the government, however powerless that person may be in real terms. This means that also the poor and marginalised have a right to demand accountability from their government.
2. Secondly, democracy introduces an additional set of restrictions on government power, in the form of a Bill of Rights that apply to all citizens. For the most part, these rights specify what the government must not do, i.e. violate citizens' civil and political rights.
3. The third component that is unique to discussions on accountability in the context of democratic governance is that a government is elected to represent the people from competing parties on the basis of a programme for how government power will be used. Demands for accountability can have not only a legal or constitutional basis, but also be based on the fact that government has not fulfilled stated commitments that were, at least in part, the reasons for a particular party being entrusted with government power in the first place.

STEPS EXPECTED FROM AN ACCOUNTABLE GOVERNMENT

In a country where the government is being accountable to its people, one would expect to see a particular set of steps with regard to implementing access to health care. The graphic simplistically explains how policy is first developed (preferably in a consultative and empirical manner), followed by policy guidelines and programming which explain the practical understanding and planning of the policy flow down to community level. Thereafter, government is expected to roll out or implement these programmes, which should see improved access at community level. However because unintended consequences exist, planning is often in a pilot phase and for a myriad of other reasons, we expect there to be constant monitoring and evaluation of the implementation to ascertain whether the policies' original objectives are being achieved in reality. This stage of measuring impact often leads to revised or refined policy and the cycle begins again.



Steps Expected by Govt: AAI Accountability Literacy 2012 {developed by P.Tucker on behalf of AAI}

COUNTRY STATUS SNAPSHOT

ENABLING ENVIRONMENT

The Minimum Standards are based on the foundation of an 'Enabling Environment'. That enabling environment for prevention, treatment, care and support on HIV, TB, Hepatitis B and C and sexually transmitted infections (STIs), rests on a myriad of factors, not least of which are the basic necessities, such as shelter, water, food, sanitation, medical care and human rights. The commitment also encompasses more complex ideas of an enabling environment, such as a legal framework; policy development; the need to reduce prison populations; and lastly the need for awareness raising, which are dealt with below. Also incorporated in the Minimum Standards are standards for managing the health needs and treatment of prisoners on admission, during their prison term and on release, as well as Workplace Wellness for prison staff and M&E. The review below, however, focuses primarily on the issues of an enabling environment, as without this, the more detailed standards set by the commitment cannot be met.

BASIC NECESSITIES

In each of the six countries examined, the basic necessities are lacking for prisoners, either permanently or intermittently. This lack creates not only an unhealthy living environment but is a direct abuse of the prisoners' human rights.

In Lesotho despite recent progress, basic conditions within the prisons are still found to be poor, with sanitation, access to potable water, lighting, bedding and ventilation and heating and cooling equipment absent or seriously problematic. Food shortages are not generally found to be an issue; however, food quality is a definite problem, posing nutritional issues. Reports of prison guards committing violence against prisoners are rare. However, in 2012, guards stripped six women in the female prison, denied them three meals and day and locked them in a closed cell for four days as punishment for fighting (US DoS DRL, 2013).

In Malawi, basic infrastructure and sanitation was also noted as being a problem. The most dire of which being the fact that Zomba Central prison, which had been condemned for human habitation, was still in use at the end of 2013. Ventilation is not necessarily problematic, but heating was provided only by wood fires. Meals were deemed lacking in nutrition and the quantity of food and meals per day was inadequate, with only one or two meals being provided every day, leading to malnutrition in the prison population (US DoS DRL, 2013).

In South Africa, potable water was available, but in inadequate supplies at times, whilst plumbing problems occurred affecting sanitation issues. Authorities provided all detainees in police cells with felt mattresses and blankets and most cells had toilets and basins, but often lacked chairs, adequate light, and ventilation. Studies have found that 7% of juvenile male prisoners have been sexually assaulted in prison and nearly half confirmed that sexual violence in a regular occurrence. Riots as a result of food shortages occurred in the period 2012-2013, which led to fires being set in prisons and to the deaths of two prisoners (US DoS DRL, 2013).

In Swaziland, pre-trial detainees relied on family to provide food, although convicted prisoners received food and potable water. The state of the facilities is mixed, depending on the age and location of the prison. His Majesty's Correctional Services (HMCS) provides free formal education to juvenile inmates and adult inmates received training in various trade skills. Treatment of minor offence prisoners with regard to freedom of movement was said to be good. No alternative sentencing options for non-violent offenders exists. Complaints against HMCS and the resulting investigations and findings are not made public. (US DoS DRL, 2013).

In Zambia, overcrowding, poor sanitation, dilapidated infrastructure, inadequate and deficient medical facilities, meagre food supplies, and lack of potable water resulted in serious outbreaks of water- and food-borne diseases, including dysentery and cholera. Prisons generally had inadequate ventilation, temperature control, lighting, and basic and emergency medical care. Many prisoners were malnourished because they received only one serving of cornmeal and beans per day, called a combined meal because it represented breakfast, lunch, and dinner. Prisons officers-in-charge often arbitrarily prohibit families from providing additional food to prisoners (US DoS DRL, 2013).

In Zimbabwe, between January 2012 and late November 2012, more than one hundred prisoners died of illnesses directly related to a lack of food and nutrition and other natural causes. Overcrowding in the country's prisons also exposes inmates to diseases such as tuberculosis. Sanitation is poor, and lighting and ventilation inadequate and not conducive to a healthy living environment. There were insufficient supplies of clothes, bedding, mattresses, sanitary wear, and other basic necessities. Even clean and drinkable water was not available (US DoS DRL, 2013). Zimbabwe Prisons and Correctional Services (ZPCS) is failing to provide clean water and proper sanitation to the more than 17,000 inmates jailed in the country's 72 prisons with Chikurubi Maximum Security Prison having had no water for more than a decade, due to a \$2 million debt owed to Zimbabwe National Water Authority {Zinwa} (Daily News report, May 29, 2014).

Prison farms are used to provide some food to prisoners and in some cases provide an excess (US DoS DRL, 2013) but in other cases, a media report said that "the shop owner [who donates food to the prison at the request of prison staff begging for food for prisoners] said that it is sad and ironic that prisoners continue to face critical food shortages yet the ZPCS has several farms... which are being underutilized." (New Zimbabwe, 2015). This is said to be due to the unavailability of farming inputs and equipment.

LEGAL FRAMEWORK AND POLICY DEVELOPMENT

Each of the six countries requires an overhaul of the national law as well as the judicial system and policy to improve the basic necessities of the enabling environment, but as also as a means to improve disease control. The following section discusses some of the results of the woefully inadequate legal and policy frameworks in the countries.

Violence within the prisons is considered a problem by the Lesotho Prison Services, with rape being a key problem, with the associated risks of HIV and other STI transmission. As the result of an investigation into violence among prisoners, a full time HIV/AIDS co-ordinator was employed who co-ordinates HIV testing, counselling, and treatment. All these services were found to be available upon inspection, including the provision of condoms (US Dos DRL, 2013).

In Malawi, a High Court Order to improve prison facilities resulted in a significant increase in the budget allocation for the Prison Service, but, "Interestingly in the year 2010-2011, Government of Malawi just more than doubled (213% more) the budget allocation for the Malawi Prison Service from K558.7m to K1.2 billion (US\$3.7m to US\$7.9 m). However, the bulk of the increase was slated for the construction of a new prison in Lilongwe, rather than improving current conditions." (CREAA, 2014) (US DoS DRL, 2013).

In Swaziland, sexual violence, including rape, does take place in prisons and some data exists on this, but due to same-sex activities being illegal in the country, no official stance is taken regarding these incidents. Training

COUNTRY STATUS SNAPSHOT (CONT)

for prisoners is available on a variety of skills: agriculture, animal husbandry, construction, electrical work, plumbing, welding, tailoring, weaving, upholstery, and other trade skills (US DoS DRL, 2013).

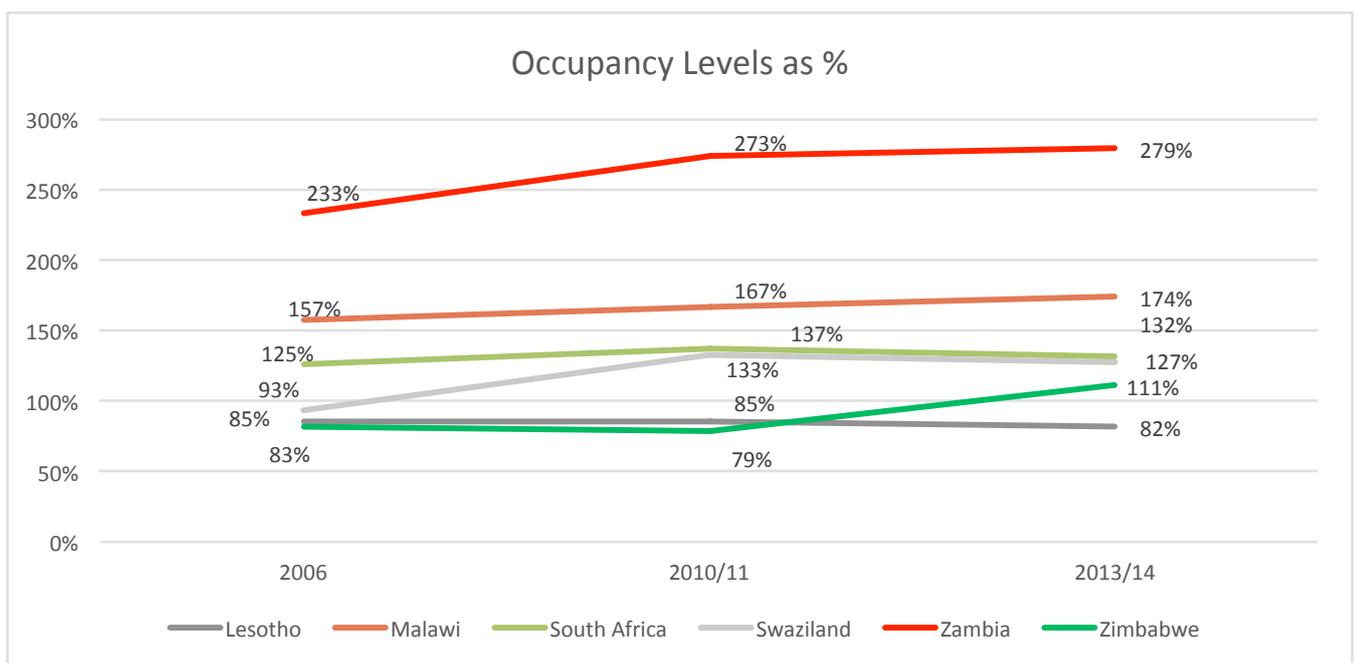
South Africa has one of the highest rates of deaths in custody in the world. In the period 2012-2013, the South African Judicial Inspectorate of Correctional Services (JICS) received 3,370 complaints of assaults on prisoners by correctional officers. According to the 2012-13 Independent Police Investigative Directorate (IPID) annual report, 706 persons died in police custody or due to police action during the 12-month period ending March 31. Of that number, nine South African Police Service (SAPS) members were charged and found guilty.

In 2012, in Zambia, private broadcaster Muvi Television submitted public evidence showing that eight prisoners died from beatings and suffocation in a Zambian prison, demonstrating warder violence against prisoners. On June 21, Zambia Prison Service Commissioner, Percy Chato, acknowledged that the service was concerned about the increasing cases of same-sex sexual activity in prison. Because the law criminalises sodomy, authorities denied prisoners access to condoms (US DoS DRL, 2013).

Zimbabwean prison guards beat and abused prisoners. Police used cruel, inhuman, or degrading treatment or punishment against those in custody. Those detained for politically motivated reasons were kept at police stations for days, weeks, or months while their court dates or bail hearings were pending. Care for special classes of offenders, such as women in general, women with children, pregnant women, mentally retarded offenders, as well as juveniles, is heavily compromised, due to the poor situation in the prisons (Daily News report, May 29, 2014). There was no prison ombudsman (US DoS DRL, 2013).

REDUCING PRISON POPULATIONS

By reducing pre-trial detention times, using non-custodial sentencing, and a rehabilitative lens rather than a punitive justice lens, countries can make huge strides in reducing the levels of prison populations they currently have and so ease the demands on already over-stretched and collapsed prison systems.



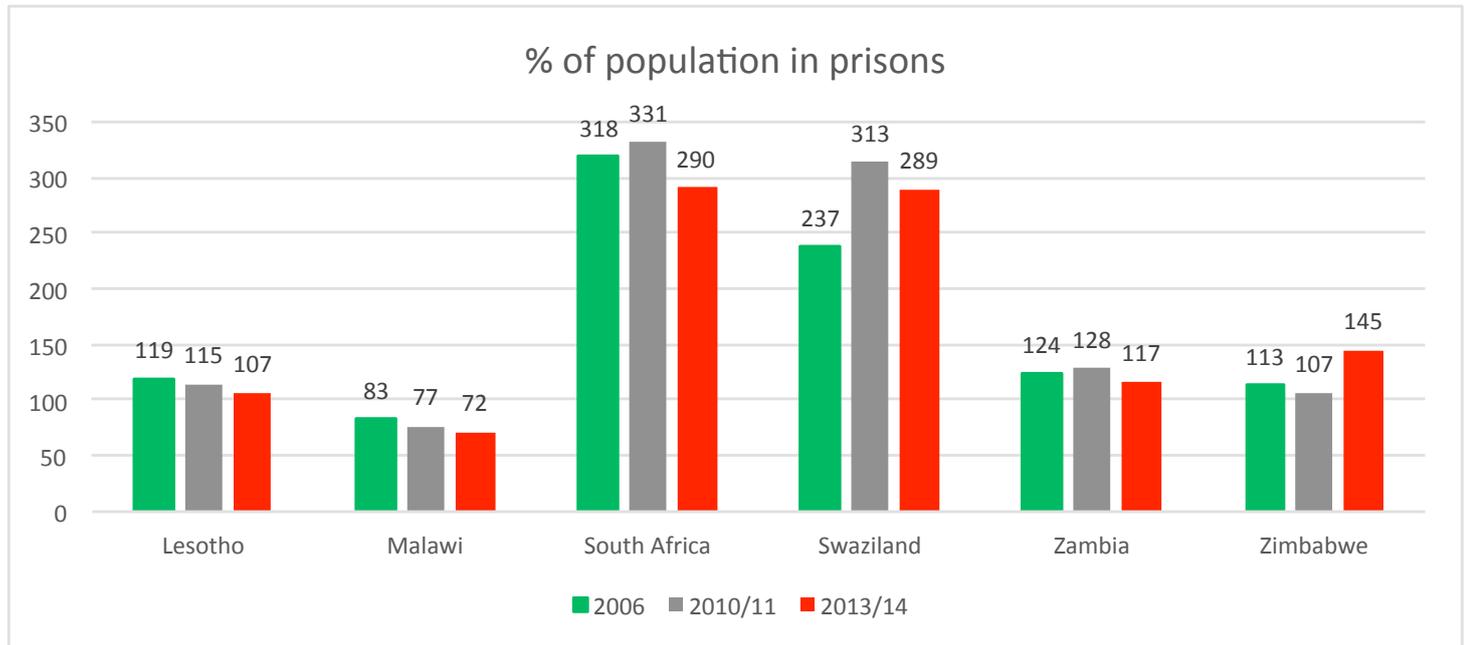
International Centre for Prison Studies, Various

Overall, the six countries remain with exceptionally high occupancy levels, even though some can be seen to have attempted to lower them, such as Swaziland and Lesotho. South Africa and Swaziland have the highest percentage of people in prison and have done so consistently over the period analysed.

Lesotho is demonstrating a will to reduce prison populations, keep occupancy levels at below 100%, and ensure that awaiting-trial prisoners do not form a large part of the prison population, thereby indicating reasonably quick access to justice.

The Malawi Human Rights Commission has expressed concern for the human rights and health and well-being of prisoners in Malawi. Malawi has seen an increasing total number of prisoners since 2006, demonstrating that there is little adherence to the commitment to reduce prison populations. Occupancy levels are the second worst of our cohort, at 174%, almost double the number of people than desired in each facility. Other evidence suggests that the system, which was built for 5,500 people, routinely holds at least double that, with 12,505 inmates in the prisons as of September 4 (US DoS DRL, 2013).

Overcrowding in South African prisons is so dire that national levels sit at 127%, even though effective efforts have been made to reduce prison populations. Research shows that some prisoners each had 13 square feet squared in which to live. (18 square feet is the size of a normal single mattress). South Africa has one of the highest TB rates in the world, including drug resistant (DR) and multidrug resistant (MDR) TB; ventilation in prisons is poor and a contributing factor to TB acquisition amongst prisoners (US DoS DRL, 2013).



International Centre for Prison Studies, Various

Swaziland has reduced the number of prisoners being held in terms of both total numbers of prisoners and as a percentage of population over the past five years. However, occupancy levels remain high at 127%.

In the Zambian prison visits of 2013, conditions were considered to be “harsh and life threatening due to outbreaks of disease, food and potable water shortages, gross overcrowding, and poor sanitation and medical care”. On January 12, prisoners in the “condemned” section at Mukobeko Maximum Security Prison protested

COUNTRY STATUS SNAPSHOT (cont)

at being kept in congested cells. Demanding to be executed if the situation could not be improved, the prisoners complained that seven or eight inmates were kept in rooms designed to hold two. On March 7, Lusaka Central Prison officer-in-charge Oliver Liseba revealed that the prison held 1,143 prisoners, although it was designed to accommodate 250 (US DoS DRL, 2013).

In Zimbabwe, prison conditions remained harsh, partly due to overcrowding in older, urban, remand facilities. Poor sanitary conditions contributed to disease, including diarrhoea, measles, tuberculosis, and HIV/AIDS-related illnesses. Out of the 17,318 prisoners in 2013, 14,462 were convicted prisoners, while 2,866 were on remand (making up close to 20% of the prison population) of whom 80 were juveniles and 308 were females, according to a report to the parliamentary thematic committee on Human Rights on May 28th 2014, by Agrey Huggins Machingauta, the deputy commissioner of prisons. There are challenges in the provision of pre- and post-natal care for female prisoners, as well as in the upkeep of children who are in prison with their mothers.” On a positive note, the ZPCS has set up an institution where young offenders can further their studies, while children of inmates whose relatives are reluctant to accept them may attend nursery schools together with prison officers’ children within prison camps. Specialist departments had also been established to cater for the rehabilitation needs of inmates, including chaplains, teachers, social scientists and trade artisans to assist with the successful reintegration of prisoners into society (Daily News 29th May, 2014).

AWARENESS RAISING

As a means of improving prison systems, it is necessary to change the way that prisoners and prisons are considered by leaders, prison staff, prisoners themselves and the public. Key stakeholders, both at regional level and at national or community level are advocating for change in the region’s prison systems. This list demonstrates some, but not all, of the work being done. The research above demonstrates that although the following organisations are all doing good work, much remains to be done, and that the sheer scale of the problem requires more actors and stakeholders to work in this arena, pushing a human rights agenda.

SADC REGION

THE AIDS RIGHTS ALLIANCE FOR SOUTHERN AFRICA (ARASA) SADC REGION

A leader in the field of prison work in Southern Africa, ARASA has been working in this area since 2009. Interventions include but are not limited to:

1. A 2009 collaboration on a joint research project “Unjust and Unhealthy: HIV, TB and Abuse in Zambian Prisons” with Prisons Care and Counselling Association (PRISCCA) and Human Rights watch {HRW}} (ARASA, 2014).
2. Convening a regional stakeholder meeting in 2010 to present the Unjust and Unhealthy report and to create dialogue among stakeholders on the issue of health and human rights in prisons in Southern Africa (ARASA, 2014).
3. Providing grants to establish rights and legal education desks in all of Zambia’s provincial prisons (ARASA, 2014).
4. Convening the Regional Dialogue on HIV, TB and Human Rights in Prisons in 2015, “to share in-country good practices and functional models in addressing health and human rights issues in prisons in southern and eastern Africa, with a specific focus on improving the management of HIV and TB. The meeting also sought to develop and prioritise a common regional advocacy strategy, which will aid in promoting the adoption and domestication of the SADC and UNODC Minimum Standards for Prisons” (ARASA, 2015).

SOUTHERN AFRICAN LITIGATION CENTRE (SALC)

SALC strengthens the rights of prisoners in the region through training, advocacy and litigation. In addition, with local partners, SALC works with international bodies such as the UN Working Group on Arbitrary Detention (WGAD) to further the rights of prisoners. Currently, the Prisoners' Rights Programme primarily works in Malawi and Zambia (SALC, 2015)

UN OFFICE ON DRUGS AND CRIME (UNODC)

The UNODC has developed guidelines (a discussion of which can be found in the snapshot literature review above) and played a key role in recommending that stakeholders “engage in dialogue to make recommendations for interventions, and identify good practices and lessons for addressing HIV and AIDS in prisons”. UNODC also played a role in advocating for policy and legal reviews and integration of prison issues into national and regional policy.

VSO RHAISA

The Regional Health and AIDS Initiative for Southern Africa (RHAISA), is VSO's flagship and focuses on health among prisoners as an advocacy issue for VSO, since research has shown that whilst prisons have higher rates of HIV infection, there is as yet little access to treatment and testing. Countries in southern Africa have ratified legal instruments, like the SADC Minimum Standards for prisons, but the countries in the region are not implementing them. VSO advocates for the implementation of these standards, in order to increase access to medication, treatment and prevention intervention in prisons.

LESOTHO

ADVENTIST RELIEF AGENCY (ADRA)

Education of prisoners on TB. (ARASA, 2014)

MALAWI

THE CENTRE FOR THE DEVELOPMENT OF PEOPLE (CEDEP)

Winner of the 2010 ARASA HIV and Human Rights award, for work on addressing prisoners needs and challenges (as well as other minority groups) and key to the release of gay and transgender couple Steven Monjeza and Tiwonge Chimbalanga from prison, after being charged with same sex intercourse (ARASA, 2014).

CENTRE FOR HUMAN RIGHTS EDUCATION, ADVICE AND ASSISTANCE (CHREAA),

With funding from Tilitonse Fund, CHREAA began a two-year-long project called, 'Achieving Responsiveness and Accountability of the Prison Service in Health Service Delivery System in Malawi', in June 2014.. The purpose of the project is to ensure adequate access to medical health services for all prisoners. At the end of the two-year period, CHREAA believes that there will be increased resource allocation for health service delivery in the Malawi Prison Service; that the Malawi Prison Inspectorate will be empowered to effectively discharge its Constitutional mandate; and there will be increased awareness of prisoners' rights and entitlements through advocacy and civic education, media awareness campaigns and lobbying.

COUNTRY STATUS SNAPSHOT (cont)

MALAWI PRISON INSPECTORATE (MPS)

Founded in 1920, under section 163 of the Malawi Constitution, MPS is mandated to “contribute to national public security and socio-economic development by means of the safe, humane custody and rehabilitation of offenders (Manda, 2015).

Justice Kenan Manda from Malawi, is a non-organisationally affiliated individual, , who is working on improving prison conditions for his compatriots.

SOUTH AFRICA

SONKE GENDER JUSTICE

In 2006 and 2007, Sonke worked in four Western Cape prisons with the aim to reduce HIV transmission in the prisons. Sonke’s project now aims to “decrease the number of inmates who experience sexual abuse and contract HIV, galvanise the gender and HIV sector to view the health and safety of inmates as a priority, and a government that is able to implement evidence-based good practices and is accountable for preventing and eradicating sexual violence and HIV in prisons.

Sonke is also co-founder and co-co-ordinator for the Detention Justice Forum, a coalition of NGOs and activists working to advance detainee rights and well-being.” (Sonke Gender Justice, 2014).

CIVIL SOCIETY PRISON REFORM INITIATIVE (CSPRI)

The CSPRI, established in 2003, is a research and advocacy project focussing on prisons and places of confinement in the African region, with the aim of furthering human rights in these settings. CSPRI is a project of the Community Law Centre of the University of the Western Cape. CSPRI has two key sub-projects, each of which has its own web-presence: Promoting Pre-trial Justice in Africa, and the Article 5 Initiative.

SWAZILAND

THE NATIONAL TUBERCULOSIS CONTROL PROGRAM (NTCP)

Working with Swaziland Correctional Officials to re-strategise how ex-prisoners can be supported after their release. Engaging with prison officials to introduce HIV/TB projects (Hlophe, 2015).

PRISON FELLOWSHIP SWAZILAND (PFS)

“PFS is a Christian Network NGO that facilitates and enhances the rehabilitation of offenders through the Power of the demonstration of the gospel of Jesus.” (PFS, 2015).

SWAZILAND FOR POSITIVE LIVING (SWAPOL)

Working with Swaziland Correctional Officials to re-strategise how ex-prisoners can be supported after release (Hlophe, 2015).

SWAZILAND POSITIVE LIVING

Rolling out VCT in Swaziland prisons (ARASA, 2014).

ZAMBIA

PRISONS CARE AND COUNSELLING ASSOCIATION (PRISCCA)

Working with prison authorities in Zambia on implementing the recommendations of the Unjust and Unhealthy Report (ARASA, 2014).

ZIMBABWE

ZIMBABWE ASSOCIATION FOR CRIME PREVENTION AND REHABILITATION OF THE OFFENDER (ZACRO)

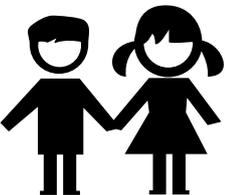
ZACRO is an organisation that works to prevent crime and promote rehabilitation and re-integration of offenders in order to have peace in society, while advocating for justice in Zimbabwe's prisons. ZACRO operates through a network of country-wide volunteer members. ZACRO's mission includes: reducing crime through providing support and rehabilitation programmes targeted at men and women convicted of crimes, ex-offenders, victims and survivors of crime. ZACRO also endeavours to assist the dependants of jailed offenders.

THE ZIMBABWEAN NATIONAL AIDS COUNCIL (NAC)

National AIDS Council (NAC) is an organisation enacted through an Act of Parliament in 1999, to co-ordinate and facilitate the national multi-sectoral response to HIV and AIDS.

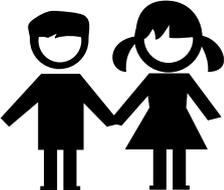
COUNTRY STATUS SNAPSHOT (cont)

LESOTHO

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|  | <p>HIV prevalence among male and female prisoners is estimated at 31.4% and 69% respectively (Lesotho Correctional Services (LCS) survey 2011). Only three of the prison facilities in the country provide antiretroviral therapy (ART), covering 375 patients of the 582 identified to be in need; 124 prison staff have been trained as peer educators. and national policies include prisoners as a vulnerable population. To prevent the spread of HIV, the LCS employed a full-time HIV/AIDS co-ordinator, and HIV testing, counselling, and treatment were available. The LCS provided condoms in all adult male and juvenile facilities.</p> |
|  | <p>The US Human Rights Country Report, which is based on prison visits by a committee of human rights experts, found that juveniles and adults were imprisoned separately, as they should be and that in both juvenile and adult facilities, men and women were kept separately too.</p> |
|  | <p>Women are held separately from men. According to LCS nursing staff, 34% of female prisoners were HIV-positive, compared with a 27% rate in the general female population.</p> |
|  | <p>As per the law, pre-trial detainees were also held separately from the convicted population. Similarly, high-threat prisoners are kept in separate maximum security facilities, with little or no difference in their conditions to other prisoners.</p> |
|  | <p>Medical staff, equipment and wards were found to be short, and thus prisoners were not receiving adequate medical care. Sometimes prisoners were escorted to government clinic facilities to receive care there. All prisons had a nurse and a dispensary to attend to minor illnesses but medical supplies were insufficient to meet prisoners' needs. Prisons lacked round-the-clock medical wards; as a result, guards confined sick prisoners to their cells from 3 p.m. to 6 a.m. Prisoners received free medical care from government hospitals. Some correctional facilities owned ambulances to transport inmates for emergency medical care.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

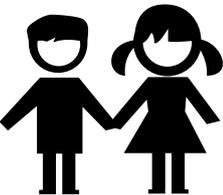
MALAWI

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|  | <p>Estimates on TB infection in prisons are at 4.4%. There are no routine TB or HIV screenings for prisoners and there is a lack of health facilities inside some of the prisons means that prisoners have to go to public health facilities. An ambulance motorcycle has been started up for this purpose. A study found that 21% of Malawi prisoners surveyed had experienced some form of sexual violence. (Kainja, 2011)</p> |
|  | <p>Malawi also has the highest rate of juvenile imprisonments of the group, with a remarkable 7.7% of the population being adolescents. This is more than double that of Malawi (3.1%-second highest) and 26 times that of South Africa (0.3% - lowest of the group). Open Society Initiative for Southern Africa indicated that the Lilongwe Police Station had 87 detainees, including four women and seven children. One of the detainees in Lilongwe had been held for seven months. Children were not separated from adults.</p> |
|  | <p>Women are routinely kept separately from men and have female guards and female presiding officers, and are considered to have better conditions due to occupancy and space levels.</p> |
|  | <p>Pre-trial detainees have risen by 5%, since 2010, demonstrating a slow and unresponsive legal system. It is supposed that because there is no space in prisons, people awaiting trial were reportedly being detained in local police holding cells (not designed for such a task) for longer periods than legally allowed, including women and children, one of whom had been held for seven months according to one OSISA report.. Pre-trial detainees were also not routinely kept separately from convicted prisoners as is required.</p> |
|  | <p>The Health Ministry's District Health Officers do conduct outreach visits to prisons, although facilities were deemed inadequate by the Human Rights Commission. Over a 9-month period in 2013, of the 38 prisoners who died in prison, three were due to tuberculosis, seven to pneumonia and 28 from AIDS, diarrhoea, and inadequate diet.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

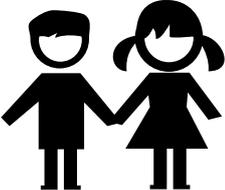
COUNTRY STATUS SNAPSHOT (cont)

SOUTH AFRICA

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|  | <p>HIV screening on intake and discharge does not take place in prisons, but in 2013, the Department of Correctional Services claimed that 50% of prisoners were tested for HIV and 65% of HIV positive prisoners were placed on ART. Prevention programmes and condom distribution also exist. There were no HIV screening programmes on intake or discharge of prisoners, but the DCS conducted HIV prevention programmes in prisons, including a condom distribution programme and awareness sessions. South Africa has one of the highest TB rates in the world, including DR and MDR TB; ventilation in prisons is poor and a contributing factor to TB acquisition amongst prisoners.</p> |
|  | <p>Children were not always separated from adults. Two juvenile inmates died in custody during the year 2012-2013. Juveniles and younger prisoners are targeted for rape.</p> |
|  | <p>In the 2012-2013 period, 15 women prisoners died in prison. Mothers are allowed to have their children with them in the prisons and some prisons even have allocated children's cribs and playgrounds for them.</p> |
|  | <p>Cases of pre-trial detainees contracting HIV due to being raped whilst in prison, occurred during the 2012-2013 period. This is a direct result of pre-trial detainees generally being held with convicted prisoners. Awaiting-trial prisoners form 31% of the prison population.</p> |
|  | <p>Complaints about health care were filed by 39,380 inmates during the year, compared with 34,202 such complaints in 2011-12. Amongst these were: a shortage of prison doctors, inadequate investigation into prisoner cause of death, and a high suicide rate. Although doctors have to sign death certificates, a large number of deaths went uninvestigated due to a shortage of doctors.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

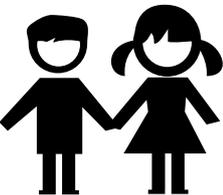
SWAZILAND

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|  | <p>Data on HIV status for male and female prisoners is available (32.3% and 70.5% respectively), as compared to 26.9% for the general population. hepatitis B and C, and syphilis data for both prisoners and officers is available. Condoms are provided to prisoners upon their release (same-sex activities are illegal). VTC is conducted on intake. There are peer educators in the prisons and links to clinics on release..</p> |
|  | <p>Juveniles were held separately from adults in pre-trial detention and in prisons. Juveniles are provided with school education at no cost. The recent Malkerns Industrial School Students Violence Probe report on the juvenile rehabilitation centre, shows institutionalised abuse - physical, sexual and verbal - of the children in the Swaziland government's care. The report reveals that various staff warders stripped naked, handcuffed and beat children in their care. They also inserted fingers into girls' private parts and forced one boy to drink his own urine.</p> |
|  | <p>Swaziland has a stand-alone female prison that provides PMTCT and family planning services (dual), and they are provided with support after release. Women and men were detained together at police stations after arrest, due to space constraints.</p> |
|  | <p>Awaiting trial prisoners form 18% of the total prison population, not as low as it could be. Pre-trial detainees and convicted prisoners were held separately. Lengthy pre-trial time is common and pre-trial detainees form 18% of the total prison population. Police are blamed for taking a long time to collect evidence and make a case; the judicial system is slow and staff shortages also contribute to the problem. Pre-trial time has exceeded the sentencing time in some cases.</p> |
|  | <p>Swaziland has a health clinic in each of its 13 facilities but there is a shortage of nurses and a lack of isolation spaces for TB infected patients. Overcrowding worsens exposure to the transmission of TB, HIV and hepatitis.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

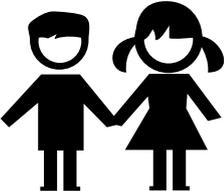
COUNTRY STATUS SNAPSHOT (cont)

ZAMBIA

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|  | <p>Antiretroviral treatment was available to prisoners infected with HIV, but poor nutrition often rendered the treatment ineffective. Staff shortages hinder access to health care. Back up health data of prisoners is kept for reference purposes, Parliamentarians have been engaged to support policy advocacy on sexual and reproductive health and HIV in prisons; A prisons Medical Directorate has been set up; and an ART centre is being set up under the Zambia Prisons Services. The national HIV policy recognises prisoners as a key population.</p> |
|  | <p>Approximately 3% of prisoners were juveniles, a significant decrease from 2012, when 10% were juveniles. The decline in the number of female and juvenile detainees was attributed to pre-trial mediation by non-governmental organisation (NGO), alternative sentencing, and presidential pardons. Juveniles were often held with adults and were victims of sexual abuse.</p> |
|  | <p>Zambia has reduced its female prison population from 18% to 3% since 2012. This is attributed to the effective intervention of NGOs in the area of work, alternative sentencing, and presidential pardons. Women are usually held separately. Women prisoners complained to the Committee on African Parliamentarians about prison authorities using the same pair of gloves to examine numerous prisoners' private parts during body cavity searches. Prisons provided no food or medical services to children and mothers had to share their meagre rations with their children in an environment lacking appropriate medical care, which often exposed children to disease.</p> |
|  | <p>Delays in court proceedings caused by an inefficient judiciary contributed to the holding of large numbers of pre-trial detainees for extended periods. According to the Prisons Care and Counselling Association (PRISCCA), the country's prisons, which were built to hold 6,700 inmates, held approximately 17,000, of whom an estimated 6,000 were pre-trial detainees. Pre-trial detainees were held with convicted prisoners</p> |
|  | <p>HIV and TB remained rampant, with HIV prevalence in prison estimated at 27.4% compared with 14.3% in the general population, especially due to lack of adequate drugs and failure to isolate sick patients. The Traditional Affairs Minister, who visited Lusaka Central Prison, labelled them "unhealthy and not conducive for human habitation". Prison deaths occurred as a result of these conditions. The prison system employs only two medical doctors.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

ZIMBABWE

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|  | <p>HIV prevalence in the prisons was 28% according to the study that was conducted in 2011, which is almost double the national HIV prevalence. The ZPCS offered peer education on HIV and AIDS and tested prisoners for HIV only when requested by prisoners or prison doctors. There were some cases of prisoners with HIV or AIDS who were denied access to antiretroviral drugs, and a court case was pending on the issue at year's end.</p> |
|  | <p>There is limited operational capacity to separate young offenders from adults, as there is only one young offenders' facility in the country, thus juveniles are exposed to all forms of violence. Juveniles were also held in adult prisons throughout the country while on remand, or when older juveniles would benefit from remaining closer to their families. Officials generally tried to place younger juvenile inmates in separate cells. Juveniles were generally sent to prison instead of to reformatory homes, as stipulated in the Children's Act. Juveniles were particularly vulnerable to abuse by prison officials and other prisoners.</p> |
|  | <p>Women are guarded by female officers, held separately from men, receive better food than men and are given sanitary wear. Children under the age of three can live with their mothers but share their mother's food allocation. NGOs theorise that female guards might be diligent about protecting female prisoners from abuse or that women do not report abuse. There is no special care or food for pregnant and nursing mothers although Zimbabwe Prisons and Correctional Services reports that they are working towards supporting safe motherhood in prisons through provision of antenatal care and other sexual and reproductive health interventions.</p> |
|  | <p>Almost 20% of the prison population is made up of pre-trial detainees. According to the ZPCS, remand prisons were overcrowded and conditions were, harsher than in newer facilities, due to antiquated structures that do not meet current acceptable standards. Authorities often hold pre-trial detainees with convicted prisoners until their bail hearings. Many detainees are held in severely overcrowded police facilities.</p> |
|  | <p>Prisoners had access to very basic medical care, with a clinic and doctor at every facility, but the department has no capacity to provide comprehensive health services and thus refers prisoners to public hospitals. Due to out-dated regulations and a lack of specialised medical personnel and medications, prisoners suffered from chronic treatable medical conditions, such as hypertension, tuberculosis, diabetes, asthma, and respiratory diseases. NGOs also reported isolated cases of meningitis and pellagra.</p> |

(SAfAIDS, 2015) (US DoS DRL, 2013)

DISCUSSION AND WAY FORWARD

PARAMETERS OF THIS PAPER

The SAfAIDS SCORE Programme and the 90-90-90 objectives of UNAIDS set a context for this discussion paper with the objective of achieving improved access to healthcare for the most marginalised groups. The aim is to not only support and assist in the attainment of the ambitious goals of 90% of people diagnosed, 90% on treatment and 90% having a suppressed viral count, but to roll out human rights access for all.

In order to frame this discussion it is necessary to have a framework and the authors have used the AAI Accountability Framework. Developed by dozens of stakeholders over a series of meetings, it uses analytical yet pragmatic forms to guide the user into a process that leads to greater accountability.

By then briefly outlining the SADC Minimum Standards for Prisons and referring to numerous other international obligations, the discussion paper places the need for an improved response to prison health as an urgent, and well documented human rights failure that requires urgent attention.

The paper then briefly highlights the inadequate responses to date in the six countries examined, as a means to show empirically that gross human rights abuses are occurring in our prisons systems and moreover, that these inadequacies undermine any efforts to curb HIV, and in fact allow for new infections to occur, and often in the most grievous and violent of ways. Prisons therefore form a reservoir for HIV infection that has the potential to spread into the wider community when prisoners are released, after serving their sentences – especially if continued antiretroviral treatment is not assured and ex-prisoners are not adequately counselled on prevention of onward HIV transmission.

ANALYSIS OF THE UPTAKE OF THE SADC MINIMUM STANDARDS

The SAfAIDS June 2015 Regional Think Tank Meeting on Prisons, held in Johannesburg, South Africa, in 2015, highlighted the fact that there had been little (if any) collaborative or consultative work done in developing the Minimum Standards, and that there is a general consensus amongst stakeholders that the document sets goals that are difficult to achieve. (SAfAIDS, 2015)

Similarly, the Minimum Standards were not signed by the relevant government representatives, and no advocacy campaign was developed or launched to ensure that ratification occurred at country level. This makes holding leaders accountable more challenging.

It was important to engage civil society at national level, to build their capacity on both the Minimum Standards and on accountability and monitoring commitments, as well as to set aside financial support to ensure their ability to follow up.

To date, there has been no follow up with countries on the Minimum Standards by SADC and no soliciting of, or reporting on progress has occurred. No tool was developed to capture progress against the commitment, neither was a framework for reporting provided to countries on what and when to report to SADC. Responsibility as to who should report is also vague.

As a result there is a lack of data on implementation of the SADC Minimum Standards and this hinders adequate monitoring and evaluation.

RECOMMENDATIONS FOR A STRATEGIC WAY FORWARD

Using the AAI Accountability Framework, and based on the key findings, this section aims to systematically and strategically identify key necessary interventions that will advance access to basic human rights in prisons in the six countries studied in the report, and in the remaining SADC countries. The Accountability Framework, developed by leaders in the field of accountability, entails three key steps: increasing transparency; promoting dialogue; and supporting action. (AIDS Accountability International, 2010)



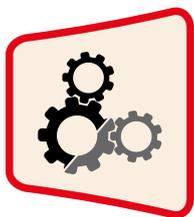
Transparency

Data: full, relevant, correct, accurate and unbiased data that is methodologically sound, periodically collected and collectively reported and discussed, as well as transparent about its failings and limitations, is a vital starting point for any discussion on developing a response to health problems.



Dialogue

Dialogue should mean all relevant stakeholders can meaningfully and freely participate, without fear, in the discussions and debates on the delivery and performance of health by public servants, especially in relation to the commitments that governments and leaders have made.



Action

Action is necessary for public servants to improve their delivery of health, share their successes and learn from their failures, making for quality, improved, sustainable and human rights-based health access for all, a reality. All leaders, not just governments, need to act to ensure transparency and dialogue are part of the health development process.

DISCUSSION AND WAY FORWARD (cont)

| | RECOMMENDATION | MECHANISM |
|--------------|--|---|
| TRANSPARENCY | 1. Greater transparency around data on prisons | A research project, such as a Scorecard, that captures, compares and contrasts detailed, disaggregated, recent and high quality data. |
| | 2. A framework or tool for collecting, reporting, verifying and validating this data, and | A development team of stakeholders to work together to develop research methodology and inputs to ensure a collaborative process. |
| | 3. A need for there to be a formal reporting submission process. | For the data to be collected at national/prison level and for governments to be part of the process. |
| DIALOGUE | 1. There is a need to bring all stakeholders back to the table to discuss and debate the virtues and weaknesses of the existing Minimum Standards, and | A regional meeting or various national stakeholder meetings hosted by a partner, such as SAfAIDS, that open the debate and remove blockages to forward progress in a constructive and collaborative manner. |
| | 2. To collaboratively and collectively agree on the best way forward that ensures incremental yet noticeable improvements in the health and human rights of prisoners in the SADC region. | Develop a discussion paper from those meetings and a roadmap for the implementation of the Minimum Standards from the perspectives of: government, civil society and relevant UN bodies. |
| | 3. Political buy-in is required at the top level to put the Minimum Standards process back on the rails. (A champion for this cause would be a useful tool to speed up and ease access to key decision-makers. | Identify and use a champion to lead the cause at the highest levels. Ensure all relevant stakeholders are invited in a timely manner and provided with the means to participate. |
| ACTION | 1. The strategic way forward or roadmap should be implemented and followed up in a collaborative manner | Civil society needs to play a role in co-ordinating stakeholders, bringing government, prison services etc. along and ensuring participation and buy-in by carrying out on-going advocacy. |
| | 2. By stakeholders. It should map out timelines, activities, resources responsible parties etc. | Civil society needs to hold stakeholders accountable to the new roadmap and the work they have committed to doing on it, by working with them, as a funded project. |
| | 3. In a highly pragmatic and transparent manner. | The work needs to be frequently communicated to relevant stakeholders and have its own communication plan to ensure inclusion, social mobilisation and transparency. |

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