



**UNODC**

United Nations Office on Drugs and Crime

**BASELINE ASSESSMENT**  
on regional and beneficiary country  
HIV/AIDS and SRHR minimum standard  
compliance for prison populations



# **BASELINE ASSESSMENT**

## **on regional and beneficiary country HIV/AIDS and SRHR minimum standard compliance for prison populations**

Angola, Eswatini, Lesotho, Malawi, Mozambique, Namibia,  
Tanzania (including Zanzibar), South Africa, Zambia, Zimbabwe

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## Abbreviations and terms

ART	Antiretroviral therapy
CDC	Centers for Disease Control and Prevention
CSO	Civil society organisation
EGPAF	Elizabeth Glaser Paediatric Foundation
HIV	Human immunodeficiency virus
HTS	HIV testing services
ICPD	International Conference on Population and Development
IEC	Information, education and communication
M&E	Monitoring & evaluation
MSF	Medecins Sans Frontieres
NSP	Needle and syringe programme
OST	Opioid substitution therapy
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
SADC	Southern African Development Community
SGBV	Sexual and gender-based violence
SSA	Sub-Saharan Africa
SOP	Standard operating procedure
STI	Sexually transmitted infection
SRH(R)	Sexual and reproductive health (rights)
TB	Tuberculosis
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNODC	United Nations Office on Drugs and Crime
USAID	United States Agency for International Development

HIV/AIDS programming involves prevention, treatment, care and support for people living with HIV/AIDS, as well as HIV/AIDS-focused interventions that are integrated within broader health programming. The aims of HIV/AIDS programming are to prevent and treat HIV and reduce HIV-related stigma and discrimination.

**Sexual and reproductive health and rights (SRHR)** programming encompasses efforts to eliminate preventable maternal and neonatal mortality and morbidity, ensure quality SRH services (including contraceptive services), and address sexually transmitted infections (STIs) and cervical cancer, violence against women and girls, and SRH needs of adolescents.<sup>1</sup>

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<sup>1</sup> WHO. Sexual and reproductive health and rights: a global development, health, and human rights priority, 2014 ([https://www.who.int/reproductivehealth/publications/gender\\_rights/srh-rights-comment/en/](https://www.who.int/reproductivehealth/publications/gender_rights/srh-rights-comment/en/))

HIV/SRH integration is based on the recognition that most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding. Also, HIV and many illnesses associated with SRH have the same root causes, including poverty, limited access to appropriate information, gender inequality, harmful cultural norms and social marginalization of the most vulnerable populations.<sup>2</sup> HIV/SRH integration is important in ensuring universal access to SRHR and HIV information and services.

Key populations are defined groups who, due to specific higher-risk behaviours, are at increased risk of HIV irrespective of the epidemic type or local context. Also, they often have legal and social issues related to their behaviours that increase their vulnerability to HIV. The following five key populations are recognized: 1) men who have sex with men, 2) people who inject drugs, 3) people in prisons and other closed settings, 4) sex workers and 5) transgender people.<sup>3</sup>

Vulnerable populations are groups of people who are particularly vulnerable to HIV infection in certain situations or contexts, such as adolescents (particularly adolescent girls), orphans, street children, people in closed settings (such as prisons or detention centres), people with disabilities and migrant and mobile workers.

Juveniles are defined as persons below the age at which ordinary criminal prosecution is possible (18 in most countries).

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<sup>2</sup> WHO, UNFPA, UNAIDS, IPPF. Sexual and Reproductive Health and HIV/AIDS: A Framework for Priority Linkages, 2005 (<https://apps.who.int/iris/handle/10665/69851>)

<sup>3</sup> WHO (2014) Consolidated guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations ([https://apps.who.int/iris/bitstream/handle/10665/128048/9789241507431\\_eng.pdf?sequence=1](https://apps.who.int/iris/bitstream/handle/10665/128048/9789241507431_eng.pdf?sequence=1))



## Executive summary

Sub-Saharan Africa (SSA) remains at the epicentre of the HIV epidemic, with the majority of all infected people living in this region. Estimates for women living with HIV/AIDS in SSA are up to twice that of men (UNAIDS 2017). Of the 1.8 million adolescents living with HIV globally, about 1.5 million (85%) live in SSA (UNICEF 2017).

Adequate health services in prisons are included in the Sustainable Development Goals (SDG 3, 5, and 16), and mandated under the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), the Bangkok Rules for Female Prisoners and in the SSA region, the Southern African Development Community (SADC) Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons.

While progress has been made in several SSA countries to improve the health conditions in prisons, little has been done to address specifically the health rights and needs of women and juveniles in prison. With respect to sexual and reproductive health and rights (SRHR), few prisons in SSA promote access to “the highest attainable standard of physical and mental health”<sup>4</sup> and adhere to a ‘minimum standard’ of SRHR requirements as international conventions and instruments require. Many prison systems continue to struggle to provide even the most basic health care services for people in prison.

UNODC project XSSW23 “Supporting Sexual and Reproductive Health and Rights for Prison Populations of Sub-Saharan Africa” was designed to respond to this gap and support the adoption and implementation of SRH services for prison populations in countries currently targeted by UNODC’s technical assistance, namely: Angola, eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania (including Zanzibar), Zambia and Zimbabwe.

As part of the programme, this baseline assessment was conducted from February to June 2019 to assess the current situation regarding HIV and SRHR programming within SSA prisons and their compliance with UN, regional and country specific normative guidelines. Its aim was to identify gaps in existing policies, legislation and practices regarding HIV and SRH programming in prisons, in staffing and resources regarding HIV and SRH needs of people in prison, and in HIV and SRHR service availability and access for people in prison, with a focus on women and juveniles.

The consolidated regional findings, as well as overall conclusions and recommendations, are summarized in the following sections.

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<sup>4</sup> International Covenant on Economic, Social and Cultural Rights. GA Res. 1966;2200A(XXI)

## Consolidated regional findings

NOTE: The questionnaire sent to Serviço Nacional Penitenciário Mozambique was not completed.

### Laws, policies and practices

#### *National laws, policies and guidelines*

- Illicit drug use is criminalised and punishable by imprisonment in all 10 countries
- Sex work is criminalised and punishable by imprisonment in 8/10 countries
- Same-sex relations are criminalised and can lead to imprisonment in all countries but Angola, Mozambique and South Africa
- Laws against domestic violence or SGBV are in place in all countries
- Anti-discrimination laws (women, people living with HIV) are lacking in eSwatini, Zanzibar and Zimbabwe
- National policies and strategies for HIV/AIDS include prison populations in all countries
- National policies and strategies for SRH that include prison populations are available only in Namibia

#### *Prison laws, policies and guidelines*

- Human rights including equivalence of care for people in prison are mandated in at least 9/10 countries
- Laws or policies against SGBV in prison appear to be lacking in Angola, Lesotho, Malawi and Zanzibar, but relevant national legislation may also apply to prison settings
- Laws or policies allowing conjugal/intimate visits exist only in Angola
- Laws or policies regarding children are available in 6/10 countries, but young children may remain with their incarcerated mothers in all 10 countries
- Guidance documents for substance abuse are currently available only in eSwatini, South Africa, Tanzania mainland and Zimbabwe
- Infection control plans are currently available in all countries except Angola and Namibia
- Prison policies for HIV/TB are available in most countries (lacking in Angola and Tanzania)
- Prison policies for SRH are available only in Namibia and South Africa
- National policies and guidelines for HIV are used in prisons in most countries
- National policies and guidelines for SRH are used in prisons in at least 6/10 countries
- Policies for HIV and SRHR linkage between prison and the community are currently available only in Angola, Lesotho and Zimbabwe

#### *Prison practices*

- Staff training and sensitisation on human rights are insufficient in all 10 countries
- Rights of people in prison are generally communicated upon admission, but seldom thereafter
- Mechanisms (internal/external) for reporting rights violations are in place in all countries except Malawi
- Mechanisms for monitoring rights violations were reported for 7/10 countries
- Non-custodial sentencing appears to be seldom, even where available

## Prison infrastructure, staffing and resources

### *Housing infrastructure*

- Prisons are overcrowded in all countries but Namibia, and none provide adequate housing
- Prison buildings are dilapidated in most countries, and ventilation, sanitation and hygiene are inadequate in prisons in all countries
- Separation of women and juveniles is not guaranteed in all prisons in all countries
- Facilities for women and juveniles are largely substandard and not appropriate

### *Health infrastructure*

- Health facilities are not available in all prisons
- Where available, facilities are largely inadequate to provide medical care
- Isolation cells for patients with active TB are currently lacking in Angola, eSwatini, South Africa, Tanzania and Zimbabwe
- In-house laboratories for diagnosis of infections are currently lacking in Lesotho, Namibia and South Africa
- Infrastructure prevents compliance with privacy and confidentiality in Lesotho, Namibia, Tanzania and Zimbabwe

### *Health care staffing*

- Health care staff shortages are reported in all countries except Angola and Zimbabwe
- Training and skills on primary health care and preventive medicine are mostly insufficient (except in Angola)
- Awareness of national guidelines on SRH is lacking in most countries
- Training on HIV and especially SRH is mostly insufficient to non-existent, except in eSwatini

### *Security staffing*

- Security staff knowledge of disease transmission is adequate in all countries except Namibia, Zambia and Zimbabwe
- Security staff knowledge of SRHR is reported to be sufficient only in eSwatini, South Africa, Tanzania mainland and Zambia
- Training and sensitisation on infections including HIV are still lacking in Namibia, Zambia and Zimbabwe
- Training and sensitisation on SRH are provided only in eSwatini, South Africa and Tanzania mainland

### *Supplies and logistics*

- Supplies for basic health, HIV and SRH needs are sufficient only in South Africa and Zimbabwe
- Inventory and supply systems are in place in at least 7/10 countries (lacking in Lesotho and Namibia)
- Transportation and storage of supplies are not appropriate in all countries

### *Monitoring & evaluation*

- Health care quality assurance and health surveillance are lacking in Malawi, Namibia and Zambia; quality assurance is lacking in South Africa
- Confidentiality of medical records is reported in at least 9/10 countries
- Prisons in eSwatini, Lesotho, Malawi, Namibia and South Africa lack a computerised system for data recording and reporting
- Prison health data is reported upward on a monthly or quarterly basis in all 10 countries
- Estimates of prevalence of HIV and TB in prison are available, but largely lacking for viral hepatitis and STIs

### *HIV and SRHR service availability and access for people in prison*

#### *Health service environment*

- Most prisons cover basic health care, such as communicable diseases
- Health screening upon admission mostly includes HIV, TB and STIs, with screening for viral hepatitis, reproductive cancers and pregnancy to be upscaled in the future
- For services not covered in prison, patients might be referred to outside health facilities
- In some countries, challenges related to transportation may prevent patients from being transferred to outside health facilities
- Privacy and thus confidentiality of health care services is reported only for Malawi and Mozambique
- HIV and SRH services are voluntary in all 10 countries
- Informed consent for HIV and SRH interventions is required in at least 8/10 countries (not in Angola)
- Clinical independence of health care staff is largely not ensured (reported only for Malawi)

#### *Services for HIV prevention, testing, treatment and care*

- Information, education and communication (IEC); HIV testing services; HIV treatment, care and support; and TB prevention and management are provided in prisons in all 10 countries
- HTS is voluntary and peer-led in prisons in most countries
- Access to condoms is provided to people in prison only in Lesotho and South Africa
- Most (7-8/10) countries prevent HIV transmission via medical/dental services, prevent mother-to-child transmission and protect staff from occupational hazards, and report providing post-exposure prophylaxis to people in prison
- Four/10 countries prevent HIV transmission through tattooing, piercing or other forms of skin penetration, and 5/10 countries diagnose and treat viral hepatitis
- Opioid substitution therapy for people in prison is available only in Zanzibar; needle and syringe programmes are not available in prisons any of the 10 countries
- Continuity of HIV care is provided in at least 9/10 countries
- Several challenges affect the provision of comprehensive and quality HIV care

### *Services for SRH care*

- Antenatal care/labour and delivery/postnatal care services are mostly provided in outside health facilities; Angola and Namibia have in-house maternal, newborn and child health care
- Prevention (via IEC) and treatment of STIs is available in all 10 countries
- Over half (6-7/10) countries provide IEC on sexuality and reproductive health, screening for reproductive cancers and measures to prevent and monitor violence
- At least 9/10 countries make appropriate referral to outside health facilities
- Abortion prevention and management is reported in South Africa, Zanzibar and Zimbabwe
- Peer-led SRH programmes appear to be lacking in Angola and eSwatini
- Several challenges affect the provision of comprehensive and quality SRH care

### *Gender and age-specific services*

- Gender and age-specific services are reported in Lesotho, Namibia, South Africa, Tanzania mainland and Zimbabwe
- Barriers to health care services exist for women, children and juveniles, including restricted opening hours, controlled access and/or delays in treatment or transport to outside health facilities
- Provision of supplies and health care services for mothers and babies is reported to be sufficient only in Angola, eSwatini, Lesotho, Namibia and Zambia
- Adequate (supplemental) food provision is limited for pregnant women, mothers and their children (reported only in Angola, eSwatini, Namibia and South Africa)

### *Linkage to community services and partnerships for HIV and SRH*

- Linkage to community services is done in most countries, but is weaker for SRH than for HIV
- Partners working with prisons focus mainly on HIV prevention, treatment and care (all 10 countries)
- Support for SRH and SRH/HIV integration is on the rise, but remains inadequate (reported only for Angola, Namibia and Zamiba)

## Conclusions and recommendations

While prison services across the region have laws mandating human rights including equivalence of health care for people in prison, in practice, substandard environmental conditions, sanitation, hygiene, supplies and health care prevent the realisation of the right of people in prison to the highest attainable standard of physical and mental health. Where available, health care facilities in prisons are characterized by shortages of staff, medicines, equipment, and poor health education and training, and poor linkage with public health care for services, monitoring and evaluation.

Compliance with international, regional and national standards and guidelines for HIV prevention, treatment and care is better than for SRH care for prison populations, as incarcerated women's (and their children's) specific health needs remain largely neglected by governments, prison management and staff, and community and donor support.

To close the gaps in compliance, the following activities are recommended:

## Laws, policies and practices

### *Short-term*

- Where unavailable, develop and implement infection control plans in prisons
- Where unavailable, develop prison policies and guidelines for HIV and SRH care that provide for equal standard of care as in the community
- Scale up training and sensitisation of prison management and staff on health and human rights of people in prison
- Ensure that people in prison are informed of their rights upon admission and regularly thereafter
- Ensure mechanisms for reporting and monitoring of violations of health and human rights of people in prison
- Update SRH policies, strategies and guidelines to include prison populations

### *Medium-term*

- Consider and provide for alternatives to imprisonment for petty, non-violent offenses and for women

### *Long-term*

- Decriminalise drug use, sex work and sex between men to reduce prison overcrowding and improve access to health care services

## Prison infrastructure, staffing and resources

### *Short-term*

- Continuously update prison staff training institution curriculum to include recent developments on health, HIV and SRHR
- Ensure separation of juveniles from adults, and adequate housing for juveniles, pregnant women, mothers and their children
- Provide sensitisation for security staff on the special needs of women in prison and the importance of their having access to health care, especially for SRH (including having female staff available to examine - or at least attend examination of - women and girls in prison)

### *Medium-term*

- Develop strategies for continuous in-service training for management, security and health personnel  
Invest in qualified medical staff and training on primary health care and HIV and SRH care

### *Long-term*

- Invest in renovating and extending prison infrastructure to meet the demand for space, water and ventilation
- Invest in and improve health facilities for all prisons to be able to deliver medical care that is equivalent to that available in the community
- Mobilise resources to ensure consistent availability and appropriate transportation and storage of medical, laboratory and SRH supplies
- Invest in improving monitoring and evaluation systems to improve data quality and identify gaps in health, HIV and SRH care

## HIV and SRHR service availability and access for people in prison

### *Short-term*

- Ensure comprehensive screening for HIV/AIDS, TB, hepatitis B and C, STIs, reproductive cancers (for men and women) and pregnancy upon admission, during incarceration and upon release as needed
- Prioritise SRH care and needs of juveniles, (pregnant) women, mothers and children
- Recognise the mental health needs of people in prison, especially those for women and juveniles, and facilitate access to necessary services

### *Medium-term*

- Provide all HIV prevention, treatment and care interventions available in the community, as applicable and appropriate in the prison setting
- Provide or increase access to condoms and lubricants in prison upon entry, during imprisonment and upon release

### *Long-term*

- Integrate needle and syringe programmes, opioid substitution therapy and other treatment of substance use disorders into prison services
- Increase budget allocation by governments and prison management to improve HIV, TB and SRH services in prisons
- Ensure the contribution of more stakeholders including community services in the provision of SRH services in the prisons, including continuity of care of such services

# 1. Introduction

## Background

People in prison have been identified as one of the key populations who are at higher risk of becoming infected with HIV and, due to legal and social issues related to their behaviours, have an increased vulnerability to HIV. <sup>5</sup>

Women are highly susceptible to infection with HIV and other sexually transmitted infections (STIs) in prison as they often come from socially marginalized groups and are vulnerable to sexual abuse and exploitation in the prison environment. <sup>6</sup> Due to a lack of personal or family support, juveniles in detention are also at increased risk of acquiring HIV, STIs and other reproductive health issues. If detained with adults, they may easily fall victim to sexual abuse and exploitation by prison staff and older prisoners. <sup>7</sup>

Despite being high-risk settings for HIV transmission, prisons face many challenges in developing and implementing HIV prevention, treatment and care programmes. Moreover, prison settings do not usually address gender-specific needs. Incarcerated women and adolescent females often come from disadvantaged environments and have high rates of chronic illness, substance abuse, and undetected health problems. Most of these females are of reproductive age and are at high risk of unintended pregnancy as well as infection with HIV and other STIs. For children born in prisons (who remain with their mothers) access to child health services, including paediatric HIV care for babies born with HIV, may be limited.

Sub-Saharan Africa (SSA) is home to the majority of all HIV infected people globally, with rates of HIV infected women estimated to be twice that of men <sup>8</sup>, and approximately 85% of HIV infected adolescents globally living in the region <sup>9</sup>. As HIV rates are higher in prison settings, and even higher for incarcerated women and girls than for males, HIV prevention, treatment and care and sexual and reproductive health (SRH) care for prison populations, in particular for women and juveniles, needs to be upscaled.

While progress has been made in several SSA countries to improve the health conditions in prisons, little has been done so far to address specifically the health rights and needs of women and juveniles in prison. With respect to sexual and reproductive health and rights (SRHR), few prisons in SSA promote access to “the highest attainable standard of physical and mental health” <sup>10</sup> and adhere to a ‘minimum standard’ of SRHR requirements as international conventions and instruments require. Many prison systems continue to struggle to provide even the most basic health care services for people in prison.

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<sup>5</sup> WHO Consolidated Guidelines on HIV Prevention, Diagnosis, Treatment and Care for Key Populations, 2016 update (<https://www.who.int/hiv/pub/guidelines/keypopulations-2016/en/>)

<sup>6</sup> UNODC, UNAIDS. Women and HIV in prison settings ([https://www.unodc.org/documents/middleeastandnorthafrica/drug-prevention-health-publications/WOMEN\\_AND\\_HIV\\_IN\\_PRISON\\_SETTINGS.pdf](https://www.unodc.org/documents/middleeastandnorthafrica/drug-prevention-health-publications/WOMEN_AND_HIV_IN_PRISON_SETTINGS.pdf))

<sup>7</sup> Topp SM, Moonga CN, Luo N, Kaingu M, Chileshe C, Magwende G, Heymann SJ, Henostroza G. Exploring the drivers of health and healthcare access in Zambian prisons: a health systems approach. Health Policy Plan. 2016 Nov;31(9):1250-61

<sup>8</sup> <https://www.unaids.org/en/regionscountries/countries>

<sup>9</sup> <https://data.unicef.org/topic/hivaids/adolescents-young-people/>

<sup>10</sup> International Covenant on Economic, Social and Cultural Rights. GA Res. 1966;2200A(XXI)



UNODC project XSSW23 “Supporting Sexual and Reproductive Health and Rights for Prison Populations of Sub-Saharan Africa” was designed to respond to this gap and support the adoption and implementation of SRH services for prison populations in countries currently targeted by UNODC’s technical assistance, namely: Angola, eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania (including Zanzibar), Zambia and Zimbabwe. Project XSSW23 builds on the experience, lessons learned and achievements of UNODC project XSSV02 in Southern Africa <sup>11</sup>. It aims to advance the realisation of SRHR and to strengthen prison-based HIV/AIDS and SRH interventions, and to build the evidence base for effective responses.

As part of the programme, this baseline assessment was conducted from February to June 2019 to assess the current situation regarding HIV and SRHR programming within SSA prisons and their compliance with UN, regional and country specific normative guidelines. Its purpose was to identify gaps in existing policies, legislation and practices regarding HIV and SRH programming in prisons, in staffing and resources regarding HIV and SRH needs of people in prison, and in HIV and SRHR service availability and access for people in prison, with a focus on women and juveniles.

#### Minimum standards for health and human rights in prisons

Adequate health services in prisons are included in the Sustainable Development Goals (SDG 3, 5, and 16). In addition, several international and regional standards emphasize health and human rights for people in prison, including for female and young offenders, and for HIV and SRHR care for prison populations.

For this assessment, the following rules and guidelines were used to measure compliance with HIV and SRH minimum standards for prison populations in sub-Saharan Africa:

#### United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)

##### *Excerpts:*

- All prisoners shall be treated with the respect due to their inherent dignity and value as human beings.
- Prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings.
- Prisoners should enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge.
- Health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including for HIV, tuberculosis and other infectious diseases.
- A physician or other qualified health-care professionals shall see, talk with and examine every prisoner as soon as possible following his or her admission and thereafter as necessary.
- All medical examinations shall be undertaken in full confidentiality.
- The relationship between the physician or other health-care professionals and the prisoners shall be governed by the same ethical and professional standards as those applicable to patients in the community.

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<sup>11</sup> Final Independent Project Evaluation of the HIV Prevention, Treatment, Care and Support in Prisons Settings in Sub-Saharan Africa 2017. Available upon request.

## United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules)

### *Excerpts:*

- Women prisoners shall be allocated, to the extent possible, to prisons close to their home or place of social rehabilitation, taking account of their caretaking responsibilities, as well as the individual woman's preference and the availability of appropriate programmes and services.
- The accommodation of women prisoners shall have facilities and materials required to meet women's specific hygiene needs, including sanitary towels provided free of charge and a regular supply of water to be made available for the personal care of children and women, in particular women who are pregnant, breastfeeding or menstruating.
- The health screening of women prisoners shall include comprehensive screening to determine primary health-care needs, and also shall determine: (a) the presence of sexually transmitted diseases or blood-borne diseases; and, depending on risk factors, women prisoners may also be offered testing for HIV, with pre- and post-test counselling; (b) mental health-care needs, including post-traumatic stress disorder and risk of suicide and self-harm; (c) the reproductive health history of the woman prisoner, including current or recent pregnancies, childbirth and any related reproductive health issues; (d) The existence of drug dependency; (e) sexual abuse and other forms of violence that may have been suffered prior to admission.
- If the woman prisoner is accompanied by a child, that child shall also undergo health screening.
- Gender-specific health-care services at least equivalent to those available in the community shall be provided to women prisoners.
- HIV/AIDS programmes and services shall be responsive to the specific needs of women, including prevention of mother-to-child transmission.
- Preventive health-care measures of particular relevance to women, such as Papanicolaou tests and screening for breast and gynaecological cancer, shall be offered to women prisoners on an equal basis with women of the same age in the community.

## United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules)

- Rule 13.4: Juveniles under detention pending trial shall be kept separate from adults and shall be detained in a separate institution or in a separate part of an institution also holding adults.

Southern African Development Community (SADC) Minimum standards for HIV and AIDS, TB, hepatitis B and C, and sexually transmitted infections prevention, treatment, care and support in prisons

*Excerpts:*

- Member States must provide services that reach all members of society, including individuals in prisons and other places of detention.
- The principle of confidentiality regarding the medical status of individuals in prisons or other places of detention must be upheld.
- Member States must uphold the human rights of individuals in prisons and other places of detention. Prisoners and detainees (...) should be treated with respect at all times.
- Member States need to ensure that evidence-based, comprehensive policies on prison health are in place and that these outline procedures for infection control, treatment, care and support. Prison health policies should facilitate the provision of health services of a standard equal to those provided to the general population.
- A comprehensive health assessment must be conducted for all persons admitted to prison and other places of detention to provide a baseline of their general health status and particularly in relation to HIV and AIDS, TB, Hepatitis B and C and STIs.<sup>12</sup>
- All prisoners who already are on treatment or who have been identified as requiring treatment for communicable and other diseases should be offered such treatment in accordance with Member States' national guidelines.
- Prison authorities must constantly cooperate and communicate with health service providers outside the prison system, as well as with other prisons, to ensure continuity of treatment after release or transfer.
- Prison authorities should establish sustainable cooperation and communication links between custodial and community health services to ensure continuity of care.
- Women prisoners must have access to health services that take into account their special health care needs. Prison health services must have confidential complaints mechanisms, especially for women who have been victims of violence and/or sexual abuse. Information on how to use those mechanisms should be provided to all women upon entry into the prison or place of detention.
- Prison staff members must be adequately and routinely trained with respect to HIV and AIDS, TB, Hepatitis B and C, STIs and nutrition.
- PEP should be provided to employees who have been exposed to HIV infection during the performance of their duties within 72 hours of such exposure and in accordance with national guidelines.

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<sup>12</sup> Officials should ensure that new prisoners or detainees receive—within 24 hours of admission and with their informed consent—the following:

- A health questionnaire (including questions on substance abuse, know-your-status, coughing, STIs, mental health, etc.)
- Provision of information on safety, procedures, complaints mechanisms, and access to postexposure-prophylaxis (PEP). These materials must be communicated verbally as well as developed in accessible language and formats, and should include images to enhance understanding
- Screening for HIV, TB and STIs
- An offer of pregnancy examination and testing for women to allow for appropriate treatment and care, and to initiate or continue PMTCT, as needed

- HIV testing and counselling must be offered in accordance with both the national guidelines and the approved Regional Minimum Standards for HIV Testing and Counselling.
- A comprehensive and simple medical register should be kept for all prisoners to facilitate follow-up and to provide necessary data (for disease surveillance etc.).
- Successful implementation of the Minimum Standards should be supported by a monitoring and evaluation (M&E) plan. Such plans should link with and reinforce existing M&E systems for HIV and AIDS, TB, Hepatitis B and C, and STIs.

Furthermore, levels of implementation of the Comprehensive package of 15 key interventions considered essential for effective HIV prevention, treatment, care and support <sup>13</sup> were evaluated. Also, the Reproductive Rights and Sexual and Reproductive Health Framework, i.e. the reproductive health care elements defined by the International Conference on Population and Development Programme of Action (Para 7.6) <sup>14</sup>, was used to select and assess the availability of nine SRH care interventions that are necessary and feasible in prison settings.

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<sup>13</sup> UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: UNODC; 2019 update

<sup>14</sup> UNFPA 2008: Making Reproductive Rights and Sexual and Reproductive Health a Reality for All, Reproductive Rights and Sexual and Reproductive Health Framework

## 2. Methodology

To assess compliance with HIV/AIDS and SRHR minimum standards for prison populations in Angola, eSwatini, Lesotho, Malawi, Mozambique, Namibia, South Africa, Tanzania (including Zanzibar), Zambia and Zimbabwe, information from the following sources was collected:

- Desk review of relevant documentation related to HIV and SRHR, including national policies, strategic documents and guidelines, UNODC assessment reports, publications and online articles, reviewed between 14 February – 1 May
- Nine responses to a questionnaire targeted towards prison authorities, collected between 11 March - 2 April 2019
- 10 remote interviews with prison commissioners, prison health commissioners, and member of civil society organisations (CSOs) conducted between 2 - 28 May 2019

For details, please see [Annex 1: List of source documents](#), [Annex 2: Questionnaire](#), [Annex 3: Respondents of the questionnaire](#), [Annex 4: Key informants](#), [Annex 5: Interview topics](#).

Based on the information gathered from the desk review and the questionnaire, an interview schedule was created. The topics were sent to the interviewees in advance to be able to prepare. Semi-structured interviews were then conducted via telephone or Skype with notes taken as back up. Per interview, the notes taken were sent to the key informants for confirmation.

Information gathered from these sources was collated, summarized and analysed, and the results are presented in the following sections.

### 3. Consolidated Regional Findings

#### Challenges for data collection and analysis

The following factors posed challenges for collecting and analysing data:

- Language barrier for the online search for policies, strategies and guidelines in Angola and Mozambique
- Some questions contained in the questionnaire did not elicit the desired information. Also, some inadequate or vague responses could not be clarified.
- The questionnaire sent to Serviço Nacional Penitenciário Mozambique was not completed.
- Key informants with different functions were interviewed; thus, the information gathered differs somewhat among the 10 countries.
- Angola provided conflicting information in the questionnaire and interview despite the same respondent/interviewee, which could not be clarified.

NOTE: In the following tables, no tick (✓) means the variable/element is not present or applicable in the country or the information was not available.

#### Laws, policies and practices

##### National laws, policies and guidelines

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Illicit drug use illegal	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Sex work illegal		✓	✓	✓		✓	✓	✓	✓	✓	✓
Same-sex relations illegal		✓	✓	✓		✓		✓	✓	✓	✓
Anti-discrimination laws - women	✓		✓	✓		✓	✓			✓	
Anti-discrimination laws - PLHIV	✓		✓	✓	✓	✓	✓	✓		✓	
Law against SGBV	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inclusion of prison populations in HIV/AIDS policies, strategies, guidelines	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Inclusion of prison populations in SRH policies, strategies, guidelines						✓					

PLHIV=people living with HIV; SGBV=sexual and gender-based violence; SRH=sexual and reproductive health

In 10/10 countries assessed, illicit drug use is illegal and punishable by imprisonment. In all countries except Angola and Mozambique, sex work and/or its related activities are criminalised. Data on the rates of sex workers and people who use drugs in prison are unavailable, but these are expected to be high due to such activities being common in the region.<sup>15 16</sup>

Same-sex relations are illegal and can lead to imprisonment in all countries but Angola, Mozambique and South Africa. In Angola and South Africa, discrimination against people based on sexual orientation is prohibited. Data on the rates of men who have sex with men in prison are not available either, as sexual activity, especially same-sex intercourse, in prisons is generally not acknowledged.

All countries have laws against domestic violence or SGBV. In Angola, Lesotho, Namibia, South Africa and Zambia, discrimination against women and people living with HIV is prohibited. Acts/laws against discrimination of women were found for Malawi, and those against discrimination of people living with HIV for Mozambique and Tanzania. Not all anti-discrimination laws, however, are fully implemented, and stigma and discrimination of both populations remain wide-spread in many countries.

National HIV/AIDS policies, strategies and/or guidelines address key/prison populations in all countries. Adequate policies, strategies and/or guidelines for reproductive health; however, are lagging behind, and only in Namibia do they appear to make mention of key/prison populations.

## Summary

- Illicit drug use is criminalised and punishable by imprisonment in all 10 countries
- Sex work is criminalised and punishable by imprisonment in 8/10 countries
- Same-sex relations are criminalised and can lead to imprisonment in all countries but Angola, Mozambique and South Africa
- Laws against domestic violence or SGBV are in place in all countries
- Anti-discrimination laws (women, people living with HIV) are lacking in eSwatini, Zanzibar and Zimbabwe
- National policies and strategies for HIV/AIDS include prison populations in all countries
- National policies and strategies for SRH that include prison populations are available only in Namibia

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<sup>15</sup> Awungafac G, Delvaux T, Vuylsteke B. Systematic review of sex work interventions in sub-Saharan Africa: examining combination prevention approaches. *Trop Med Int Health*. 2017; 22:971-993

<sup>16</sup> Degenhart L, Peacock A, Colledge S et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. *Lancet Glob Health*. 2017; 5:e1192-e1207

## Prison laws, policies and guidelines

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Law or policy mandating human rights, including equivalence of care for prison populations	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Law or policy against SGBV in prison		✓				✓	✓	✓		✓	✓
Law or policy allowing intimate visits	✓										
Law or policy regarding children of incarcerated mothers				✓		✓	✓	✓	✓	✓	✓
Guidance document for substance abuse		✓					✓	✓			✓
Infection control plan		✓	✓	✓			✓	✓	✓	✓	✓
Prison policy/guidelines for HIV/TB		✓	✓	✓		✓	✓			✓	✓
National policy/guidelines for HIV/TB used	✓		✓	✓	✓	✓		✓		✓	✓
Prison policy/guidelines for SRH						✓	✓				
National policy/guidelines for SRH used		✓	✓	✓		✓	✓	✓			
Policies for HIV and SRHR linkage between prison and the community	✓		✓								✓

SGBV=sexual and gender-based violence; TB=tuberculosis; SRH=sexual and reproductive health

Prison services in nine countries have laws (Constitution or Prison Act) or policies regarding human rights including equivalence of care for people in prison as mandated by the Nelson Mandela Rules. Laws or policies against SGBV in prison appear to be lacking in some countries, but relevant national legislation against this type of violence may also apply to prison settings, e.g. as they do in Zambia.

Laws regarding conjugal or intimate visits exist only in Angola (permitted but not implemented) and Zimbabwe (visits prohibited). Children appear to be allowed to remain with their incarcerated mothers for their first few years in all 10 countries, but relevant laws or policies are lacking in Angola, eSwatini and Lesotho.

Guidance documents for prevention and treatment of drug/alcohol abuse are available only in eSwatini, South Africa, Tanzania mainland and Zimbabwe.

Infection control plans for blood-borne and airborne pathogens were reported only for seven countries: eSwatini, Lesotho, Malawi, South Africa (not fully implemented), Tanzania, Zambia and Zimbabwe.

Policies regarding HIV/TB (and STI) management in prison settings are in place in eSwatini (including pre-release planning for people living with HIV), Lesotho, Malawi, South Africa (including prevention of mother-to-child transmission of HIV [PMTCT]), Namibia, Zambia (outdated) and Zimbabwe. National guidelines for HIV/TB are available in Angola (also international and regional standards/guidelines), Lesotho (including PMTCT), Malawi (also international and regional standards,



and national guidelines for antiretroviral therapy [ART], STIs), Mozambique, Namibia (including STIs, poor dissemination), Zambia and Zimbabwe.

Prison policies for SRH are largely lacking, and where they exist (Namibia, South Africa), not all staff are sensitised on women's SRH needs. National guidelines for SRH are available in eSwatini, Lesotho (family planning), Malawi (STI treatment), Namibia (poor dissemination), South Africa and Tanzania mainland.

HIV and SRHR linkage between prison and the community is reported only for Angola (no formal policy), Lesotho and Zimbabwe.

## Summary

- Human rights including equivalence of care for people in prison are mandated in at least 9/10 countries
- Laws or policies against SGBV in prison appear to be lacking in Angola, Lesotho, Malawi and Zanzibar, but relevant national legislation may also apply to prison settings
- Laws or policies allowing conjugal/intimate visits exist only in Angola
- Laws or policies regarding children are available in 6/10 countries, but young children may remain with their incarcerated mothers in all 10 countries
- Guidance documents for substance abuse are currently available only in eSwatini, South Africa, Tanzania mainland and Zimbabwe
- Infection control plans are currently available in all countries except Angola and Namibia
- Prison policies for HIV/TB are available in most countries (lacking in Angola and Tanzania)
- Prison policies for SRH are available only in Namibia and South Africa
- National policies and guidelines for HIV are used in prisons in most countries
- National policies and guidelines for SRH are used in prisons in at least 6/10 countries
- Policies for HIV and SRHR linkage between prison and the community are currently available only in Angola, Lesotho and Zimbabwe

## Prison practices

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Staff training/sensitisation on human rights*		✓	✓	✓		✓				✓	✓
Information for people in prison on human rights*		✓	✓			✓				✓	
Mechanisms for reporting rights violations	✓	✓	✓			✓	✓	✓	✓	✓	✓
Mechanisms for monitoring rights violations	✓	✓	✓	✓	✓	✓				✓	
Non-custodial measures for petty offenses or for women **						✓				✓	✓

\* Information gathered from desk review or interviews; \*\* Only asked during interviews

Training and/or sensitisation of prison staff on international and regional/national standards for health and human rights varies, and nowhere does either appear to be adequate or sufficiently frequent. Basic/recruitment training is not followed up with refresher courses, and workshops provided by CSOs are either too seldom to be effective or not cascaded.

People entering prison may be informed of their rights and mechanisms to report violations e.g. in eSwatini, Lesotho (SOP in place), Namibia and Zambia, but this information is not necessarily refreshed. Complaints may be gathered weekly to be further reported according to existing mechanisms (e.g. in eSwatini); however, it is not clear to what extent people in prison make use of these mechanisms. In Zambia, people in prison are reported to meet every morning to discuss rights issues, which may then be taken up with paralegals and further until possible legal representation. Here, the Prison Care and Counselling Association (PRISCCA) reports having trained 25 people in prison across facilities on human rights in prison.

Monitoring of rights violations was not specifically queried but found to be done in Lesotho and Namibia by visiting legal officers/office of the Ombudsman, in eSwatini and Zambia by the Human Rights Commission, and in Malawi via the Centre for Human Rights Education Advice and Assistance (CHREAA). Disciplinary action in case of breaches of human rights by prison staff are reported in these countries, with consequences including suspension or dismissal, depending on the severity of the violation.

According to interviews with CSOs dealing with rights and advocacy for people in prison in Namibia, Zambia and Zimbabwe, although non-custodial measures such as community sentencing for petty, non-violent offenses and for women are possible, these are hardly used. This is partly due to a lack of supervision/monitoring and fines being too high, but also due to the cultural mindset that offenders must be punished. In Zimbabwe, there is no policy for non-custodial sentences and petty offenses are not defined: *“all crimes are seen as crimes”* (paraphrased from key informant interview); however, a new prison act is being developed addressing open community facilities and open prison systems. Although no such information was gathered for the other countries assessed, it is likely that the situation is similar. In Zambia, juveniles are counselled, with those recommended for good behaviour possibly being sent back to school rather than prison.

## Summary

- Staff training and sensitisation on human rights are insufficient in all 10 countries
- Rights of people in prison are generally communicated upon admission, but seldom thereafter
- Mechanisms (internal/external) for reporting rights violations are in place in all countries except Malawi
- Mechanisms for monitoring rights violations were reported for 7/10 countries
- Non-custodial sentencing appears to be seldom, even where available

## Prison infrastructure, staffing and resources

### Housing infrastructure

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Overcrowding	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓
Adequate* housing infrastructure											
Adequate* ventilation, sanitation and hygiene											
Separation of women from men		✓	✓	✓		✓	✓	✓	✓	✓	✓
Separation of juveniles from adults		✓		✓		✓	✓	✓	✓	✓	

\* As defined in source documents and in interviews

Overcrowding is reported in all countries but Namibia, with occupancy levels exceeding ~200% in Malawi, exceeding 200% in Mozambique, and exceeding 300% in Zambia. Many prisons in SSA were built in the pre-colonial era and do not have the space to adequately house the increased prison population that exists today. Also, buildings are largely dilapidated and unable to meet even the most basic minimum standards for people in prison such as adequate ventilation, sanitation and hygiene. Water shortages are reported for Namibia, South Africa, Zambia and Zimbabwe, and electricity shortages for Tanzania.

Women and juveniles are minority groups in prison. Both groups have an increased vulnerability to (sexual) violence and HIV infection and should be held separately during incarceration. Strict separation of juveniles from adults may not always be ensured in Zambia due to there being one juvenile centre in the country, nor in Lesotho where juveniles' incarceration may be classified according to maturity, mental age and behaviour rather than actual age. In Zimbabwe, all under 21-year olds are reported to be housed together.

Facilities for pregnant women, mothers and children, and for juveniles, are affected by the same substandard conditions as reported generally. In South Africa, however, an increased number of mother and baby units are now in place improving the conditions under which they are housed. In Namibia, a female correctional centre opened this year with a health clinic and child-friendly area. Otherwise, women-only prisons, available in eSwatini, Lesotho, South Africa, Tanzania, Zambia and Zimbabwe, are often far away from home and from health care services.

### Summary

- Prisons are overcrowded in all countries but Namibia, and none provide adequate housing
- Prison buildings are dilapidated in most countries, and ventilation, sanitation and hygiene are inadequate in prisons in all countries
- Separation of women and juveniles is not guaranteed in all prisons in all countries
- Facilities for women and juveniles are largely substandard and not appropriate

## Health infrastructure

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Adequate* health facilities	✓					✓	✓				
Isolation cells for active TB patients **			✓	✓	✓	✓				✓	
In-house laboratories	✓	✓		✓				✓	✓	✓	✓
Infrastructure allowing privacy and confidentiality	✓	✓		✓			✓			✓	

TB=tuberculosis; \* As defined in source documents and in interviews; \*\* Only asked in interviews with prison health sector

Health facilities are established within the prison system in all countries but are largely inadequate to provide medical care due to substandard infrastructures (e.g. Lesotho) and/or not being available in all prisons (Malawi, Mozambique, Zambia). Health care facilities are reported to be adequate for basic needs and for HIV and SRH care in South Africa. In Angola, health care facilities cannot provide for SRH services.

Regarding specialised prison health facilities, Lesotho has three ART/TB clinics, Angola has two prison tertiary hospitals with an over 300 bed capacity and one hospital built and fully equipped in 2016, as well as a tertiary psychiatric hospital (catering mainly to incarcerated males), and in Zimbabwe, two facilities are equipped to deal with people with mental health issues.

Isolation cells for people in prison with active TB are only reported for Lesotho (one facility), Malawi (only a few prisons), Mozambique (one facility), Namibia (isolation of people with contagious diseases) and Zambia. In Mozambique, UNODC supported the refurbishment of three isolation wards in Machava prison in Maputo, which has reportedly helped curb TB transmission.

Laboratories for diagnosis of infections are available in Angola, eSwatini (one mini mobile lab), Malawi (in four prisons), Tanzania (insufficient staff and equipment), Zambia and Zimbabwe (two prisons; + seven microscopy sites). In Namibia, HIV rapid tests are procured at the Institute of Pathology, in South Africa at the National Health Laboratory Service.

This lack of appropriate infrastructure (and of health care staff) also renders it difficult to comply with medical ethics such as privacy and confidentiality of examinations and interventions.

### Summary

- Health facilities are not available in all prisons
- Where available, facilities are largely inadequate to provide medical care
- Isolation cells for patients with active TB are currently lacking in Angola, eSwatini, South Africa, Tanzania and Zimbabwe
- In-house laboratories for diagnosis of infections are currently lacking in Lesotho, Namibia and South Africa
- Infrastructure prevents compliance with privacy and confidentiality in Lesotho, Namibia, Tanzania and Zimbabwe

## Health care staffing

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Sufficient staff numbers	✓										✓
Resident doctor	✓	✓		✓	✓	✓	✓			✓	
Medical/clinical officers	✓							✓		✓	
Nurses	✓	✓		✓		✓	✓	✓	✓	✓	✓
Psychologists/social workers	✓	✓				✓			✓	✓	
Technicians	✓	✓		✓	✓			✓	✓	✓	
Pharmacists						✓	✓		✓		
Midwives		✓				✓					
Nutritionists			✓					✓			
HIV counsellors/coordinators				✓		✓				✓	
Sufficiently trained and skilled staff - primary care and preventive medicine	✓										
Sufficiently trained and skilled staff - HIV		✓	✓				✓				
Sufficiently trained and skilled staff - SRH		✓									

SRH=sexual and reproductive health

Prisons in most countries are affected by a shortage of qualified health care staff and/or insufficient training on primary care or preventive medicine. Staff numbers are reported to be insufficient everywhere but in Angola (25 resident doctors) and Zimbabwe (despite no resident doctor, specialist staff or social workers).

Prisons typically must make do with few resident doctors (n=1 in Namibia, Malawi and Zambia, n=2 in eSwatini, n=3 in Mozambique, n=9 in South Africa) or visiting doctors who do not always comply with schedules (Lesotho). In Tanzania and Zimbabwe, no information is available on whether or how often an outside doctor visits the prisons.

Training and skills on primary care and preventive medicine are reported to be insufficient in nine countries.

Awareness of health care staff of national guidelines for HIV is minimal in Angola, and for SRH issues partly non-existent in Angola, Lesotho, Malawi, Namibia, South Africa, Zambia and Zimbabwe. Training on HIV prevention, treatment and care and SRH issues is reported to be inadequate in Angola, Malawi, Mozambique, Namibia, Tanzania, Zambia and Zimbabwe, and on SRH altogether lacking in Angola, Lesotho and Mozambique. In Malawi, Mozambique and Zimbabwe, UNODC has supported cascade training for HIV/AIDS.

## Summary

- Health care staff shortages are reported in all countries except Angola and Zimbabwe
- Training and skills on primary health care and preventive medicine are mostly insufficient
- Awareness of national guidelines on SRH is lacking in most countries
- Training on HIV and especially SRH is mostly insufficient to non-existent, except in eSwatini

## Security staffing

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Staff knowledge of disease transmission	✓	✓	✓	✓	✓		✓	✓	✓		
Staff knowledge of SRHR		✓					✓	✓		✓	
Training/sensitisation provided on infections including HIV	✓	✓	✓	✓			✓	✓	✓		
Training/sensitisation provided on SRHR		✓					✓	✓			

SRHR=sexual and reproductive health rights

Security staff is reported to be unaware or receive no education on disease transmission in Zambia and Zimbabwe, and on SRHR rights or people in prison in Namibia and Zimbabwe. In Angola, security staff have knowledge of disease transmission, but it is reported to be inadequate.

In eSwatini, workshops on transmission and prevention of communicable diseases and on SRH are conducted. In Lesotho, training on human rights, transmission and treatment of infections, but not on SRHR, is provided. In Malawi, HIV/AIDS, drug use disorders and gender issues are communicated, but not women's specific needs. In Mozambique, security staff is reported to be trained on health matters. In South African prisons, education on transmission of communicable diseases and to some extent on SRH is provided. In Tanzania mainland, weekly to monthly sensitisation sessions on HIV, TB, STIs and SRHR are held, and in Zanzibar, seminars on disease transmission conducted. Lack of training of officers on mental health is reported for Zambia and is likely the case for all other countries.

## Summary

- Security staff knowledge of disease transmission is adequate in all countries except Namibia, Zambia and Zimbabwe
- Security staff knowledge of SRHR is reported to be sufficient only in eSwatini, South Africa, Tanzania mainland and Zambia
- Training and sensitisation on infections including HIV are still lacking in Namibia, Zambia and Zimbabwe
- Training and sensitisation on SRH are provided only in eSwatini, South Africa and Tanzania mainland

## Supplies and logistics

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Sufficient medical and laboratory supplies for HIV		✓					✓				✓
Sufficient medical supplies for SRH							✓				✓
Sufficient commodities for menstrual hygiene	✓						✓		✓		✓
Inventory and supply chains in place	✓	✓		✓			✓	✓	✓	✓	✓
Appropriate transportation	✓	✓	✓				✓		✓	✓	✓
Appropriate storage	✓	✓				✓	✓			✓	✓

SRH=sexual and reproductive health

Medical and laboratory supplies to cover basic health needs and HIV and SRH needs including supplies for children are largely irregular and insufficient across the region. In eSwatini, South Africa and Zimbabwe, supplies for HIV prevention, treatment and care are reported to be covered, even when other supplies are not. SRH supplies including sanitary napkins are inadequate or lacking in most countries.

Supplies are generally obtained by the Ministry of Health in each country, with procurement done via request for quotation in Angola, Malawi, Namibia and via voted funds in Lesotho. Tanzania prisons also receive donations from partners on the mainland. In case of lack of medical supplies, relatives of people in prison must bring the required medicines from outside the prison (e.g. in Tanzania and Zimbabwe).

Inventory and supply chain systems are in place in all countries but Lesotho and Namibia. Reliable and suitable transportation of supplies is reported as lacking in Malawi, Namibia and Tanzania mainland. Storage of supplies is inadequate in Lesotho and Malawi. In Tanzania, this is due to electricity shortages, and in Zimbabwe, due to lack of refrigeration). No relevant information was obtained for Mozambique.

### Summary

- Supplies for basic health, HIV and SRH needs are sufficient only in South Africa and Zimbabwe
- Inventory and supply systems are in place in at least 7/10 countries (lacking in Lesotho and Namibia)
- Transportation and storage of supplies are not appropriate in all countries

## Monitoring & evaluation

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Health care quality assurance	✓	✓	✓					✓	✓		✓
Health surveillance	✓	✓	✓				✓	✓	✓		✓
Confidentiality of medical records	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Computerised system in place	✓				✓			✓	✓		
Health data reporting (monthly/quarterly)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estimated prevalence of HIV	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Estimated prevalence of TB		✓	✓	✓		✓			✓	✓	✓
Estimated prevalence of viral hepatitis and STIs						✓			✓		

TB=tuberculosis; STIs=sexually transmitted infections

Health care quality assurance and health surveillance are conducted in Angola, eSwatini (by partners), Lesotho, Tanzania and Zimbabwe. Only health surveillance is done in Angola, eSwatini, Lesotho (by District Health Management Team), South Africa (TB/HIV system initiated), Tanzania (mainland and Zanzibar) and Zimbabwe.

Confidentiality of medical records is reported to be upheld in nine countries (no information for Mozambique) by being accessible only to medical personnel (locked cabinets in health facilities), or in Angola via a computerised health system. Most countries still use a manual system for recording and reporting. Mozambique is currently piloting a computerised system (training and equipment provided by UNODC). In Tanzania, records are filed manually and electronically. Computers and printers for M&E are lacking in Namibia.

In all 10 countries, health data is reported monthly and/or quarterly to one or more of the following: head office/prison headquarters, district/province health officers, Ministry of Health. It is not clear however, whether these data are disaggregated by age/sex/HIV status, whether SRH data are collected, or how data are used for planning purposes. Current estimates (from at least 2017) of HIV prevalence are available online and were also provided in the questionnaire; for TB, estimates were available everywhere but Angola, South Africa and Tanzania mainland. Hepatitis and STIs prevalence estimates are largely unavailable and were only provided for Namibia (STIs) and Zanzibar (both).

### Summary

- Health care quality assurance and health surveillance are lacking in Malawi, Namibia and Zambia; quality assurance is lacking in South Africa
- Confidentiality of medical records is reported in at least 9/10 countries
- Prisons in eSwatini, Lesotho, Malawi, Namibia and South Africa lack a computerised system for data recording and reporting
- Prison health data is reported upward on a monthly or quarterly basis in all 10 countries
- Estimates of the prevalence of viral hepatitis and STIs in prison are largely lacking



## HIV and SRHR service availability and access for people in prison

### Health service environment

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Provision of primary health care	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Health screening on admission		✓	✓	✓		✓	✓		✓	✓	✓
Referral to outside health facilities	✓*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment provided free of charge				✓		✓				✓	
Privacy during examinations or Interventions**				✓	✓						
HIV/SRH services – voluntary and confidential	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV/SRH services – informed consent required		✓	✓	✓		✓	✓	✓	✓	✓	✓
Clinical independence of health care staff**				✓							

\* Conflicting information between questionnaire and interview

\*\* Only asked during interviews

Most prisons are reported to cover primary health care, such as treatment of endemic diseases (e.g. Angola), communicable diseases (e.g. Lesotho, Namibia, South Africa), non-communicable diseases (e.g. Namibia) and prevention, diagnosis, treatment and care (e.g. Tanzania). In Malawi, the complete package of health services according to national guidelines for key populations is provided. Angola has two tertiary prison hospitals and one tertiary psychiatric hospital (catering mainly for men).

Health screening on admission for HIV, TB, HBV, HCV, STIs, reproductive cancers and for pregnancy is reported for South Africa and Zanzibar. In eSwatini, screening includes viral hepatitis. In Lesotho, screening includes cervical cancer and pregnancy. In Namibia, screening for HIV, TB, STIs and pregnancy is done. Prisons in Malawi and Zimbabwe cover HIV, TB and STIs. In prisons in Tanzania mainland and in Zambia, screening is only conducted for HIV and TB. In Angola, only HIV screening is done upon admission in some prisons.

For services not provided in prison, such as further treatment or specialised services, patients might be referred to outside health facilities. In Tanzania, patients with HIV and SRH needs are referred to outside health facilities. In Malawi, specialised services are provided in an outreach mode from the nearest outside facility: for example, patients with drug-resistant TB are released for treatment in the community. In Angola and Lesotho, patients may request consultations with private doctors at their own expense.

Transfer of patients to outside facilities, however, may be delayed or hindered by a lack of staff to escort patients, security concerns (Malawi, Namibia), or a lack of appropriate transportation and/or of fuel (Mozambique, Zimbabwe).

Privacy and thus confidentiality of primary health care are reported to be compromised in Lesotho, Namibia, Tanzania (drug dispensing in front of prison staff), Zambia and Zimbabwe (drug dispensing in front of fellow incarcerated people), but not in Malawi, despite challenges. HIV and SRH services are reported to be voluntary in all countries and require informed consent in all countries but Angola. Clinical independence of health care staff is reported for most prisons in Malawi, but not ensured in Zambia due to health care staff having a double role as security staff. Zambia and Zimbabwe, however, have recently developed, with UNODC support, new prison acts which cover medical ethics such as independence of health staff, among other issues.

### Summary

- Most prisons cover basic health care, such as communicable diseases
- Health screening upon admission mostly includes HIV, TB and STIs, with screening for viral hepatitis, reproductive cancers and pregnancy to be upscaled in the future
- For services not covered in prison, patients might be referred to outside health facilities
- In some countries, challenges related to transportation may prevent patients from being transferred to outside health facilities
- Privacy and thus confidentiality of health care services is reported only for Malawi and Mozambique
- HIV and SRH services are voluntary in all 10 countries
- Informed consent for HIV and SRH interventions is required in at least 8/10 countries (not in Angola)
- Clinical independence of health care staff is largely not ensured (reported only for Malawi)

## Services for HIV prevention, testing, treatment and care

15 key interventions for HIV prevention, treatment and care for people in prison	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Information, education, communication	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Condom and lubricant programming			✓				✓				
Prevention of sexual violence		✓					✓	✓	✓		✓
Needle and syringe programmes and overdose prevention and management											
Opioid substitution therapy and other evidence-based drug dependence treatment									✓		
Prevention of transmission through medical or dental services	✓	✓	✓	✓		✓	✓	✓			✓
Prevention of transmission through tattooing, piercing and other forms of skin penetration							✓	✓		✓	✓
Post-exposure prophylaxis	✓	✓	✓	✓		✓	✓	✓		✓	
HIV testing services	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
HIV treatment, care and support	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓
Prevention, diagnosis and treatment of tuberculosis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
(Vaccination,) diagnosis and treatment of viral hepatitis		✓				✓	✓		✓	✓	
Sexual and reproductive health		✓	✓			✓	✓	✓	✓	✓	✓
Prevention of mother-to-child transmission of HIV, syphilis and HBV	✓	✓	✓				✓	✓		✓	✓
Protecting staff from occupational hazards		✓	✓	✓			✓	✓		✓	✓
Peer-led programmes			✓	✓	✓	✓	✓	✓	✓	✓	✓
Continuity of care	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓

Provision of the key interventions for people in prison, as defined by UNODC *et al.*<sup>17</sup> ranges from 7/15 interventions in Angola to 13/15 interventions in South Africa.

Information, education and communication (IEC); HIV testing services; HIV treatment, care and support; and prevention, diagnosis and treatment of TB are provided in all countries. Condoms are

<sup>17</sup> UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: UNODC; 2019 update

provided to people in prison only in Lesotho and South Africa. In Angola, Malawi, Zambia and Zimbabwe, lobbying for access to condoms and lubricant programmes in prison is underway.

Seven countries report having peer-led interventions to promote HIV testing. Additional prevention interventions such as voluntary male medical circumcision and pre-exposure prophylaxis are reported for Lesotho (both), Namibia (pre-exposure prophylaxis) and Zambia (voluntary male medical circumcision). In Malawi, the 3-phase screening model (HIV, TB, STIs) developed by Medecins Sans Frontieres (MSF; sometimes including hepatitis B) is reported to be well accepted by people in prisons.

Generally, where interventions are reported to be available, not all prisons within the same country have the facilities, staff or resources to provide them or to the same extent.

Challenges reported for providing quality HIV services include lack of prison management and staff's understanding of the importance of such services (Angola, Zambia), limited financial support (Angola, Tanzania), bureaucracy (Angola), inadequate infrastructure, resources and supplies (Lesotho, Mozambique, Namibia, Tanzania), shortage of qualified staff e.g. to provide ART (Malawi, Namibia, South Africa, Tanzania, Zambia), lack of nutritional support (Namibia, Zambia) and continuous counselling for those on ART (Namibia), reluctant uptake of HIV testing (eSwatini), stigma and discrimination (Zambia, Zimbabwe), and inadequate transport to outside health facilities (Mozambique, Zambia).

Continuity of HIV care - mainly upon admission and during interfacility transfer, but also upon release from prison - is reported for most countries. Challenges to continuity of care include people not having started a pre-release linkage programme (Lesotho), lack of referral letters/systems (Malawi, South Africa), use of manual systems (Zimbabwe) and people leaving incorrect addresses upon release or not wanting to disclose their HIV status. For Mozambique, conditions for follow up are being initiated by partners working with prisons. Continuity of care is reported to be better for sentenced people than for people in remand in Malawi, Namibia and Tanzania. In Zambia, continuity of care is supported by CSOs.

## Summary

- IEC; HIV testing services; HIV treatment, care and support; and TB prevention and management are provided in prisons in all 10 countries
- HTS is voluntary and peer-led in prisons in most countries
- Access to condoms is provided to people in prison only in Lesotho and South Africa
- Most (7-8/10) countries prevent HIV transmission via medical/dental services, prevent mother-to-child transmission and protect staff from occupational hazards, and report providing post-exposure prophylaxis to people in prison
- Four/10 countries prevent HIV transmission through tattooing, piercing or other forms of skin penetration, and 5/10 countries diagnose and treat viral hepatitis
- Opioid substitution therapy for people in prison is available only in Zanzibar; needle and syringe programmes are not available in prisons any of the 10 countries
- Continuity of HIV care is provided in at least 9/10 countries
- Several challenges affect the provision of comprehensive and quality HIV care

## Services for SRH care

SRH interventions for people in prison	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Family planning			✓		✓		✓	✓	✓		✓
Information, education and counselling on sexuality and reproductive health		✓	✓			✓	✓	✓		✓	✓
Prevention of sexually transmitted infections (via IEC)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Treatment and care of sexually transmitted infections	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Screening for reproductive cancers (prostate, cervical, and/or breast)		✓		✓	✓	✓	✓			✓	✓
Prevention and surveillance of violence, care for survivors of violence	✓	✓				✓		✓	✓		✓
Antenatal, safe delivery and postnatal care	✓	✓	✓	✓		✓	✓	✓		✓	✓
Prevention of abortion and management of the consequences of abortion							✓		✓		✓
Appropriate referrals for further diagnosis and management of the above	✓*	✓	✓	✓		✓	✓	✓	✓	✓	✓
Peer-led programmes			✓	✓		✓	✓	✓	✓	✓	✓
Integration of HIV/SRH services			✓				✓	✓			✓

SRH=sexual and reproductive health; \* Conflicting information between questionnaire and interview

Provision of the queried interventions for SRH in prison range from 5/9 interventions in Angola and Malawi to 8/9 interventions in South Africa and Zimbabwe.

Services for antenatal care, labour and delivery and postnatal care are mostly provided in outside health facilities. Angola and Namibia have in-house maternal, newborn and child health care. Prevention and treatment of STIs is also provided in all 10 countries, but in Mozambique only in two prisons. Regarding family planning offered in five countries, this may likely be only to prison staff. In Lesotho, cervical cancer screening in outside health facilities is facilitated; and in Malawi and Namibia, screening for reproductive cancers was recently conducted with UNODC support. In line with lacking integration of HIV and SRH in the community in all countries, HIV/SRH integration in prisons is also largely lacking.

Challenges in providing all SRH interventions in prisons include limited funding for SRH (Namibia, Tanzania), inadequate infrastructure, resources and supplies (Lesotho, Mozambique, Namibia, Tanzania, Zimbabwe), lack of pregnancy testing (Angola), staff shortages (South Africa, Tanzania), lack of training for service providers (eSwatini, Mozambique, Zambia), lack of standardised guidelines for SRH (Tanzania), lack of policies or practices for prevention and management of SGBV

(Malawi), limited access to health care for women and children and negative staff attitudes (Zimbabwe), and shortage of security staff to escort women to outside services (Zambia).

### Summary

- Antenatal care/labour and delivery/postnatal care services are mostly provided in outside health facilities; Angola and Namibia have in-house maternal, newborn and child health care
- Prevention (via IEC) and treatment of STIs is available in all 10 countries
- Over half (6-7/10) countries provide IEC on sexuality and reproductive health, screening for reproductive cancers and measures to prevent and monitor violence
- At least 9/10 countries make appropriate referral to outside health facilities
- Abortion prevention and management is reported in South Africa, Zanzibar and Zimbabwe
- Peer-led SRH programmes appear to be lacking in Angola and eSwatini
- Several challenges affect the provision of comprehensive and quality SRH care

### Gender and age-specific services

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Gender and age-specific services			✓			✓	✓	✓			✓
Equal access to health care for women, children and juveniles	✓	✓		✓	✓	✓				✓	
Sufficient provision of supplies and health care services (immunisation)	✓	✓	✓			✓				✓	
Adequate food provision for pregnant women, mothers and infants	✓	✓				✓	✓				

Health care services are reported to be gender and age-specific or sensitive in Lesotho, Namibia, South Africa, Tanzania mainland and Zimbabwe. In Angola and eSwatini, health care services are reported to be the same for women and juveniles as for adult men, thus obviating the need for gender or age-specific services. Angola even reports separate health facilities for women. For prisons in Tanzania, women and juveniles are reported to be treated separately. In eSwatini, three midwives are available for women and childbirth in the women's health centre.

Restricted opening hours ("unlock") for women and juveniles and/or controlled access to health facilities in prisons are reported in Malawi, Mozambique, Zambia and Zimbabwe, preventing them from having their health care needs met.

The general low level of awareness of SRHR and negative staff attitudes towards women and/or incarcerated children also cause delays in access to treatment or transport to outside health facilities in Namibia, Zambia and Zimbabwe. The literature reported lacking routine check-ups for women in Namibia and lacking standard operational procedures (SOPs) for treating women in Mozambique

and Zambia. Unhygienic practices (body cavity searches using the same glove for many women) in Zimbabwe have been reported to place women at risk of acquiring STIs.

Regarding mental health services, these are limited for incarcerated women in South Africa; no information was obtained for the other countries.

Lesotho reports peer education conducted by women for women and for juveniles by someone formerly incarcerated at a young age. SRH information tailored for the needs of juveniles is lacking, for example, in Zimbabwe.

### Summary

- Gender and age-specific services are reported in Lesotho, Namibia, South Africa, Tanzania mainland and Zimbabwe
- Barriers to health care services exist for women, children and juveniles, including restricted opening hours, controlled access and/or delays in treatment or transport to outside health facilities
- Provision of supplies and health care services for mothers and babies is reported to be sufficient only in Angola, eSwatini, Lesotho, Namibia and Zambia
- Adequate (supplemental) food provision is limited for pregnant women, mothers and their children

### Linkage to community services and partnerships for HIV and SRH

	Angola	eSwatini	Lesotho	Malawi	Mozambique	Namibia	South Africa	Tanzania		Zambia	Zimbabwe
								Tanzania mainland	Zanzibar		
Linkage to community services	✓	✓	✓			✓	✓		✓	✓	✓
Partner support for HIV in prison	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Partner support for SRH in prison	✓					✓				✓	

Linkage to community services is reported for Angola, eSwatini (education) and Lesotho (facilitated by CSOs and addressing violence, HIV, TB and SRHR in prison and challenges associated with being/having been incarcerated), Namibia (to track patients, and with involvement of technical working groups and steering committees), Tanzania (via CSOs for follow up of HIV care) and South Africa (via CSOs and the Community Corrections department).

Community services are reported, however to a limited degree, in Angola (weak communication, little CSO involvement in providing services in prison) and Zimbabwe (via CSOs). In Zambia, a referral system is in place but requires improved monitoring, and a pilot project is ongoing under the Prisoner Reintegration and Empowerment Organization and the Planned Parenthood Association of Zambia. No information was provided for Mozambique.

The following international organisations and others have contributed to improving HIV prevention, treatment and care in prisons in terms of training (e.g. HIV testing and counselling) and equipment: Global Fund to Fight AIDS, Tuberculosis and Malaria (Angola, Lesotho, South Africa, Zambia), PEPFAR (Angola, eSwatini, Malawi, Namibia, South Africa, Tanzania) UNAIDS (Angola), UNODC (all 10 countries), EGPAF (eSwatini, Lesotho, Malawi and Mozambique [sponsored by CDC/USAID]) and CDC, USAID and the EU (Zambia).

In all 10 countries, multiple regional and local organisations also provide support for prison populations in terms of health services for HIV prevention, treatment and care including continuity of care or health and human rights and advocacy.

Support for SRH and SRH/HIV integration, especially for women and juveniles, is lagging behind for the general population, and thus also for people in prison. In Angola, which has upscaled SRH services in the community, the prison health commissioner reported collaboration with such services.

Since 2016, UNODC has been supporting the establishment of model health centres in prisons in Malawi, Mozambique, Namibia, eSwatini, Tanzania, Zambia and Zimbabwe through the refurbishment of infrastructure, provision of resources including furniture and medical, laboratory and computer equipment, and training of staff on the use of this new equipment.

### Summary

- Linkage to community services is done in most countries, but is weaker for SRH than for HIV
- Partners working with prisons focus mainly on HIV prevention, treatment and care
- Support for SRH and SRH/HIV integration is on the rise, but remains inadequate



## 4. Discussion

“All persons, including key populations, have a right to equitable health services, which includes access to adequate HIV prevention, treatment and care, support services and SRH. They further have the following relevant rights guaranteed under international, regional and national laws: right to be free from discrimination; right to equality; right to be free from torture and cruel, inhuman and degrading treatment; right to dignity; right to security of the person; and right to information”<sup>18</sup>.

Compliance with these standards relies on the following elements being in place:

- Supportive and enabling laws, policies and practices regarding HIV and SRH in prisons
- Adequate infrastructure, staffing and resources regarding HIV and SRH needs of prisoners
- HIV and SRHR service availability and access by people in prison

### Laws, policies and practices

National laws against drug use, sex work and same-sex relations in sub-Saharan Africa are placing many people in prison who are 1) not harmful to society and 2) who have an increased susceptibility to HIV infection, viral hepatitis and STIs. As drug use and sex work are common in the region<sup>19 20</sup>, incarceration of people who engage in these activities leads to overcrowding in prison, rendering it difficult to ensure conditions that comply with health and human rights. Overpopulated prisons and overrepresentation of high-risk populations in prison contribute to increased transmission of HIV and other communicable infections.<sup>21</sup>

All countries in this assessment were found to include key or prison populations in their national policies, strategies and guidelines for HIV. However, little to no mention is made of these populations in SRH policies and strategies. Equivalence of care for HIV/AIDS and SRH issues requires that prison populations, which have a higher prevalence of HIV and STIs than the community and thus need at least the same standard of care, be not only mentioned but prioritised in national guidance documents.

While health care in prison is mandated to conform with international/regional standards and/or domestic laws and policies regarding equivalence of care at least nine countries assessed (no information obtained for Mozambique), lacking infection control plans in Angola and Namibia compromise compliance with these standards and policies. Where prison-specific guidance for HIV/TB is lacking, at least national guidelines are followed (except for Zanzibar), but for SRH, Angola, Zanzibar, Zambia and Zimbabwe use neither, leaving incarcerated women without evidence-based treatment, care and support.

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<sup>18</sup> SADC regional strategy for HIV prevention, treatment and care and sexual and reproductive health and rights among key populations

<sup>19</sup> Awungafac G, Delvaux T, Vuylsteke B. Systematic review of sex work interventions in sub-Saharan Africa: examining combination prevention approaches. *Trop Med Int Health*. 2017; 22:971-993

<sup>20</sup> Degenhart L, Peacock A, Colledge S et al. Global prevalence of injecting drug use and sociodemographic characteristics and prevalence of HIV, HBV, and HCV in people who inject drugs: a multistage systematic review. *Lancet Glob Health*. 2017; 5:e1192-e1207

<sup>21</sup> UNODC. WHO, UNAIDS (2006) HIV/AIDS Prevention, care, treatment and support in prison settings. A framework for an effective national response.

Policies on health and human rights for people in prison are only useful if prison management and security staff is aware and trained on these rights, people in prison are aware of their rights, and compliance with rights is monitored. Reporting mechanisms are in place in all 10 countries; however, staff training on health and human rights of people in prison was found to be largely inadequate due to lacking resources to train and sensitise staff.

#### Prison infrastructure, staffing and resources

While prisons in all 10 countries comply with the obligation to protect the health of the people held there and ensure medical attention when needed, their conditions, facilities and resources are largely such that they cannot ensure the prevention, treatment and control of diseases, or guarantee the realisation of people's right to the highest attainable standard of physical and mental health <sup>22</sup>.

Overcrowding is prevalent in all countries but Namibia, with Malawi, Mozambique and Zambia reporting prison occupancy levels of  $\geq 200\%$ . Old and dilapidated prison buildings do not provide adequate ventilation, sanitation and hygiene. Food provision, at least for pregnant women, mothers and children, was found to be insufficient. Considering that prisons' holding capacities are often exceeded, food provision and diet is likely to be inadequate for the entire prison population.

Juveniles, who have increased vulnerability to violence and to infection with HIV and other STIs, may not always be housed separated from adults everywhere due to lack of juvenile centres, leaving them exposed to manipulation and physical and sexual abuse by adults <sup>23 24</sup>. Also, women-only prisons are often far away from home and from health care services, which is not in line with the Bangkok Rules.

Prison health facilities that are adequate to provide basic medical care and care for HIV and SRH issues were reported only in Angola, Namibia and South Africa. Elsewhere, substandard infrastructure, lacking health clinics, isolation cells and/or laboratory facilities and equipment in all prisons prevent compliance with equivalence of care including observance of medical ethics e.g. privacy and confidentiality of examinations, test results and interventions.

Another factor affecting the availability and quality of health care in prisons is the shortage of qualified and skilled health care staff and insufficient in-service training on primary care or preventive medicine. Staff numbers are insufficient in all countries except Angola and Zimbabwe. The lack of doctors in all other countries means that medical care is provided by professionals who are not medically trained. In line with lacking policies and guidelines for SRH in prisons, awareness of and training on SRH especially is minimal to non-existent in most countries.

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<sup>22</sup> International Covenant on Economic, Social and Cultural Rights. GA Res. 1966;2200A(XXI)

<sup>23</sup> Topp SM, Moonga CN, Mudenda C, et al. Health and healthcare access among Zambia's female prisoners: a health systems analysis. *International Journal for Equity in Health* 2016; 15:157

<sup>24</sup> Sarkin J. Prisons in Africa: an evaluation from a human rights perspective. *Sur Rev Int Direitos* 27 Hum. 2008; 5:22–51.

Because security staff's knowledge of transmission of disease and awareness of the health rights of people in prison, including SRHR, is crucial in facilitating access to health care, these also require relevant awareness and education. For most countries, security staff is reported to receive training on health care matters; however, a low level of awareness of SRHR and negative attitudes towards women remain, in some countries hindering women and their children from access to necessary health care.<sup>25</sup>

Across the region, irregular and insufficient medical and laboratory supplies to cover basic health care and HIV and SRH needs including supplies for children also render it difficult to provide people in prison with adequate health care and hygiene. Even where sufficient, unreliable and unsuitable transportation of supplies may affect the potency of some medicines rendering them ineffective.

Reliable monitoring & evaluation of health care is hampered by lacking quality assurance and surveillance systems in many countries. While confidentiality of medical records is ensured in all 10 countries, record-keeping and data recording are still mostly done manually, presenting challenges for referral for continuity of care and for upward reporting. Availability of computers, printers and computerised systems would facilitate data collection and quality, measurement of health care performance, and data reporting to inform policies and strategies (e.g. by disaggregation of health data by factors such as sex, age and HIV status). Across the region, there is a general lack of accurate information on the prevalence of communicable disease and related matters in prisons which hinders effective and efficient programming and planning for communicable diseases in the prison sector<sup>26</sup>.

#### HIV and SRHR service availability and access for people in prison

Comprehensive screening for at least HIV, TB and STIs for all persons admitted to prison, as mandated by SADC Minimum Standards<sup>27</sup>, is reported for most countries, but should also include viral hepatitis, reproductive cancers and pregnancy. Prisons in most countries also treat people in prison for non-communicable diseases, and where treatment is unavailable, patients are referred to outside health facilities provided transportation is not hindered by a lack of security staff, vehicles or fuel.

Regarding the UNODC 15 key interventions for HIV prevention, treatment and care for people in prison<sup>28</sup>, regional compliance is good with respect to information, education and communication; voluntary and often peer-led HIV testing services; HIV treatment, care and support; and TB prevention and management, as these are mostly available in the community. Over half the countries provide PEP, prevent HIV transmission via medical/dental services, and protect prison staff

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<sup>25</sup> Van Hout MC, Mhlanga-Gunda R. Contemporary women prisoners health experiences, unique prison health care needs and health care outcomes in sub Saharan Africa: a scoping review of extant literature. BMC Int Health Hum Rights 2018; 18:31

<sup>26</sup> UNODC, UNAIDS, World Bank. HIV and Prisons in sub-Saharan Africa: Opportunities for Action ([http://data.unaids.org/pub/report/2007/hiv\\_prison\\_paper\\_en.pdf](http://data.unaids.org/pub/report/2007/hiv_prison_paper_en.pdf))

<sup>27</sup> Southern African Development Community (SADC) Minimum standards for HIV and AIDS, TB, hepatitis B and C, and sexually transmitted infections prevention, treatment, care and support in prisons ([https://www.sadc.int/files/2814/1898/8336/SADC\\_MINIMUM\\_STANDARDS\\_FOR\\_HIV\\_AND\\_AIDS\\_TB\\_HEPATITIS\\_B\\_AND\\_C\\_AND\\_SEXUALLY\\_TRANSMITTED\\_INFECTIONS\\_PREVENTION\\_TREATMENT\\_CARE\\_AND\\_SUPPORT\\_IN\\_PRISONS\\_IN\\_THE\\_SADC\\_REGION\\_A4.pdf](https://www.sadc.int/files/2814/1898/8336/SADC_MINIMUM_STANDARDS_FOR_HIV_AND_AIDS_TB_HEPATITIS_B_AND_C_AND_SEXUALLY_TRANSMITTED_INFECTIONS_PREVENTION_TREATMENT_CARE_AND_SUPPORT_IN_PRISONS_IN_THE_SADC_REGION_A4.pdf))

<sup>28</sup> UNODC, ILO, UNDP, WHO, UNAIDS. HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions. Vienna: UNODC; 2019 update

from occupational hazards. Less than half of the countries prevent HIV transmission through tattooing, piercing or other forms of skin penetration, or diagnose and treat viral hepatitis.

Condoms are only provided in prisons in Lesotho and South Africa. In some other countries, denial is persistent, despite sexual activity including same-sex intercourse, and coercive relationships and rape occurring in prisons. Availability of needle and syringe programmes and opioid substitution therapy is limited in the region and thus not available in prison, except in Zanzibar, where opioid substitution therapy is provided in some prisons, despite the high prevalence of people who use drugs in these settings.<sup>29</sup> Continuity of HIV care, which is crucial for people in prison living with infectious disease and/or drug-related problems<sup>30</sup> and for reducing HIV transmission rates, is reported for most countries.

Generally, where interventions are reported to be available, not all prisons within the same country have the facilities, staff or resources to provide them or to the same extent. Further challenges for providing quality HIV services include limited financial support, bureaucracy, lack of nutritional support and continuous counselling for those on ART, reluctant uptake of HIV testing, stigma and discrimination, and inadequate transport for outside services.

Compliance with standards for SRHR in prisons fares less well than for HIV, in line with the general lack of guidelines, awareness, training and support for the SRH needs of women in prison. Prevention and treatment for STIs is reported for all countries, although lack of laboratory equipment in-house may prevent timely communication of results as samples will mostly be tested outside the facility. Antenatal care, labour and delivery and postnatal care is also reported to be provided in at least nine countries (no information obtained for Mozambique), mostly in outside hospitals, but challenges in transportation also compromise the quality and timeliness of these services.

Gender and age-specific services or at least equal access to health care services including those for HIV and SRH for incarcerated women and juveniles are not guaranteed everywhere. As mentioned, limited support for women's (and their children) specific health care needs in prison affects their provision of food and nutrition, basic SRH supplies and commodities, and access to health care. Little information was obtained on service availability and access for juveniles but is indicated to also be inadequate and not age-specific.<sup>31</sup>

Several international partners have been or are involved in addressing HIV prevention, treatment and care in sub-Saharan Africa. Support for prison populations in the region mainly involves HIV relevant training and equipment, provided by Global Fund, PEPFAR, UNAIDS, UNODC, MSF and EGPAF among others. While UNFPA/UNAIDS is conducting a "SRHR and HIV Linkages Project" in 6/10 countries in this assessment, donor support for SRHR in prisons in the region is lagging, with only UNODC providing for SRH needs e.g. relevant equipment for the health clinic in a new women's facility in Namibia and screening for reproductive cancers in Malawi). Regional and national organisations also focus on HIV care including continuity of care and rights of people in prison.

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<sup>29</sup> Fazel S, Yoon IS, Hayes AJ. Substance use disorders in prisoners: an updated systematic review and meta-regression analysis in recently incarcerated men and women. *Addiction*. 2017 Oct; 112(10): 1725–1739

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<sup>31</sup> Van Hout MC & Mhlanga-Gunda R. Prison health situation and health rights of young people incarcerated in sub-Saharan African prisons and detention centres: A scoping review of extant literature. Submitted to BMC International Health and Human Rights. 2019: 19:17

Likewise, linkage to community services exists mainly for HIV, with only Angola, Namibia and Zambia reporting collaboration with community services for SRH.

Despite regional commitment to integration of HIV and SRH, programme linkage falls short in the community and is minimal for prison populations. UNFPA/UNAIDS' "SRHR and HIV Linkages Project" is showing promising results to date; it is expected that this initiative will also be expanded to prison settings.

#### Limitations of the assessment

Care was taken to cover all aspects affecting compliance with HIV/AIDS and SRHR minimum standards for prison populations in SSA; however, inclusion of the following factors would have made the assessment more complete.

Considering that many people are incarcerated for drug use and that drug use is prevalent in prisons, assessment of screening for drug dependence upon admission as stipulated for women in prison in the Bangkok Rules, as well as investigation of laws and challenges regarding provision of NSP and OST in prisons, would have aided in understanding the limited provision of such services.

Furthermore, women are known to have a higher prevalence of mental health issues (including drug dependence) in prison than their male counterparts<sup>32</sup>, and incarcerated juveniles may also be disproportionately affected by poor mental health.<sup>33</sup> Therefore, compliance with the Bangkok Rules regarding mental health screening and availability of comprehensive mental health and rehabilitation programmes<sup>34</sup> especially for these populations, would have provided additional useful information. With respect to HIV and SRH services, interviews with people in prison (if at all possible) on their access and use of available services would have provided a more rounded picture of their effectiveness.

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<sup>32</sup> Van den Bergh BJ, Gatherer A, Fraser A, Moller L. Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. *Bull World Health Organ.* 2011; 89:689–694

<sup>33</sup> Barnert ES, Perry R, Morris RE. Juvenile incarceration and health. *Acad Pediatr.* 2016; 16:99–109.

<sup>34</sup> United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) GA Res 2010; 65/229

## 5. Conclusions and recommendations

While prison services across the region have laws mandating human rights including equivalence of health care for people in prison, in practice, substandard environmental conditions, sanitation, hygiene, supplies and health care prevent the realisation of the right of people in prison to the highest attainable standard of physical and mental health. Where available, health care facilities in prisons are characterized by shortages of staff, medicines, equipment, and poor health education and training, and poor linkage with public health care for services, monitoring and evaluation.

Compliance with international, regional and national standards and guidelines for HIV prevention, treatment and care is better than for SRH care for prison populations, as incarcerated women's (and their children's) specific health needs remain largely neglected by governments, prison management and staff, and community and donor support.

To close the gaps in compliance, the following activities are recommended:

### Laws, policies and practices

#### *Short-term*

- Where unavailable, develop and implement infection control plans in prisons
- Where unavailable, develop prison policies and guidelines for HIV and SRH care that provide for equal standard of care as in the community
- Scale up training and sensitisation of prison management and staff on health and human rights of people in prison
- Ensure that people in prison are informed of their rights upon admission and regularly thereafter
- Ensure mechanisms for reporting and monitoring of violations of health and human rights of people in prison
- Update SRH policies, strategies and guidelines to include prison populations

#### *Medium-term*

- Consider and provide for alternatives to imprisonment for petty, non-violent offenses and for women

#### *Long-term*

- Decriminalise drug use, sex work and sex between men to reduce prison overcrowding and improve access to health care services

### Prison infrastructure, staffing and resources

#### *Short-term*

- Continuously update prison staff training institution curriculum to include recent developments on health, HIV and SRHR
- Ensure separation of juveniles from adults, and adequate housing for juveniles, pregnant women, mothers and their children
- Provide sensitisation for security staff on the special needs of women in prison and the importance of their having access to health care, especially for SRH (including having female staff available to examine - or at least attend examination of - women and girls in prison)

### *Medium-term*

- Develop strategies for continuous in-service training for management, security and health personnel  
Invest in qualified medical staff and training on primary health care and HIV and SRH care

### *Long-term*

- Invest in renovating and extending prison infrastructure to meet the demand for space, water and ventilation
- Invest in and improve health facilities for all prisons to be able to deliver medical care that is equivalent to that available in the community
- Mobilise resources to ensure consistent availability and appropriate transportation and storage of medical, laboratory and SRH supplies
- Invest in improving monitoring and evaluation systems to improve data quality and identify gaps in health, HIV and SRH care

## HIV and SRHR service availability and access for people in prison

### *Short-term*

- Ensure comprehensive screening for HIV/AIDS, TB, hepatitis B and C, STIs, reproductive cancers (for men and women) and pregnancy upon admission, during incarceration and upon release as needed
- Prioritise SRH care and needs of juveniles, (pregnant) women, mothers and children
- Recognise the mental health needs of people in prison, especially those for women and juveniles, and facilitate access to necessary services

### *Medium-term*

- Provide all HIV prevention, treatment and care interventions available in the community, as applicable and appropriate in the prison setting
- Provide or increase access to condoms and lubricants in prison upon entry, during imprisonment and upon release

### *Long-term*

- Integrate needle and syringe programmes, opioid substitution therapy and other treatment of substance use disorders into prison services
- Increase budget allocation by governments and prison management to improve HIV, TB and SRH services in prisons
- Ensure the contribution of more stakeholders including community services in the provision of SRH services in the prisons, including continuity of care of such services

## 6. Annexes

### Annex 1: List of source documents

#### Regional

- SADC Regional Strategy for HIV Prevention, Treatment and care and Sexual and Reproductive Health and Rights among Key Populations
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## Annex 2: Questionnaire

### Questionnaire on national framework and prison programmes and services for HIV and SRH

Country / Correctional Service: \_\_\_\_\_  
 Respondent (Name, position): \_\_\_\_\_  
 Contact details (Email address, phone number): \_\_\_\_\_  
 Date: \_\_\_\_\_

Responsibilities	
National body responsible for prison administration:	
Who is responsible for prison health care services in prison?	
Who funds prison health care services?	
Other ministries / organisations / agencies involved in prison health care? Specify	
Major international donors to prison health care (e.g. funding, equipment, training). Specify	
National laws and policies	
Is the use of illicit drugs a crime / punishable by imprisonment?	/
Is sex work a crime / punishable by imprisonment?	/
Are same-sex relations a crime / punishable by imprisonment?	/
Is sexual and gender-based violence (e.g. assault) a crime / punishable by imprisonment?	/
Is abortion illegal in the country? / punishable by imprisonment?	
Are there policies for equal rights to health care in prison as in the community? (Y/N, specify)	
Are there policies, strategies or guidelines for prevention and treatment of HIV/TB in prison? (Y/N, specify)	
Are there policies, strategies or guidelines for prevention and treatment of drug/alcohol use in prison? (Y/N, specify)	
Are there laws or policies for conjugal (intimate) visits in prison? (Y/N, specify)	
Are there laws or policies for sexual and gender-based violence in prison? (Y/N, specify)	
Are mechanisms in place for people in prison to report violations of human rights? (Y/N, specify)	



Are there policies for children accompanying mothers / born in prison? (Y/N, specify)	
Are there policies for HIV services in prison? (Y/N, specify)	
Are there policies for SRH services in prison? (Y/N, specify)	
Are there policies for HIV and SRHR service linkage between prisons and the community (Y/N, specify)	
<b>Prison system and population</b>	
Number and types of prisons (including temporary detention centres, women's prisons, centres for juveniles):	
Total holding capacity of prisons:	
Annual size of total prison population <b>2018</b> :	
Number	
per 100,000	
Number / percentage of .... in <b>2018</b> :	
Men	
Women (and children accompanying their mothers)	Held separately (Y/N):
Juveniles in detention (under 18)	Held separately (Y/N):
Men who have sex with men	
Transgender	Held separately (Y/N):
Migrants/foreign nationals	
People who use drugs	
Sex workers	
Estimated prevalence of HIV 2018 (%)	
Prevalence of TB (%)	
Prevalence of HBV / HCV (%)	/
Prevalence of STIs (%)	
<b>Staffing and resources, quality assurance in prison</b>	
Does health care staffing meet staff norms? Please indicate norm vs actual number for physicians, nurses, technicians, social workers, others separately.	
Is health care staff (physicians, nurses, technicians, social workers, HIV counsellors) adequately trained and skilled in areas relating to HIV and SRH?	
Are all health care staff aware of national guidelines for HIV prevention, treatment and care?	

Are non-health care staff educated on the transmission of diseases, especially TB and HIV, HBV, HCV, STIs and forms of protection? How is this education provided?	
Are all staff aware of national guidelines for sexual and reproductive health and rights?	
Are non-health care staff educated on sexual and reproductive health and rights? How is this education provided?	/
Are the health care facilities adequate to provide medical services including HIV and SRH?	
Do prison facilities have laboratory services?	
What are the mechanisms for procurement of laboratory and medical supplies?	
Are inventory / supply chain systems in place?	
Is reliable and suitable transportation and storage of laboratory and medical supplies ensured?	
Are laboratory and medical supplies on site sufficient to cover HIV prevention, testing, treatment and care services?	
Are laboratory and medical supplies on site sufficient to cover women's SRH needs?	
Are female prisoners provided with items necessary for menstrual hygiene (like sanitary napkins)?	
Is an infection control plan used that addresses blood-borne and airborne pathogens? If yes, specify	
What guidelines and protocols are used in prisons for:	
HIV prevention, treatment and care	
SRH including labour and delivery	
Are health care quality assurance programmes in place? Describe	
Is a health surveillance system in place? Describe	
What mechanisms are in place to ensure confidentiality of medical records?	
Is there a regular health data reporting system? If yes, to whom and how often are data reported?	
<b>HIV and sexual and reproductive health services in prison</b>	
What health care services are available for HIV and SRH? Please indicate Yes/No as appropriate, and elaborate	

HIV prevention, testing, treatment, care			Sexual and reproductive health		
Intervention	Y/N	Comment	Intervention	Y/N	Comment
Information, education and communication on HIV routes and risks of transmission			Family planning		
Condom and lubricant programming			Information, education and counselling on sexuality and reproductive health		
Prevention of sexual violence			Prevention of sexually transmitted infections		
Needle and syringe programmes and overdose prevention and management			Treatment and care of sexually transmitted infection		
Opioid substitution therapy and other evidence-based drug dependence treatment			Screening for reproductive cancer (prostate, cervical and breast)		
Prevention of HIV transmission through medical or dental services			Prevention and surveillance of violence, care for survivors of violence		
Prevention of HIV transmission through tattooing, piercing and other forms of skin penetration			Antenatal, safe delivery and postnatal care		
Post-exposure prophylaxis			Prevention of abortion and management of the consequences of abortion		
HIV testing and counselling			Appropriate referrals for further diagnosis and management of the above		
HIV treatment, care and support					
Prevention, diagnosis and treatment of tuberculosis					

Vaccination, diagnosis and treatment of viral hepatitis					
Sexual and reproductive health					
Prevention of mother-to-child transmission of HIV, syphilis and HBV					
Protecting staff from occupational hazards					
What challenges exist in providing comprehensive HIV/AIDS services?					
What challenges exist in providing comprehensive SRH services?					
Are people in prison screened for HIV, TB, HBV, HCV, STIs, reproductive cancer and for pregnancy on admission to and during imprisonment and pre-release?					
Are HIV and SRH services integrated?					
Are services gender- and age-specific? If yes, specify					
Are services voluntary and confidential?					
Is informed consent required before interventions?					
Are there services for prevention and treatment of sexual and gender-based violence?					
What is known about sex bartering?					
Are peer-led programmes for HIV / SRHR implemented?					
Is continuity of care for HIV / SRH ensured on admission, during transfer between prison facilities and upon release? If yes, how?					
What challenges exist in providing continuity of care for HIV / SRH?					
<b>Partnerships for HIV and sexual and reproductive health and rights</b>					
Describe involvement of CSOs in delivering HIV / SRH services in this prison?					
List partners implementing HIV /SRH services in prisons.					
Are there linkages between prison health care and HIV / SRH services in the community? If so, specify					

### Annex 3: Respondents of the questionnaire

- Dr Manuel Pereira Freire Dos Santos, National Health Director, Angola Correctional Service, on 14 March 2019
- Makhosazana R. Dlamini, Deputy Commissioner General Health Care Services, His Majesty's Correctional Services eSwatini on 15 March 2019
- Phoka Scout, Senior Assistant Commissioner of Corrections, Lesotho Correctional Service on 15 March 2019
- Dr Lawrence Chiwaula, Head of Prisons Health Service, Malawi Prison Service on 19 March 2019
- Trefina Itengula, Senior Chief Correctional Officer at Namibia Correctional Service on 15 March 2019
- Kaslutho Maria Mabena, Deputy Commissioner Health Care Services, Department of Correctional Services South Africa, interviewed on 18 March 2019
- Dr Hassan Mkwiche, Head of Health Services, Tanzania Prison Services on 20 March 2019, and by Seif Mabadi Makungu, Head of Law and Corrections Unit and Rashid Mselem Rashid, Head of Medical Service, Zanzibar Correctional Facility on 25 March 2019
- Yotam Lungu, Head Health Directorate, Zambia Correctional Service on 2 April 2019
- Dr Evidence Gaka, Director of Health Services, Zimbabwe Prisons and Correctional Service on 11 March 2019

### Annex 4: Key informants

- Dr Manuel Pereira Freire Dos Santos, National Health Director, Angola Correctional Service, on 14 March 2019, via Edgar Songanga as interpreter, interviewed on 28 May 2019
- Phindile Dlamini, Deputy Commissioner General, His Majesty's Correctional Services eSwatini, interviewed on 10 May 2019
- Phaello Malataliana, Deputy Commissioner, Lesotho Correctional Service, interviewed on 7 May 2019
- Paul Puleni, Technical Advisor HIV Testing Services & Key Populations, Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), interviewed on 15 May 2019
- Dr Crimilde Anli Moambe, Director, Health Services, Servico Nacional Penitenciario Mozambique, via Mario Vicente as interpreter, interviewed on 9 May 2019.
- Timothy Shangadi and Hendrik Mauyoma, Office of the Ombudsman Namibia, interviewed on 10 May 2019
- Dr Lawrence Lekashingo, Zonal Technical Advisor, AIDSFree Tanzania/ John Snow Inc (SPPCHS Project) interviewed on 2 May 2019
- Clement Moonga, Deputy Chief of Party, Centre for Infectious Disease Research in Zambia (CIDRZ), interviewed on 9 May 2019, and Dr Godfrey Malembeka, Executive Director, Prison Care and Counselling Association (PRISCCA), interviewed on 14 May 2019
- Dr Godfrey Malembeka, Executive Director, Prison Care and Counselling Association (PRISCCA), Zambia, interviewed on 14 May 2019
- Teclah Ponde, Regional Prison Health Coordinator, Voluntary Services Overseas (VSO), interviewed on 7 May 2019, and Pardon Gonorashe, Programme Officer for Health in Prison, Zimbabwe Association for Crime Prevention and Rehabilitation of the Offender (ZACRO), interviewed on 16 May 2019.

## Annex 5: Interview topics

### Senior prison management

- Staff training on international and regional standards guiding health and human rights for people in prison
- Prisoners' information on their rights to humane treatment and equivalence of care, and awareness of mechanisms to report violations
- Use made of these mechanisms
- Consequences for breaches of human rights
- Challenges in adhering to standards for health care and rights

### Health sector in prison

- Availability and adequacy of health facilities available to address the health care needs of people in prison
- Availability and adequacy of sexual and reproductive health care services adequate to address the specific health care needs of women in prison
- Access and barriers to prison-based clinics for women and juveniles
- Health care staff training to be able to address HIV and SRH issues?
- Staff turnover and employment of sufficient numbers of staff
- Challenges exist in providing equivalence of care

### Civil society – HIV and SRH services for people in prison

- Availability, coverage, quality, accessibility and uptake of medical services for people in prison, and of HIV and SRH services in particular
- Continuity of care upon admission, during interfacility transfer and on release
- Integration between prison health and public health
- Challenges in providing needs-based HIV and SRH services to people in prison
- Civil society involvement in providing HIV and SRHR services in prisons

### Civil society – Rights and advocacy regarding people in prison

- Adequate training of prison staff on international and regional standards guiding health and human rights for people in prisons, including for women, juveniles and people living with HIV
- Challenges in complying with standards for health and human rights in prisons
- Information for prisoners' on their rights to humane treatment and equivalence of care, and aware of mechanisms to report violations
- Medical ethics – voluntary interventions, informed consent, privacy of consultations, confidentiality of prisoners' health status and of medical records
- Availability and adequacy of mental health services in prison
- Possibility of and challenges in implementing non-custodial measures for petty, non-violent crimes, and for women especially