Barriers to Translation of the Legislative Acts on Health for Inmates in Correctional Centres: A Case Study of Mukobeko Maximum Prison and Lusaka Central Correctional Centre

By

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A Dissertation Submitted in Partial Fulfilment of the Requirements for the Degree of Master of Public Health – Health Policy and Management

THE UNIVERSITY OF ZAMBIA
LUSAKA

2019

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DECLARATION

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CERTIFICATE OF APPROVAL

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ABSTRACT

Worldwide the rates of infectious and non-infectious diseases in prisons is generally higher than that of the general population. Apart from the international guidelines, Zambia has developed local legal frameworks that deal with prisoners' health. Despite these provisions, the disease burden has remained higher in Zambian prisons. This study therefore explored barriers to translation and implementation of the Legislative Acts that deal with health for inmates in correctional facilities.

The study utilised qualitative method. Data was gathered through Key Informants Interviews with the Ministry of Home Affairs, the Ministry of Health (MoH), the Ministry of Justice, the Zambia Correctional Service, USAID DISCOVER Health, CIDRZ, PRISCCA, UNODC as well as review of key Policy documents. The policy triangle was used to guide data collection. Data was analysed using thematic analysis and Nvivo 12.

There are legal documents that provide for inmates healthcare. Context analysis revealed political will to address inmate's health. However, analysis further noted resource constraints, inadequate health facilities and man power. Analysis of Actors revealed that some were not aware of legal documents addressing inmates' health. It was at the health workers discretion on how they treated or visited inmate. ZCS took up the major responsibility on inmate's health yet the Health Directorate established in 2004 with the purpose of supplementing MoH is not funded. This has made it difficult for ZCS to implement legal provisions on inmate's health. Nevertheless, a group called PHAC was formed and it is committed to providing healthcare and to coordinate all health related activities in correctional facilities unfortunately is has no legal standing and it is not funded. Finally, process analysis showed that top down approach in formation of legal documents, weak inter-ministerial collaboration and lack of completion of domestication process of the international guidelines had resulted in poor implementation of legal provision on inmates' health.

Most of the major legal documents on health have provided for inmates' health, nevertheless, not all partners were involved in their formulation and were not aware of them. The study further highlighted financial constraint that had also contributed to the implementation challenge. Consequently, disease burden in correctional facilities has remained higher than in the general population.

Keyword: *legal framework, inmates/prisoners, Health, Collaboration*

ACKNOWLEDGEMENTS

Gratitude goes to the Zambia Correctional Service for granting me leave to undertake MPH programme.

MPH classmates and policy stream especially Gabriel Yali, Elli Kapulisa and Mercy Chisashi for the moral support during the course of the programme.

I would also like to thank my supervisors Dr. Wilbroad Mutale, Dr. Joseph Zulu especially Mr. Chris Mweemba for the guidance and whose valuable input made this work possible.

In addition, a thank you to all members of faculty and all the participants that consented to be interviewed.

Finally, special thanks to my family for encouragement, understanding and unconditional support.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
CDC	Centre for Disease Control and Prevention
CELIM	Centre for Italian Laypersons for the Missions
CIDRZ	Centre for Infectious Disease Research in Zambia
HIV	Human Immunodeficiency Virus
ICESCR	International Covenant on Economic, Social and Cultural Rights
IDI	In-depth Interview
KII	Key Informant Interview
PFF	Prisoners' Future Foundation
MHA	Ministry of Home Affairs
MoH	Ministry of Health
NASF	National Aids Strategic Framework
NHP	National Health Policy
NHRA	National Health Research Authority
NHSP	National Health Strategic Plan
PRISCCA	Prisons Care and Counselling Association
SMR	Standard Minimum Rules
STI	Sexually Transmitted Infection
UN	United Nations
UNODC	United Nations Office on Drugs Crime
USAID	United States Agency for international development

USAID DISCOVER-Health USAID District Coverage of Health Services Project

UTH University Teaching Hospital

VSO Voluntary Service Overseas

WHO Word Health Organisation

SNDP Seventh National Development Plan

ZCS Zambia Correctional Services

ZLDC Zambia Law Development Commission

ZPHSP Zambia Prisons Health Strategic Plan

DEFINITION OF KEY TERMS

Translation of the Law: In this study, translation of the law means uptake or taking the law into action.

Prisoner and Inmate: These shall be used interchangeably and will mean any person whether convicted or not under detention in any prison or correctional facility (Republic of Zambia, 2004).

Prison Officer: Any member of the Service including any public officer seconded to the Service (ibid).

Correctional Facility/Prison: All authorised places of detention within a criminal justice system, holding all prisoners, including those who are held during the investigation of a crime, while awaiting trial, after conviction and before and after sentencing (Republic of Zambia, 2004).

Medical Officer: A person appointed or nominated or engaged as a medical officer of prison under section sixteen (Republic of Zambia, 2004).

Health: The World Health Organisation (WHO) defined health in its broader sense in its 1948 constitution as a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (Callahan, 1973).

Legislative Acts: the term that describes an act and states what the future law will be for cases arising from it.

Policy: Broad statement of goals, objectives and means that create the framework for activity. Policies often take the form of explicitly written documents, but may also be implicit or unwritten.

Health Policy: Embrace courses of action (and inaction) that affect the set of institutions, organisations, services and funding arrangements of the health system. It includes policy made in the public

sector (by the government) as well as policies in the private sector (Buse *et al*., 2005).

Policy Actor: Short-hand term used to denote individuals, organisations or even the state and their actions that affect policy.

Policy Content: Substance of a particular policy which details its constituent parts (Buse *et al*., 2005).

Policy Context: Systemic factors – political, economic, social or cultural, both national and international – which may have an effect on health policy.

Policymakers: Those who make policies in organisations such as central or local government.

Policy Process: The way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated.

CHAPTER 1: BACKGROUND

1.1 Introduction

This chapter provides an introduction to the barriers to translation of the legislative acts that deal with the health of inmates in correctional facilities and it looks at the international perspective of the challenges faced in prisons and how policies have been changed to ensure that translation of the law is effective. Further, it brings out the Zambian situation in terms of prisons challenges and the existing laws and policies. Additionally, the statement of the problem, rational, objectives and theoretical framework are presented.

1.2 Global Perspective on Inmates Health

It has been documented that worldwide, about 10.2 million people are held in prisons (Fazel and Baillargeon, 2011) with four to six times this number passing through the world's prisons every year. This population keeps increasing leading to the world's notorious problem of overcrowding (Raviglione and Uplekar, 2006). Due to this overcrowding, the rates of infectious and non-infectious diseases in prisons are generally higher than those of the general population (Fazel and Baillargeon 2010). While Bhaumik and Mathew, (2015) and DeViggiani, (2007) attribute high infections in prisons to poverty as a majority of prisoners come from less privileged families and knowledge about healthy lifestyles is limited or none at all. There are other factors, inter-alia, sanitation, nutrition and coercion that lead to high rates of infections in prisons (Topp *et al.*, 2016) but this study does not go in detail to look at causes of high infection as it focusses on the translation of legislative acts and policies on inmates' health.

Accordingly, sub-Saharan African countries, being low to middle income, have had severe disease burden in Correctional Centres. Prisoners are subject to inadequate sanitation, ill-treatment, poorly trained staff and high rates of both communicable and non-communicable diseases (Todrys *et al.*, 2011). It is, therefore, right to indicate that with such a situation, the rights of prisoners are violated and present a high health risk to the communities to which they are eventually released to (Topp *et al.*, 2016a). To this effect, Fernandez and Rainey (2006) clearly indicated that sick inmates are one of the sources of immediate

and significant long-term threat to public health. This is the case because most inmates are serving short term sentences and are eventually released and reintegrated in their respective communities. Apart from being released, there is still high contact between the two communities on either side of the prison walls. The alluded to contact is ensured via the prison staff who are on daily basis exposed to the correctional facility/prison health conditions and can expose their families and contacts outside of prison (Human Rights Watch, 2010). Additionally, significant interaction within the prison system itself, prisoners being circulated in different cells, different prisons, between judiciary systems and jails and even between health centres (Fernandez and Rainey, 2006). This makes prisons a hive for infections and reinfections.

To this effect, it is stated by Reid *et al*., (2006) that the United Nations provides for prisoners' entitlement to health care of a similar standard to that received by non-prisoners. On the contrary, substandard health care and a high burden of illness remain common features of prisons in low and middle-income countries such as sub-Saharan African Countries (ibid).

To address the above prison situation, international bodies have come up with, among others, policies and rules to uphold prisoner's right to health care and to be protected against inhumane and degrading treatment (Elger, 2008). Health care personnel and public policy makers play a central role in the protection of these rights and in the pursuit of public health goals (ibid). Some of these international bodies include; International Covenant on Economic, Social and Cultural Rights (ICESCR) Article 12 which establishes the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (United Nations, 1966). Human Rights Watch (2010) explained that Article 12 of the ICESCR applies to prisoners just as it does to every other human being. Those who are imprisoned retain their fundamental right to enjoy good health, both physical and mental health and retain their entitlement to a standard of health care that is at least equivalent to that provided in the wider community. To consolidate with article 12 of ICESCR, United Nations (1990) gave the basic principles for the treatment of prisoners and in Principle 9, it stated that prisoners should have access to the health services available in the country without discrimination on the grounds of the legal situation. To this effect,

Human Rights Watch (2010) expanded that when a state deprives people of their liberty, it takes on a responsibility to look after their health and promote their well-being.

Furthermore, the WHO guide to the essentials in prison health (Møller *et al*., 2007) emphasised on the need to recognise that prison health affects public health. World Health Organisation, encouraged the formulation of national policy through advice from senior staff members in the prison services and senior health policy advisers. Moreover, the guide recommends that prison staff members have easy access to key documents, such as the guide in mention, in their own language or another language they understand. Likewise, UN Nelson Mandela Rules [revised Standard Minimum Rules (SMR)], WHO Moscow Declaration and Good Governance for Prison Health in the 21st Century also agree that Prison Health is a Part of Public Health. They all acknowledged that the government ministry responsible for prison health, should be the ministry responsible for public health services. They further stated that health ministries should provide and be accountable for health care services in prisons and advocate healthy prison conditions. They strongly recommended that prison health services work closely with health ministry so that they provide the same standard of care as local hospitals and communities (Torriente *et al*., 2016; Veillard, 2005; WHO, 2003; WHO, 2007; Møller *et al*., 2007).

1.3 Prison Health Condition in Zambia

The Zambia Correctional Service is one of the agencies of the Criminal Justice System falling under the Ministry of Home Affairs. It is charged with the responsibility to effectively and efficiently provide and maintain humane custodial and correctional services to inmates and to enhance the maintenance of internal security (ibid). On the 5 January 2016, there was a transition from punitive to corrections after the assertion to the Constitutional Amendment Bill by the Republican President (Adamu, 2016).

Zambia is a signatory to most of the above stated international guidelines and has the National Health Services Act 17 of 2005, Prisons Act (Chapter 97) repealed by Act 16 of 2004, the Public Health Act (Chapter 295) and National Health Policy to enable deliverance of an adequate and efficient internationally

acceptable health system to prisoners. Moreover, the Constitution of the Republic of Zambia guarantees human rights and equal treatment to all citizens irrespective of whether they are incarcerated or not (Republic of Zambia, 2016).

1.3.1 Zambia Correctional Service Demographic Overview

The Zambia Correctional Service runs 87 conventional and open-air correctional facilities throughout Zambia. According to SHAReII (2015), the Zambia Correctional Services holds an inmate population of 20, 000 against a capacity of 8, 150.

The prison population has been growing exponentially thereby overstretching the available human resource, infrastructure, transport, cells for the prisoners and nutrition support available to manage the population (Topp *et al*., 2016). Therefore, this makes it easy for the spread of diarrheal diseases and many other health conditions, including airborne diseases like Tuberculosis which further weakens the health of inmates infected with HIV, respiratory infections and skin conditions (Todrys *et al*., 2011; Topp *et al*., 2016). Additionally, the greater proportion of its infrastructure was put up in the pre-colonial and colonial times, and it is now old and fragile. The sanitation and water reticulation systems are dilapidated and cannot sustain the current demand.

Despite the Zambian Law establishing a minimum standard for medical care in prisons to such an extent as to stipulate that an officer in charge of each prison maintains a properly secured hospital, clinic, or sick bay within the prison, a serious gap exists between these legal requirements and practice (Prison Rules, 1966). Furthermore, there is little medical care available at most of Zambia's 87 prisons. Only 20% of Zambia's prisons have health clinics or sick bays, and many of these clinics have little capacity beyond distributing paracetamol (Topp *et al*., 2016a). This critical gap between the requirements and practice needs to be investigated so as to pave the way for the gradual improvement of healthcare delivery to inmates that satisfies the minimum international and local requirements.

This study, therefore, examined the national laws and policies governing inmates' health and their translation, and how this is affected by the actors, content, context and process. This was achieved using the policy triangle by

Walt and Gilson (1994). This method provided insights into the enablers and challenges in the translation of Legislative Acts and policies.

1.4 Statement of the Problem

There are international guidelines and local legal frameworks in place to enable the deliverance of an adequate and efficient internationally acceptable healthcare to prisoners that is equal in standard to that available in the community (Topp *et al*., 2016a). Despite these provisions, the rates of infectious and non-infectious diseases in prisons, both internationally and locally, are generally higher than those of the general population (Dolan *et al*., 2007, Simooya *et al*., 2001). For example, HIV and AIDS prevalence in prisons was at 27% compared with the general population that was at 14% in 2001 (Simooya, 2001). This could be attributed to both the inadequate health facilities and poor quality health care provision in prison. For instance, in Zambia, only 18 out of the 87 correctional facilities (20%) have clinics, but with little capacity beyond distributing paracetamol (Todrys *et al*., 2011). This imbalance presents a high health risk not only to prisoners but also to communities to which they are eventually released (Topp *et al*., 2016a). Furthermore, there is a fragmented policy environment that exists in the health sector in Zambia (Topp *et al*., 2016a), meaning that policies are not coordinated. Therefore, the current status is that the National Health Policy (NHP) developed in 2012 acts as an overarching health policy framework in the health sector (Republic of Zambia, 2012), and is assumed that inmates' health is catered for in this document. Unfortunately, NHP has not helped to address the health problems in correctional facilities (Topp *et al*., 2016). Challenges that exist in understanding the translation of legislative acts are compounded by the lack of empirical research in this field. The review of literature did not bring out studies done on the translation of legislative acts and policies on inmate's health.

As a result of the problems outlined above, there has been growing attention on prisoner ill-health in sub-Saharan Africa, but there is little empirical research to help understand discrepancies between the existing legal framework, which is supposed to be committed to providing timely and responsive health care, and the much weaker translation of these legal frameworks into reality (ibid).

1.5 Rationale

As far as the literature review for this study was concerned, there was no previous research that explored how legislation and policies on inmates' health were formulated, taking into account actors, content, process and context. This study was an attempt to fill the gap and also help understand the challenges involved in coming up with health-related policies in correctional centres and measures to be taken to ensure Legislative Acts and policies are translated accordingly.

To this effect, this study showed that a policy triangle can be able to explain the root cause of challenges in actualising Legislative Acts and policies on inmates' health. From this study, it was established that the lack of key stakeholder engagement in the development process of legislative acts and policies on inmates' health affected implementation. Furthermore, contextual factors, among others, inequality in the treatment of sick inmates, inadequate resources and lack of domestication of international guidelines resulted in inmates not benefiting from legislation and policies on their health.

Therefore, this study has provided very useful information that should be used in the development of legislative acts and policies on inmate health that will be able to achieve the intended goal. For example, the Zambia Correctional Health Policy that is being developed can follow the right process, engage key stakeholders, take into consideration contextual factors and ensure the content is exhaustive. Most of all international guidelines have to be fully domesticated. In addition, the findings from this study will contribute to the body of knowledge on the translation of Legislative Acts and policies on inmate's health.

1.6 Research Question

What are the barriers to translation of Legislative Acts that deal with health for inmates in correctional facilities?

1.7 Objectives

1.7.1 General Objective

The general objective of the study was:

To explore barriers to the translation of the Legislative Acts that deal with health for inmates in correctional facilities in Zambia.

1.7.2 Specific Objectives

1. To review the extent to which content of the Legislative Acts and health policies address the health needs of inmates in correctional facilities.
2. To assess the process of translation of Legislative Acts and health policies in the delivery of health services in correctional facilities.
3. To explore the context in which the Legislative Acts and policies are translated to meet the health needs of inmates in correctional facilities.
4. To investigate the nature of collaboration among the key actors involved in prisoners' health services.

1.8 Organisation of the Dissertation

This dissertation is organised in six chapters. The first chapter provides a background on barriers to translation of the Legislative Acts and policies on health for inmates in Correctional Centres. It looks at the international perspective of the challenges and how policies have been changed to ensure that translation of the law on inmates' health is effective. Furthermore, it brings out the challenges that the Zambia Correctional Service has in terms of health and the existing laws and policies. Additionally, the statement of the problem together with the description of the research purpose, rational and objectives are presented.

Chapter two provides literature on translation of legal provisions on inmates' health in the Zambia Correctional Centres through the policy triangle, that is, Content, Context, Process and Actors. The chapter concludes by presenting a Conceptual framework for policy analysis adopted from Walt and Gilson (1994) in relation to this study.

Chapter three provides and justifies the methods used in this study. It begins by presenting the design adopted and describes the research site. In addition, the study population, sample size, selection of participants, methods of data collection and analysis are presented. The chapter concludes by addressing ethical considerations.

Chapter four concentrates on the main findings of the study informed by qualitative study design.

A detailed analysis of the findings presented in Chapter four is presented in Chapter 5. This chapter discusses major findings that emerged from the study whilst comparing and contrasting them with data from the literature.

Finally, Chapter six concludes the study, and presents recommendations.

CHAPTER 2: LITERATURE REVIEW

Translation of Legislative Acts and policies can be explained in many different forms. In this study, it has been explained in four forms which are; Content, Process, Context and Actors. For instance, *Content* is part of translation in that it is the content of the legal provision that needs to cascade at different stages to finally get to intended beneficiaries. Similarly, the *Process* is an integral part of the translation as the content of the Legislative Act have to be initiated, developed and communicated across different platforms. *Contextual* factors also play a big role in the success of the translation. Finally, *Actors* are determinants of the content that has to be translated and are, therefore, key players that ultimately decide whether or not a certain concern, such as inmates' health, should be included in the document.

2.1 Overview of Prison Health

Health for inmates remains a challenge. Studies have shown that in most cases, health for inmates is provided for in highest laws-of-the-land such as constitution but it does not translate in other provision that cascade to the intended beneficiaries (Todrys *et al*., 2011 and Topp *et al*., 2016). Additionally, WHO (2001) states that policymakers usually neglect or give low priority to prison health especially where there are limited financial resources. Studies have shown that there is a wide spectrum of health problems which prisoners take to prison. Similarly, prisoners are predisposed to a lot of health challenges in prisons due to the relatively higher disease prevalence than in the general population (Watson *et al*., 2004; Maggard *et al*., 2015; Shields and de Moya, 1997; Cowan-Dewar *et al*., 2011). Therefore, healthcare in prisons is an area of increasing international concern (Reed and Lyne, 1997).

According to Hogerzeil *et al*., (2006), most countries in the world have acceded to or ratified to at least one worldwide or regional covenant or treaty confirming the right to health. This, however, does not exclude inmates' right to health albeit their right to health is limited. One of the frameworks that can be used to assess whether policies and legislation respond to intended needs of its target population and are being implemented is the policy triangle in which a policy

analysis framework consists of actors, content, process and context (Gilson and Raphaely, 2008), it is presented in greater detail below under the theoretical framework.

2.1.1 Policy Content

In situations where policies and Legislative Acts are translated accordingly but content does not reflect the needs of the target population, it may not serve the desired purpose. Some studies have stated that content is the most substantive element of policy (Jones and Newburn, 2005). Equally, other studies have indicated how the content of the policies can be influenced by the most powerful and influential actors who can even decide what to maintain and what to get rid of after some time; for example, the American Legislative Exchange Council's (ALEC) diffuse approach of prioritising legislators' personal interest during the drafting of the legislation models (Cooper *et al.*, 2016). Technocrat input in a legal document is very cardinal. Its absence can compromise on the content that may lack scientific evidence. This affects the achievement of expected desired policy goals. Similarly, a study by Faydi *et al.*, (2011) assessing the mental health policies of Ghana, South Africa, Uganda and Zambia concluded that, in all four countries, there was lack of internal consistency in terms of policy content. The study further states that none of the countries in the study satisfactorily incorporated all or a sufficient number of key policy elements (vision, values and principles, objectives, and areas for action). According to Faydi and others (2011), areas for action were loosely elaborated and fragmented throughout the policy documents, thereby reducing the strength of the document, introducing ambiguity and uncertainty over the main policy directions.

Some countries have used strategies such as commitment and consensus to ensure policy content is maintained and what is translated is the right content that finally fits the beneficiary. For example, Ghana maintained the maternal fee exemption policy on the agenda over the years because there was collaboration through interactions, consensus building with all the actors of interest (Pelletier *et al.*, 2011). Therefore, it is essential to have coordinated support and effort from all actors/stakeholders in order to maintain the content of policy over time.

To this upshot, Legislative Acts that clearly outline the provision of healthcare to inmates need to be adequately translated and understood by implementers.

2.1.2 Policy Context

Effective policy implementation leads to better health service delivery. Lines (2006) indicates that people in prison should have a right to a standard of health care equivalent to that available outside of prisons. Strides towards equivalent healthcare needs are being made in an attempt to address the extreme health problems evident in prisons worldwide (ICPS, 2004; Todrys *et al*., 2011). In achieving this goal, the state needs to enforce its legal obligations to safeguard the lives and well-being of people it holds in custody (WHO, 2007).

Furthermore, Buse *et al*., (2012) state that public health practitioners do not understand how issues end up on policy agenda, yet they are one of the key factors to the successful implementation of legislation and policies. Therefore, several articles have shown the factors that determine the success or failure of the policy. For example, individual characteristics of policy actors such as ideological predispositions, professional expertise and training, play a role in policy formulation and implementation (Etiaba *et al*., 2015, Koduah *et al*., 2015b). Additionally, memories of similar policy situations, position and power resources, political and institutional commitments, loyalties, personal attributes and goals also play a part in policy formulation and implementation, and most importantly, the policy content (ibid).

Studies have shown that as much as the world may seem a global community, the success of laws and policies is dependent on history and culture of a particular country. For example, studies have suggested further exploration of the extent to which historical paths dependencies and diverse culture of different nations can account for differences in penal-policy outcomes (Karstedt, 2002; Melossi, 2001; Tonry, 2001). On the other hand, some studies have stressed the importance of politics in policy formulation and implementation. These studies have shown that changing political contexts affects the success of policy (Philpott *et al*., 2002; Etiaba *et al*., 2015). Furthermore, other studies have indicated that politics have an influence on the origins, formulation, and implementation of health laws and policies and consequently, affecting the

health outcomes positively or negatively (Glassman, 2008; Navarro *et al*., 2006). Navarro *et al*., (2006) concluded that there is an empirical link between politics and policy, and emphasises a need to establish the interactions between politics, policy, and health outcomes. This was after carrying out a 50-year study in Organisation for Economic Co-operation and Development (OECD) countries. Conversely, Halász and Michel (2011) and May *et al*., (2014) pointed out that; policy implementation is quickly achieved in countries where there is a clear and strong political commitment.

For example, palliative care policy in Ireland was a success as it enjoyed the public support of influential policy actors including the Prime Minister and the Health Minister (May *et al*., 2006). Equally, politics and other factors can lead to the failure of a policy. For example, a study by Bhaumik and Mathew (2015), aimed at deliberating on the various systematic barriers in the Indian prison health system and how these might be overcome to make primary healthcare truly available for all. The study stated that almost all prisoners returned back to the community and this made it imperative to link prison health with the public health system and bring them under the coverage of primary health care. However, the study noted a gap between stated policy and the reality where human rights had rated them poorly for not providing the basic standards of living. This gap, according to the study, was as a result of politicians, policymakers and the general public in India who believed in the traditional notion that sinners deserve neither mercy nor money. Owing to this mindset, policymakers allocated the resources as per law rather than as per needs, consequently, leading to the failure of the policy.

Similarly, a study in Zambia by Topp *et al*., (2016a) aimed at obtaining information on administrative and financing arrangements, and senior officials' perceptions of the key barriers and facilitators to prison health system strengthening. This study used mixed methods design and data collection included document review, in-depth interviews and memos generated from workshop minutes and informal observations during project activities. Findings from this study flagged critical intersection between lack of domestic financing and poorly realised governance structures that undermine both technical and service delivery capacity across the system. Nevertheless, it suffices to mention

that, in their findings, health financing was a central and underlying challenge. The study further stated that all the alluded to challenges were in existence despite the availability of a range of provisions within Zambia's legal framework that nominally guarantee health services and prison access to routine and good quality healthcare.

Finally, success or failure to implement the above stated legal obligations can be explained by the contextual factors.

2.1.3 Policy Actors

Results from a study by Walt and Gilson, (1994) showed the importance of all necessary actors in policy reforms. The study argued that many health policies wrongly focus attention on the content of reform, and neglect the actors involved in policy reform. Furthermore, the study gave an example of Zambia's economic reforms of the 1980s as having neglected the actors of the economic policy.

The above reforms had measures which were largely developed outside Zambia by the IMF, World Bank and foreign consultants leaving out the Zambian local actors, therefore, the country went into an economic impasse. Similarly, Gatherer *et al*., (2005) added that for a policy to achieve the desired outcome in prison healthcare system, there is a need for a strong partnership between primary healthcare professionals and prison authorities which can result in improved prison health and public health in general. This is what led countries such as Norway, France, and England to bring prison health into their national health systems. Other authors have also shown how actors play a vital role in the policy process. For instance, Tantivess and Walt (2008) have argued that having experts and technocrats in the policy-making ensures that all the right steps are taken to translate policies and implement them accordingly. Policies and Legislative Acts that are translated and implemented are those that are contained in the mentioned documents. Therefore, it is important that all the relevant actors and stakeholders participate in coming up with the content of policies and Legislative Acts. For example, Daniels *et al*., (2012) carried out a study aimed at exploring contemporary Lay Health Worker policy development processes and the extent to which issues of gender are taken up within this process.

This study results showed that gender as an issue never reached the policy-making agenda because in the process of defining the problem, there were no actors with interest on gender to bring up the gender issue to the attention of policy developers and ensure that it was included in the policy document. In a case where the policy or Legislative Act has all the relevant issues in it but exhibits high power imbalances among stakeholders and the policy process focuses on the content and neglects all the relevant actors, this may lead to serious policy implications. The above mentioned situation may result in neglected actors being unhappy with the general policy development process and may not support or participate in policy implementation, monitoring and evaluation (Zulu *et al.*, 2013).

Some studies have stressed the importance of political actors (Navarro *et al.*, 2006; Halász and Michel, 2011; Zulu *et al.*, 2013; May *et al.*, 2014). In Zulu *et al.*, (2013) it is stated that political commitment should not go beyond boundaries of expertise, meaning each specific policy should have experts taking the lead in the whole process of formulation because the content should have significant influence from experts who might not have the power but could be technocrats and know exactly what the policy should consist of. This means that the mix of actors in policy formulation should be proportionate for it to serve the right purpose and be implemented accordingly.

2.1.4 Policy Process

According to Jones and Newburn (2005), formal policy represents the outcome of a set of processes. The importance of the process in policy implementation has been expressed in several studies (Mayhew *et al.*, 2000; McConnell, 2010; Gilson and Raphaely, 2008; Tantivess and Walt, 2008). For example, Mayhew *et al.*, (2000) flagged out the critical need to re-examine the nature of the processes by which managers implement reproductive health policies. In the same breath, Gilson and Raphaely (2008) suggest that clear attention must be given to the process that brings about change and the discourses surrounding policy change processes.

Additionally, the importance of the policy process to have networks has been emphasised in the study by Tantivess and Walt (2008). The aforesaid study

aimed at examining the processes by which the universal ART policy developed between 2001 and 2007, with the focus on the connections between actors who shared common interests called policy networks. Using qualitative approaches, the study found that non-state network's supportive role could be observed at every policy stage (actual development and implementation of health policy), and at different levels of the health sector in the policy process. On the contrary, El-Jardali *et al*., (2014) used a case study of Lebanon to generate in-depth insights on the public policymaking process, identifying the factors that influence policymaking and assessing to what extent evidence is used in this process. The study revealed the absence of a structured decision-making approach that utilised research evidence in the policymaking process. Local studies on nursing in Lebanon that could have informed policy development were available but not used and this meant weakness in the translation of knowledge and absence of effective communication between researchers and policymakers, and ultimately affecting the content of the policy. Similarly, Zulu *et al*., (2013) suggested that some actors within the strategic team of their study were more influential than others in informing the policy agenda and determining the process. Additionally, the article stated that the policy-making process had less consultation of other valuable actors, consequently, the policy content did not adequately address key content issues. This means that policy-making process, in the last two studies, was unlikely to be as planned due to the process that was not overarching.

2.2 Theoretical Framework

2.2.1 The Health Policy Triangle

There are several policy analysis frameworks that exist such as stages heuristic, institutional analysis and development, multiple streams, punctuated equilibrium health policy triangle. For this research, the health policy triangle framework by Walt and Gilson (1994) in (Figure1) will be adopted with regard to (i) the context within which the policy is formulated and executed, (ii) the actors involved in policymaking, (iii) the steps associated with the development process, and (iv) the policy content (Zulu *et al*., 2013). Policy triangle has been used because it helps to explore systematically the somewhat neglected place of politics in health policy and it can be applied to high, middle and low-income

countries (Buse *et al*., 2005). This framework has influenced health policy research in varied groups of countries and has been used to analyse a large number of health policy issues (Walt *et al*., 2008). With this framework studies have found cardinal lessons that can be used to enhance policy formulation and implementation in different sectors (Mukanu, 2017). For example, Etiaba *et al*. (2015) established that the Oral Health Policy in place in Nigeria succeeded because the government in place had been democratically elected and there were complex interactions between the context and actors who facilitated its approval. On the contrary, in a study by Zulu *et al*., (2013) it is reported that the development process of the National Community Health Assistant Strategy may have been influenced by actors with power in the political hierarchy who played a disproportionate role in shaping the process as well as the content of health policy reform.

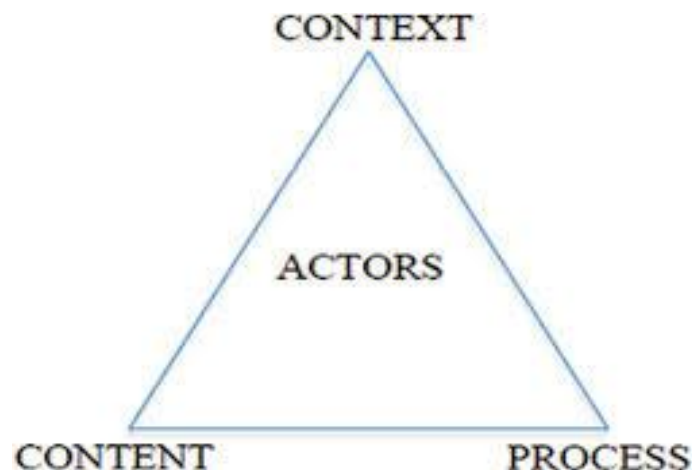

Figure (1) Policy Triangle Framework Adopted from Walt and Gilson (1994)

In this study, the policy triangle framework will be used to retrospectively analyse the Public Health Act, Prisons Act and the National Health Policy (NHP) to see how the policies in question got onto the agenda, how they were initiated, formulated and eventually answer the question of why healthcare for inmates is neglected and not implemented as legislated. The components of the policy triangle are

Actors; these individuals, organisations or the state, and their actions that can affect health policy implementation (Buse *et al*., 2005). Examples of actors in this study will include politicians, decision makers at the Ministry of Home Affairs, the Ministry of Health, the Zambia Correctional Services - including all officers and inmates, international NGOs such as Centre for Infectious Disease Research in Zambia (CIDRZ), the United Nations Office on Drugs Crime (UNODC), USAID DISCOVER - Health and local NGOs such as Prisons Care and Counselling Association (PRISCCA).

Context: these are the systematic factors - political, economic, social or cultural, both national and international - which may affect health policy implementation (May *et al*., 2014). The study will find out the political interest and environmental factors that may have motivated the formulation of the Legislative Acts and policy under review and how they have influenced their implementation. Structural factors - the study will try and understand the institutional framework governing the implementation of the health Legislative Acts and policy pertaining to an inmate's health. Cultural factors - the study will assess how the community's attitude towards inmates has affected the implementation of the Legislative Acts and policy. International or exogenous factors - the study will be looking at how the external factors such as international bodies, among others and Mandela Rules have been influencing the implementation of these legislative acts and policies (UNODC, 2015).

Content: this involves understanding the substance of a particular policy or policies which details the subjects and topics covered (Buse *et al*., 2005). This study will analyse available health Legislative Acts and policies in line with health delivery to inmates. A desk review will be conducted in order to ascertain the content of National Health policy, Prisons Act and the Public Health Act. A desk review will be done to ascertain both deficiencies and stumbling blocks that hinder health delivery in prisons.

Process: this is the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated (ibid). Therefore, this study will review the National Health Policy, Prisons Act and the Public Health

Act and other necessary legislative documents to ascertain the type of process that was used during formulation as well as the process of implementation.

CHAPTER 3: METHODOLOGY

3.1 Study Design

The study used a qualitative case study. Yin (2003a) states that the distinctive need for case studies arises out of the desire to understand complex social phenomena. For rigour and validity, the study used multiple sources of data collection (Baxter, 2008). The case in this study was the gap between existing legislative acts, policies and translation of these laws and policies. Therefore, to examine the gap, the study analysed the inmate health aspect of the Legislative Acts, National Health Policy and National Health Strategic Plan.

3.2 Study Site and Study Population/ Sample Size

The study sites were Lusaka and Central provinces which were conveniently selected because each site has a central correctional facility with high inmate population and the study concentrated on decision makers and these are mainly based in Lusaka and Central Region. From each province, one hospital and one clinic were purposively selected (see Table 1). A correctional facility clinic was selected so that the views of correctional centre nurses were also captured and these were selected from the central correctional facility of each province. Additionally, health centres that were selected from the general community were those that were key places for admission of inmates (see Table 1). Other sites were the Ministry of Health, the Ministry of Home Affairs, the Zambia Correctional Services-Headquarters, Prisons Care and Counselling Association (PRISCCA), Centre for Infectious Disease Research in Zambia (CIDRZ), the United Nations Office on Drugs Crime (UNODC) and USAID DISCOVER-Health in Lusaka. Document review was done at the MOH, MHA and ZCS. It included relevant policies, strategic plans, guidelines and activity plans.

3.3 Selection of Participants

Participants from the ministries and cooperating partners were purposively drawn based on the researchers' knowledge of key individuals with knowledge of Legislative Acts and policy on inmates' health. Health professionals from health facilities were also purposively selected based on their contact with inmates. The study selected one doctor from each facility because he/she was able to represent other doctors; and two nurses were pick from each facility

because they were able to represent other nurses. The challenge of accessing key informants made the sample size reduce from the planned 21 to 16 (see Table 1). The participants were a combination of health professionals and non-health professionals.

3.3.1 Inclusion Criteria

The study targeted documents that were health related. Key informants were both health and non-health professionals who had worked for at least 2 years and had either knowledge of the health Legislative Acts, policies and other related documents on inmates or experience in working with Zambia Correctional Service, the Ministry of Health or the Ministry of Home Affairs. Some officers who were absent were represented by other officers with knowledge of Legislative Acts on inmates' health. The cooperating partners were selected based on their involvement in prisoner's health in the past 3 years.

3.3.2 Exclusion Criteria

Those who were not actively involved in inmate healthcare in the last one year.

3.4 Data Collection Plan and Tools

Data collection for the study was done from 24 November to 2 March 2018. The first step in data collection involved the review of policy documents (see Table 2) which was followed by interviews of key informants (see Table 1).

3.4.1 Document Review

Using an extraction matrix (see Appendix 4), the study reviewed the HIV and AIDS Policy, Mandela Rules, NASF, Prisons Act, Prisons Amendment Act Number 16 of 2004, Commissioner's Standing Order, Zambian Constitution, and the Prison Health Strategic Plan (see Table 2).

Table 1: Interviewed Key Informants and Sample Size in the Study

No	Organisation	Respondent	Reason for Selection	Sample Size
1	**Zambia Correctional Service (ZCS)**	Representative	Key interested party (beneficiary).	4
2	**Ministry Home Affairs (MOHA)**	Representative	MHA is responsible for ensuring that policies are implemented by the ZCS.	1
3	**Ministry of Health (MoH)**	Representative	Responsible for the formulation of health policies and provides leadership and governance in the Zambian health system (WHO, 2014).	2
4	**the Centre for Infectious Disease Research in Zambia (CIDRZ)**	Representative	Have been coordinating and implementing prison-based health services through the Zambia Prisons Health Systems Strengthening Project (ZaPHSS), and has done a number of researches.	1
5	**United Nations Office on Drugs Crime (UNODC)**	Representative	It has been providing HIV Prevention, Treatment, Care and Support in Prison Settings in sub-Saharan Africa funded by the Swedish Government.	1
6	**USAID DISCOVER-Health**	Representative	Provides advocacy and other efforts to improve the conditions for inmates, including reducing HIV vulnerability and improving access to HIV treatment and healthcare services for inmates.	1
7	**Prisons Care and Counselling Association (PRISCCA)**	Representative	Their main objective is to complement government efforts in improving prison conditions and ensuring that prisoners access their rights countrywide.	1
8	**University Teaching Hospital (UTH)**	Representative	Likely to have both knowledge of health laws and policies pertaining to inmates and experience attending to inmates	3
9	**Lusaka Central Correctional Facility Clinic**	Representative	Their experience with inmates and may have knowledge of laws and policies pertaining to inmates/prisoner health.	2
12	**Kabwe General Hospital**	Representative	Likely to have both knowledge of health laws and policies pertaining to inmates and experience attending to inmates.	3
13	**Kabwe Maximum Prison Clinic**	Representative	Experience with inmates and may have knowledge of laws and policies pertaining to inmates health.	2

Table 2: Documents Reviewed in the Study

Document/Report	Year (Period)	Relevance to the Study
Constitution of Zambia	2016 (amended)	It is a set of fundamental principles or established precedents according to which Zambia is governed.
Acts of Parliament of the Republic of Zambia		
Public Health Act Chapter 295 (As Amended by No. 25 of 1969)	1969	Provides for the prevention and suppression of diseases and generally to regulate all matters connected with public health in Zambia.
Prisons Act No. 56, as Amended by Act No. 16 of 2004, CAP 97	2004	Provides for the general wellbeing of inmates and includes specific health needs for inmates/prisoner.
Zambia Across Sector Documents		
Vision 2030	2006	This document serves as a guide for all development efforts of the country. As such, the goals and targets set in the vision determine the strategic focus in all economic sectors including equal access to healthcare.
Seventh National Development Plan	2013-2016	This document is the main instrument for the implementation of government programmes in the medium term in Zambia.
Zambia Health Sector Specific Document		
National Health Policy (NHP)	2013	This document states clear directions for the development of the Health Sector in Zambia. It sets out policy measures that are supposed to guide strategies and programmes in the health sector.
National Health Strategic Plan (NHSP)	2011-2016	It operationalises the national health policy in the medium term.
The Prisons Service Health Strategic Plan	2015-2020	This document marks an important journey towards the provision of quality health services to the prison community.

3.4.2 Key Informants Interviews (KII)

Key Informants Interviews are interviews with individuals who are well informed about the subject, accessible and can provide leads about other information (Gilchrist, 1992). In this study, KII were selected based on their knowledge and experience working with the Zambia Corrections Service, the Ministry of Home Affairs or the Ministry of Health. Letters seeking permission to conduct interviews were delivered and the affirmative response was received except for the Ministry of Health Key Informant who delegated to another officer under policy department. The study used an interview guide adapted from Creswell (2014) (see Appendix 3) and the interviews were conducted at participants' offices. Permission was granted to use audio recorder and KII gave the general idea of how the Legislative Acts, policies and strategies that consisted of inmate's health were formulated and implemented.

3.5 Data Management and Storage

All data collected was anonymised through assigning a code on the recorder and placed on the computer where it will be stored using a password that only the researcher had access to. Information that was still on the recorder was stored together with the notebooks under lock and key. Transcribing was done just after the interview so that no information was not forgotten or lost. Written notes will be destroyed by first shredding and then burning as soon as the research is completed.

3.6 Data Analysis Plan

Analysis was conducted simultaneously with data collection because findings emerging from the field affect the types of data and how it is collected (Newton, 2012). Thematic analysis approach was adapted from Braun and Clarke (2006). The data was derived from document review and Key Informants Interviews which were recorded using a digital audio recorder with permission from the participants. Firstly, all documents were read for familiarisation and attention was paid to sections in the documents that were addressing the inmate's health to establish the relevance of that document to the study. Subsequently, a summary of the document was then made. From the summary of the document, codes were identified. Secondly, the recording was transcribed verbatim. The

data was coded, and subsequently categorised according to the broad idea that they represented. Categories (sub-themes) were then analysed and grouped according to the predetermined themes that were derived from the policy triangle (see Table 3). Since data was collected from the two sources mentioned above, triangulation was used for comparison.

The study only used comprehensive qualitative data analysis software Nvivo 10 for organising interviews and storage. This software package can also be used to field notes, textual sources, and other types of qualitative data including image, audio and video files (Trustees, 2011-2012). Further, validation was done through the research assistant who the researcher compared notes with after interviews and a transcriber whose work was validated with the researcher's work. The transcript was also shared with two supervisors for verifications and review. Additionally, the reflexive journal was used to counter bias that the researcher could have introduced by virtue of being an employee in the organisation of interest. The reflexive journal heightens reliability and added considerably to the credibility and usefulness of this qualitative study (Roller, 2012). The reflexive journal consisted of the following steps adopted from Blaxter (2001):

i. Listed start codes in a journal, along with a description of what each code meant and the source of the code.
ii. Provided detailed information as to how and why codes were combined, what questions the researcher was asking of the data, and how codes were related.
iii. Noted how the codes were interpreted and combined to form themes.
iv. Notes which included the process of understanding themes and how they were fitting together with the given codes. Answers to the research questions and data-driven questions were well-supported by the data.
v. Each theme was described by the researcher within a few sentences.
vi. The researcher documented why particular themes were more useful at making contributions and understanding what was going on within the data set.

Table 3: Themes and Sub-themes from the Data Analysis

Themes	Sub-Themes
Content	1. International guidelines • Mandela Rules 2. National legal documents • ZPHSP • NHSP • SNDP 3. Stakeholders perspective on the implementation of both international and local guidelines • Lack of domestication of international guidelines • Lack of provisions for inmates' entitlement • Policy direction on key population • Ignorance of the existing legal documents on inmates' health
Process	• Stakeholders involvement in formulation and sensitisation on inmate's health-care laws • Fragmented legal provisions • Delayed court hearing • Lack of correctional training at ZCS Training School • Prioritizing the general public at the expense of inmates • Accountability of inmates healthcare provision • Poor reporting
Context	• Resource inadequacies • Funding • Shortage of correctional health centers • Understaffing of health personnel • Economic performance • Open door policy • Political environment • Inequalities in public health-care delivery
Actors	• -Ministry of Health • -PRISCCA • -CIDRZ • -USAID DISCOVER-Health • -UBUMI • -UNODC • -VSO • -CELIM • -CDC • -ZLDC • -In But Free

3.7 Ethical Consideration

Prior to interviewing informants, official permission was sought from the organisations. Written consent was provided through the office of the Permanent Secretary at the Ministry of Health, at the Zambia Correctional Service it was through the office of the Commissioner-General, while for the cooperating partners, it was through their Chief Executive Officers. This enabled the informants to participate freely in the study (See Appendix 2 and Appendix 5). However, the aforesaid letters of clearance were not used to coerce the informants into participation in the study, they still had the right not to participate in the study if they so wished, for example, a director from one of the institutions denied to participate even after proof of clearance letter.

To further ensure that informants were comfortable and protected, the researcher informed them that the interviews were highly confidential at all stages of the research and maintaining privacy and confidentiality was given deserved consideration. The names and positions of participants were withheld, that is, when writing the report individuals were not identified by their names or profession. For example, the report did not state what the doctor or Permanent Secretary said, but as an alternative, codes were used. The results were protected from unauthorised observation. The participants were always reminded that they were allowed to withdraw at any time if they felt uncomfortable.

Furthermore, the researcher informed the informants that there were no direct benefits to the researcher, however, it would benefit the Zambia Corrections Service (ZCS) by recommending necessary measures to be taken to enhance collaboration with stakeholders and translation of the law. In addition, all informants voluntarily participated in the study and none demanded or expected benefits. All the interviews were conducted in private (informants offices), and all hard and soft copies of the data were kept securely by the Principal Investigator.

The study proposal was reviewed and approved by the University of Zambia Biomedical Research Ethics Committee and cleared by the National Health Research Authority (NHRA) before data collection commenced.

3.8 Dissemination of Information

The results will be disseminated to the Zambia Correctional Services, the Ministry of Home Affairs, the Ministry of Health, the Prisons Care and Counselling Association (PRISCCA), the Centre for Infectious Disease Research in Zambia (CIDRZ), the United Nations Office on Drugs Crime (UNODC) and USAID DISCOVER-Health and necessary stakeholders through workshops. The information will further get to other stakeholders by publishing in a credible journal, annual reports and brochures.

CHAPTER 4: FINDINGS

4.1 Policy Content

Both international and local strategies and guidelines indicated that every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation.

4.1.1 International Guidelines

The review of the international guidelines showed that the provision of health-care for prisoners is a State responsibility. These guidelines emphasise that 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 without discrimination on the grounds of their legal status. They further revealed that health-care services should be organised in close relationship to the general public health administration and in a way that ensures continuity of treatment and care, including HIV, tuberculosis and other infectious diseases, as well as drug dependence.

Furthermore, the guidelines emphasised healthy accommodation, teamwork and qualified manpower. They state that the healthcare agenda should be driven by an interdisciplinary team and qualified personnel. They brought out how imperative personnel acting in full clinical independence was and further highlighted the importance of encompassing sufficient expertise in psychology, psychiatry and dentistry. The analysis also revealed that clinical decisions should not be made by people who are not health-care professionals and should not be overruled or ignored by non-medical prison staff (UNODC, 2015).

The guidelines specified that circumstantial children should be given child-specific health-care services, including health screenings upon admission and ongoing monitoring of their development by specialists. Additionally, they indicated that adequate space should apply to all prisoners without exception, and that health-care personnel should not have any role in the imposition of disciplinary sanctions or other restrictive measures.

4.1.2 National Legal Documents

The Prions Act revealed that any medical officer appointed shall have the general care of the health of prisoners and shall visit the prison daily where practicable or when called upon by the Officer-in-Charge. Further analysis revealed that authority is given to the Officer-in-Charge to decide whether or not an inmate should go to the hospital. It is worth noting that the Prisons Act further instructs a medical officer to inspect every part of the prison and during such inspection, to pay special attention to the sanitary state of the prison, the health of the prisoners, and the adequacy and proper cooking of food. The document further indicated that the content of the diet was to be fish, maize, bread, soup, vegetables, meat, groundnuts, fruits and tea.

The National Health Policy (NHP) stressed on scaling-up prevention and control services among prisoners and other high-risk groups. Similarly, the National Strategic Plan for HIV and AIDS and STI 2017 – 2024 was informed by the NHP and therefore, included prisoners and other incarcerated people as the main key population groups. The Strategic Plan further states that the key populations often suffer from punitive laws or stigmatising policies, and are among the most likely to be exposed to HIV, therefore, their engagement is critical to a successful HIV response.

The Prisons Health Strategic Plan was formulated when the National Strategic Plan had expired. This document is oriented towards addressing overcrowding, poor physical infrastructure for inmates/prisoners, nutritional status, new HIV infections and mitigate the impact of HIV and AIDS among prison inmates and defines prison communities, malaria cases in prisons, and ensures that circumstantial children have the same opportunities to health-care as those born outside of prison.

It was further observed, from the content analysis, that the Penal Code Act, Cap 87 provided for non-custodial sentencing which is community sentencing. The Seventh National Development Plan focused on strengthening the capacities of institutions within the legal and justice sector to ensure that these challenges of the backlog of court cases, delayed disposal of court cases, and congestion in prisons were addressed. Furthermore, Vision 2030 generalised health by

highlighting the aim of providing equitable access to quality health-care to all by 2030 which, according to Vision 2030, will be an indicator of development.

4.1.3 Stakeholders Perspective on the Implementation of International and Local Guidelines

4.1.3.1 Lack of Domestication of International Guidelines

Informants felt that international guidelines cannot be one size fits all, and further stated that developed and developing countries have different priorities, depending on the economic performance, therefore, cannot be expected to have the same approach. For example, contrary to international provisions, there were mixed feelings among informants on correctional health personnel completely shunning away from disciplinary sanctions. Some informants felt officers needed to perform any duty that befalls them, while others felt that officers responsible for inmates' health were only supposed to concentrate solely on health. Below is what they had to say

> *"…developing countries like Zambia with limited resources it's better to let an officer multi-task and as long as an inmate is working with inmates they cannot do away with security." (KI 02 ZCS 24-11-17).*

On the contrary, informants felt that because of security implications in dealing with inmates, disciplinary sanctions cannot be done away with. Therefore, correctional health workers perform both custodial and rehabilitation work.

> *"…correctional health workers do both custodial and rehabilitation duties but that is so unethical, they don't have to be involved in punishing prisoners…" (KI 16 Cooperating Partner 22-12 17).*

Therefore, informants recommended the domestication of international guidelines.

4.1.3.2 Lack of Provisions for Inmates' Entitlement

Some of the informants were of the view that it was not right for an Officer-in-Charge to have the authority to give permission to an inmate to visit the hospital as alluded to in the local legal documents. They expressed how this was not favouring inmates and infringed on their right to health. An informant explained:

"…Officer-in-Charge will decide for an inmate to be taken to the health centre according to the Prisons Act, it is giving power to the Officer-in-Charge and if the Officer-in-Charge says no, an inmate would not be taken to the hospital…" (KI 02 Zambia Correctional Service 24-11-17).

Some informants expressed how reality in terms of diet contradicted what was provided for in the legal documents. They revealed that governments and the Zambia Correctional Service, in particular, did not meet the Prisons Act prescribed diet for inmates. They spoke out on inmates' monotonous diet that contained beans, kapenta, Nshima, sample and rice. They further attributed this situation to insufficient funding.

"…the challenge is that government and ZCS don't meet the standard of diet… in the Act, there is milk, beef, fruits, eggs but we don't manage because of funding…" (KI 02 ZCS 24-11-17).

Some informants stated that the Prisons Act did not provide for inmates with special diets such as those on ART. They stated that this means that the Zambia Correctional Service remains dependant on well-wishers and cooperating partners for food that has to be given to this special group of inmates.

"*…there is no provision for a special diet for those on ART in the Act..." (KI 14 Cooperating Partner 24-11-17).*

4.1.3.3 Lack of Implementation of Non-Custodial Sentencing

Informants expressed disappointment by the lack of implementation of community sentencing which is supposed to reduce overcrowding by taking up all misdemeanour cases. They further expressed how it can be appropriate for a person who has offended the community with the petty offence to be of service to the community by sweeping and cleaning public buildings and surroundings. Additionally, they stated that unless overcrowding is addressed, rates of infectious disease in correctional centres will be high, meaning implementation of measures to curb transmission of disease will continue being a challenge. An informant remarked:

"...petty offences need community service, why don't offenders sweep at the market, clean public toilets, we would have saved the space in prison and that person would have provided a service and paid back in kind to the community or the society that he has offended (KI 14 Cooperating Partner 24-11-17).

4.1.3.4 Ignorance on the Existing Legal Documents on Inmates' Health

Some informants from the Ministry of Health were not aware of the content of the documents relating to inmates' health. Other participants had seen some health worker treating inmates like second class citizens, they also added that most health workers prefer working in outside clinics than in correctional health centres at the Zambia Correctional Service. Some informants concluded that such people lacked guidance and exposure to legal documents that state that inmates should be treated like patients from the general community. Some of the informants had the following to say:

"I don't know anything about prison health guidelines or policy. I have never seen anything written or any document on them" (KI 13 University Teaching Hospital 01-11-18).

"...I have seen a number of health workers outside the correctional centre neglecting inmates maybe for reasons known to themselves, not to us. So they are lacking policy guidelines" (KI 05 Zambia Correctional Service 20-12-18).

4.2 Policy Process

This study endeavoured to find out the ways in which legal provisions on inmates' health were translated, that is, how legal provisions cascaded from formulation to the actual beneficiary. This was done by reviewing health legal provisions with a focus on inmates' health and through key informant interviews. Some of the issues that arose included; unsensitised community, top-down approach in the formulation of laws on inmates' health, stakeholder consultation during formulation of legal provisions on the health of inmates, fragmented legal provisions, delayed court hearings, lack of correctional training

at the Zambia Correctional Service Training School and prioritising the general public at the expense of inmates. Each of these issues is presented below.

4.2.1 Stakeholders Involvement in Formulation and Sensitisation on Inmate's Health-care Laws

An informant reported that the existing legal documents on inmates' health were formulated using a top-down approach. They further stated that it is the reason implementation has been difficult because the other important stakeholders have not owned these legal documents and they feel alienated from what the documents demanded.

The aforementioned top-down approach also suggests that the bottom stakeholders, inter-alia, beneficiaries were not consulted. Some informants expressed a lack of full consultation during the formation of some Legislative Acts that are currently existing. Therefore, some health workers were not aware of any guidelines and others stated that they were non-existence. It was revealed that it made some key implementers not to attach importance or take time to know what is expected of them.

> *"…it was a bit difficult to implement what was in the Prisons Act because some officers were not able to understand what the Prisons Act says in terms of the health of inmates…" (KI 02 Zambia Correctional Service 24-11-17).*

> *"…health facilities don't have guidelines or they are completely ignorant on how they should treat inmates that's why others may even refuse to attend to them…" (KI 04 Ministry of Health 14-12-17).*

Nevertheless, informants stated that there are a few documents such as the Zambia Correctional Health Strategic Plan that were very consultative during the formulation and they believe it might be successfully implemented because key stakeholders will own the document and ensure its success. The only problem they feel it might face is the fact that it was formulated when the National Health Policy, the National Health Strategic Plan and the Sixth

National Development Plan had expired. This means that it did not buy in, in any of the alluded to cardinal national documents.

> *"…the process of coming up with the ZCHSP was quite inclusive and it was representative…" (KI 12 Cooperation Partner 29-11-17).*

4.2.2 Fragmented Legal Provisions

A number of informants said that the process of implementation had been a challenge due to fragmented policies, strategies and guidelines which were quite expensive. They added that people and institutions were working in silos, this made resources to be spread thin and less effective in achieving the intended goal. They further stated that most of the Legislative Acts, policies, strategies and guidelines lacked frameworks to be implemented. An informant remarked:

> *"…there is a running Prison Health Strategic Plan that doesn't feed in any plan, not even the National AIDS Strategic framework…legal documents are not speaking to each other…" (KI 15 Cooperating Partner 01-02-18).*

> *"…The policies, legislation need a framework to be translated, if they are not there, what are we doing? Meaning it is just on paper…" (KI 06 Cooperating Partner 22-02-18).*

Informants further stated that the Health Directorate in collaboration with some cooperating partners were trying to bring together all organisations dealing with the health of inmates at the Zambia Correctional Service. Key actors that were on board were, inter-alia, the Ministry of Justice, the Ministry of Health, the Ministry of Home Affairs, and other cooperating partners. This would reduce duplication so that all available resources would be utilised in priority areas and would make an impact on staff and prisoners.

4.2.3 Delayed Court Hearing

Some informants stated that they applauded the government for building more prisons to reduce congestion that was notorious for spreading diseases. However, this was not a complete panacea to the problem. They added that the new prisons would be congested as well so long as other criminal justice

systems were not addressed, for example, delayed cases. Therefore, they suggested a holistic approach to the problem.

> *"…how can the police investigate their cases if it's shoddily done? Someone's case can languish in the judiciary for years and they end up in the correctional centre even longer, so we need a holistic approach" (KI 16 Cooperating partner 22-12-17).*

4.2.4 Lack of Correctional Training at Zambia Correctional Service Training School

It was revealed by informants that after the Constitution was amended to change Zambia Prisons to the Zambia Correctional Service, the curriculum at the Zambia Correctional Service (ZCS) training school has remained punitive. They stressed how the new Constitution demands that they produce officers who will respect the inmate's right to health and ensure that the ZCS becomes a healthy environment to complete public health vision.

> *"…Correctional Service Training school is regimental training and what the service wants it to be, are so apart. The training is done in a military way and yet they want to go correctional way…" (KI 07 Cooperating Partner 21-02-18).*

4.2.5 Inequalities in Public Health-Care Delivery

Unlike other legislation that only focus on inmates, Mandela Rules focus on staff as well. Incorporating Zambia Correction Service staff in health-care enables staff to appreciate inmates' right to health-care and eradicates the problem of unequal treatment of sick inmates compared to the patients in the general community. Informants identified inequality in the treatment of sick inmates as a barrier to the translation of legal provisions on inmates' health. Informants stated that some Correctional Health Centres were found attending to community members first before inmates. This was because of the misconception that inmates are not entitled to health-care, but this is contrary to the civilised approach that gives inmates' entitlement to access the same quality of health service as the general community. Informants suggested that officers need training so that they can understand the paradigm shift to corrections. They

further pointed out that officers are one of the major facilitators of access to health-care for inmates. An informant said the following:

> *"….after training and sensitising the officers on Mandela Rules, staff realised that inmates' access to health is equally important as their own access to health." (KI 16 Cooperating partner 22-12-17).*

4.2.6 Accountability and Reporting on Inmates Health

Informants reported that there was no monitoring and evaluation of the translation of the law. Some attributed this to a lack of funding. They stated that implementation was part of the translation of the law and it is very cardinal because, without it, the law on paper is useless. They suggested systems to be in place to monitor and evaluate all the stages of translation, that is, from initiation of the legal provision through to implementation. Below is what an informant had to say;

> *"…there should be a system to monitor implementation of the law just like the way they develop statutory instruments to enact an Act there should also be systems to monitor the implementation of a law that has been passed…"(KI 02 Zambia Correctional Service 24-11-17).*

Informants reported that there is deceiving reporting by juniors at the Zambia Correctional Service. Informants further stated that juniors always report on unlock and lockup cases and state that the situation is normal at the correctional centre. This is the report that is given to the Minister who also presents to the Cabinet. Consequently, the President thinks the situation in the correctional service is normal and good.

> *"…officers should state things as they are so that seniors report to the PS, or the Minister of Home Affairs so that when the Cabinet Honourable Minister Kampyongo will have what to say not just telling the President all is well…"(KI 08 Cooperating Partners 02-03-18).*

4.3 Policy Context

4.3.1 Resource Inadequacies

It emerged that inadequate resources had played a huge role in lack of implementation of Legislative Acts, policies and strategies. For example, the Prisons Act prescribed a sufficient diet for healthy prisoners, unfortunately, implementation of such a Section of the Act had only taken place partially due to financial constraints. Informants pointed to situations where stakeholders were willing to implement stated requirements but resources could not allow. They further stated that if inmates had to be fed according to what the Prisons Act provides, they can be in good health. Below is what two informants had to say:

> *"…when you see what inmates eat then you start wondering where is the problem, of course, am not saying the Zambia correctional service are not buying food…because they also are simply the recipient of budget allocation from the government..."(KI 11 Ministry of Justice 04/01/2018).*

> *"…laws are adequate that's what I am saying, we have drafted policies… plans, what has not come in equal measure are resources…" (KI 03 Zambia Correctional Service 07/12/2017).*

Furthermore, informants explained that inadequate resources had led to a shortage of Correctional Health Centres. Informants mentioned that there was need for each and every correctional centre to have a health facility if health-care provision had to be equal to that provided in the community. However, they pointed out that only 25 out of the 88 correctional centres had health facilities within.

Informants also attributed the understaffing of health personnel to inadequate resources. Some informants felt that the policies could not be implemented because of inadequate staff from both the Zambia Correctional Service (ZCS) and the Ministry of Health (MoH). They further illustrated that the Zambia Correctional Service only has 88 nurses against an inmate population of about 21,200 and this population excluded ZCS staff. An informant explained;

"…presently I think we only have about 88 nurses out of a fender population of about 25-26 thousand that includes correctional staff…"(KI 04 Zambia Correctional Service 07/12/2018)

Informants also associated resource constraints with the country's economic performance. They pointed out that economic performance determines how much is allocated to Correctional Service. They further mentioned that the government usually prioritises other vulnerable groups and the Zambia Correctional Service is usually the least in line. Informants stated that usually inmates are viewed as unwanted and deserve less attention and that includes health-care. An informant elaborated on economic performance;

"…resource availability has to do with the performance of our economy generally and various competing needs you are well aware we are in a developing country our levels of poverty officially stand at over 50% with 20% there about leaving in abject poverty we have competing needs from the fact that if you look at access to health index is still below internationally accepted levels…" (KI 03 ZCS 07/12/2017).

In relation to the foregoing, other informants added that the Health Directorate that was established to improve prison health by supplementing the Ministry of Health function is not funded. This makes it very difficult to discharge its functions efficiently and effectively, consequently, depending so much on MoH. Unfortunately, MoH has no deliberate guidelines on prisons health, therefore, it is at the health workers discretion on how they treat prisoners or whether they visit prisons or not. Some informants find this luck of guidelines okay while others felt there is need for a deliberate guideline, below is what they had to say;

"…ZCS Health Directorate does not receive funding so the MoH is supposed to take that responsibility to failure, let them start funding the Health Directorate…" (KI 02 ZCS 24-12-17)

"…there should be policies just like policies which have been formulated for Zambia correctional service so that health workers can be trained and understand fully the health of inmates…" (KI 05 ZCS 20-12-17).

4.3.2 Political Environment

According to informants, there was political will as shown by the President assenting to the Constitution on 5 January, 2016. They further stated that the government has given attention to the needs of the Zambia Correctional Service. They also added that the government is also working on harmonising salaries for correctional staff, this will motivate them to execute their duties diligently.

> *"…the political will we have seen of changing prisons to correctional service tells the whole nation that those are human beings, therefore, the attention should be increased…" (KI 14 Cooperating Partner 24-11-17).*

However, there were divided views among informants on how to open the Zambia Correctional Service (ZCS). Some thought it is to the public, others thought the ZCS had opened up enough for public partnership while others thought they can still open up more to break the barriers to translation of legislative acts on inmates health.

> *"…ZCS has opened up but more can be done, security issue also hinder the way or how much ZCS can open up…" (KI 08 Cooperating Partners 02-03-18).*

4.4 Policy Actors

In order to provide health-care to inmates, the Zambia Correctional Service has been working in collaboration with the Centres for Infectious Diseases Research in Zambia (CIDRZ), the Ministry of Health, Mother Theresa, PATH, PRISCA, Prisons Health Advisory Committee, UBUMI, UNODC, VSO, CELIM, CDC, ZLDC and In But Free. These collaborating partners formed a platform which used to be called Prisons AIDS Advisory Committee (PAAC) but was rebranded not just to look at AIDS but health in totality hence the change to Prisons Health Advisory Committee (PHAC). This is where all the partners that are supporting the prisoner's health in whatever aspect come together with the correctional service to discuss how services are going to be provided in the correctional facilities. Unfortunately, it emerged from informants that the platforms' full potential is not tapped due to lack of funding and it has no legal backing. One informant explained;

"…we have the Prisons Health Advisory Committee (PHAC) that has these different stakeholders from civil society, faith-based organisations and non-governmental organisation" (KI 14 Cooperating Partner 24-11-17).

"Prisons Health Advisory Committee is a forum or a platform that can be used to generate ideas on how prisons can be run in totality because that forum was meant to bring ideas to the fore but I think we are not making full use of it…" (KI 16 Cooperating Partner 22-12-17).

Some informants felt that the Ministry of Health (MoH) is charged with the responsibility for health for all. Therefore, they expected it to take up the supervisory role. They added that they expect the MoH to take the first step in collaborating with the Zambia Correctional Service (ZCS) not vice-versa as the status quo is. They gave an example of the cholera outbreak where they expected MoH to be in the forefront ensuring that ZCS had the necessary equipment and doing the right thing but ZCS was not even part of the planning process. They stated that ZCS had to find its way of participating in the national committee to ensure that prevention of the infectious and the waterborne disease was addressed in correctional centres. Below is what an informant said;

"…the collaboration with MoH is not yet 100% there are still challenges…" (KI 07 Zambia Correctional Service 21-02-18).

Informants revealed that cooperating partners had done a lot and made a lot of effort to address the health problems in correctional centres. They further noted that to achieve what is prescribed in the Prisons Act, Mandela Rules, Prisons Health Strategic Plan and Commissioner's Standing Order on Prisoners' Health, the Zambia Correctional Service and stakeholders have been providing various services. The Zambia Correctional Service provides comprehensive care by providing custodial and rehabilitation services. Comprehensive care entails the use of the needs-based services which aim at the maintenance of the wellbeing of persons in the custody of the Correctional Service. An informant stated:

"…the Zambia Correctional Service, therefore, ensures that all services are provided to inmates even if it is evident that it is not adequate to service delivery"(KI 08 Zambia Correctional Service 23-02-18).

Informants attributed inadequate service delivery to insufficient funding from the central government. However, informants submitted that the Zambia Correctional Service receives support from partners with the mandate to provide support to inmates through the Prisons Health Advisory Committee (PHAC). Through this coordinating platform, partners share work plans for increased collaboration and sourcing of additional support. These partners are PRISCCA, UBUMI, CIDRZ, VSO, CELIM, UNODC and DISCOVER- Health. Informants stated:

". …organisations complement the Zambia Correctional Service in the provision of legal, Nutritional, spiritual, counselling and advocacy support. Health-care provision, clothing/beddings as well as services aimed at rehabilitation" (KI 14 Cooperating Partner 24-11-17).

Informants revealed that the organisations that provide legal support to the Zambia Correctional Service are PRISCCA, ZLDC and PFF. They stated that PRISCCA and PFF have been offering legal aid to inmates, training para-legal and sensitising prisoners' on their rights so as to facilitate case processes. They added that ZLDC provides legal services and deals with regulations and related legislation. They concluded that these organisations provide legal services simultaneously as there are a lot of inmates seeking legal advice. An Informant remarked:

"……ZLDC is currently reviewing the Parole Rules and Community Service Regulations" (KI 12 Cooperation Partner 29-11-17).

Informants stated that Nutrition is very important in maintaining good health. They further stated that cooperating partners rendering nutritional support to the Zambia Correctional Service are UBUMI, PRISCCA and CELIM. They render support to ART and TB patients, children and other inmates with special diets. An informant further elaborated that UBUMI, PRISCCA and CELIM were

offering nutritional support in Chimbokaila, Chipata and Mukobeko group of prisons and that CELIM was in seven correctional centres.

Informants revealed that the content on inmates' health that is provided for in the legal documents can only be implemented by a stakeholder who understands and own the content. Therefore, they indicated that UNODC and VSO have been running workshops sensitising on the legal document. They added that UNODC and VSO launched a Joint Regional Programme on understanding the need to improve policy and service delivery so that we improve the rights of prison populations in Zambia. Furthermore, CIDRZ, IN BUT FREE, USAID DISCOVER-Health and UNODC collaborated in strengthening the Zambia Correctional Service Training School curriculum. CIDRZ and IN NUT FREE funded the activity while USAID DISCOVER-Health and UNODC provided technical support. They also stated that ZLDC was collaborating with UNODC and CIDRZ in facilitating and funding the review of the Zambia Correctional Service Regulations that was supposed to take place. UNODC was going to fund the activity and ZLDC was going to facilitate the process while CIDRZ was going to participate. One informant stated the following:

> *"…cooperating partners have been sensitising on legal documents so that they can be appreciated by officers and inmates..." (KI 06 Cooperating Partner 22-02-18).*

Some informants pointed out that education has been known to turn around life-enhancing attributes in individuals while religion is the one value that remains constant in a person's life. In the quest to ensure rehabilitation is achieved, some informants revealed that PFF has been offering religious programmes, CDC, USAID DISCOVER- Health and CIDRZ have been offering support that is aimed at imparting health-related knowledge while UNODC and CELIM have been offering educational and skills training material. This is what informants had to say:

> *"…PFF, UNODC, CDC, USAID DISCOVER- Health and CIDRZ have been supporting rehabilitation activities in Zambia Correctional Service. These organisations sometimes co-fund activities..." (KI 07 Cooperating Partner 21-02-18).*

To ensure the health of inmates is well taken care of, informants stated that the Zambia Correctional Service efforts are complemented by cooperating partners such as UNODC that has been offering capacity building, VSO has been ensuring smooth reintegration of ex-offenders, USAID DISCOVER–Health has been providing access to HIV, family planning and mother-and-child health services, CELIM has been providing quality health assistance to prisoners in targeted prisons, MoH provides drugs, CDC, UBUMI, IN BUT FREE and CIDRZ equally help to ensure good health. Below is what an informant stated:

> *"…UNODC, VSO, USAID DISCOVER –Health, CELIM, CDC, UBUMI, IN BUT FREE and CIDRZ have been supporting good health in the Zambia Correctional Service" (KI 04 Zambia Correctional Services 07-12-17).*

Some informants concluded that there were also cooperating partners who have been advocating for increased funding for the Zambia Correctional Service (ZCS). They indicated that in 2013, CIDRZ and UNODC co-sponsored two high-level meetings where they brought parliamentarians together to solicit for increased funding to ZCS. UNODC provided DSA while CIDRZ paid fuel refund. They added that this activity resulted in an increase in funding to ZCS that also improved nutrition. In the same year, ZPS, MOH, MCDMCH with support from CIDRZ embarked on an ambitious 3-year prisons health system strengthening programme.

CHAPTER 5: DISCUSSION

This paper has analysed the legal provisions and policy framework that deal with health for inmates and how they are implemented. It scrutinised the existing legislation on inmates' health and how it finally benefits the inmates. This was done by trying to understand the policy content, process, context and Actors. The study results showed overcrowding, fragmented policies, resource inadequacies, economic environment, lack of coordination and awareness of key stakeholder's responsibilities as barriers to the translation of the law on inmates' health. Most of the findings from this study are consistent with findings from prison health studies done in Zambia (Topp *et al*., 2016; Topp *et al*. 2016 ; Todrys *et al*. 2011; Maggard, 2015) as they are all indicating that despite the existing legislation on inmates' health, translation has been a challenge. Therefore, the discussion follows the policy triangle theme.

5.1 Content

Internationally, inmates' health has been declared as a State responsibility and the inmate is expected to access health-care equivalent to that of the community (UNODC, 2015). Sub-Sahara African countries are also taking the same directions (Todrys *et al*., 2011; Topp *et al*., 2016). It is for this reason that most African countries have subscribed to international bodies that prescribe the health minimum standards for an inmate (UNODC, 2015). Apart from international bodies, analysis of national legal documents on health revealed that akin finding by Topp *et al*., (2016), Zambia has provided for inmates' health in legal documents such as the Acts, policies and strategies. However, it was revealed that the content in some of the documents had gaps (Zulu *et al*., 2013). For example, the Prisons Act needs to be reviewed too, inter-alia, address a provision that requires the Officer-in-Charge to decide when an inmate should go to the Hospital/Clinic (Government of Zambia, 2004) and the Act needs to provide for inmates on a special diet. To emphasise how cardinal prison health is Fyodor Dostoevsky in Carpenter (2014) stated that the degree of civilisation in a society can be seen by how the inmates are looked after. This means that the effort that is exerted to have a healthy community should also be applicable to correctional centres because all efforts would be meaningless unless inmates are

also included. Therefore, public health specialists should ensure that policies respond to inmates' health needs.

Some strategies such as the Zambia Correctional Health Strategic Plan (ZPSHSP) were not informed by the National Health Strategic Plan and the Seventh National Development Plan because, during formulation of the ZPSHSP, the two documents had expired. Therefore, the ZPSHSP has not addressed some issues contained in the two documents (ShareII, 2015-2019). Additionally, international legal documents have not been domesticated. Similar to the findings by Shiffman (2007) who attributed policy success to interaction of actors and process, this study showed that the existing gap was attributed to, inter-alia; lack of stakeholders involved in the formulation and knowledge of laws on inmate's health-care, delayed court hearings, lack of correctional training at ZCS Training School, prioritising the general public at the expense of inmates. Similar to findings by Mukanu *et al.*, (2016), the identified gap in this study makes implementation difficult, therefore, the gap needs to be addressed so as to ensure the inmates' smooth access to health-care and international provisions need to be domesticated to tailor them to the local needs. Nevertheless, the review of the national legal provisions have some positive attributes that reflect international recommendations (Zulu *et al.*, 2013), these include among others, provision for a balanced diet and doctors' visit to correctional centres.

5.2 Process

5.2.1 Stakeholders Involvement in Formulation and Knowledge of Laws on Inmate's Health-Care

During the formulation of any legal provision, it is vital to involve all necessary stakeholders because it determines the success of implementation. This is supported by Gilson and WHO (2012) who stated that actors are critical to the success of public health policies.

The content of the legal documents on inmates' health is attractive with a lot of positive provisions but implementation has been a challenge because these legal provisions were formulated using the top-down approach than the democratic preferred bottom-up (deLeon, 2002). Additionally, this study showed that laws

surrounding inmates' health are not well known and understood by some of the key stakeholders, consequently, they are not fully utilised and appreciated. For example, the Prison Act talks about inmate's health being the responsibility of the Ministry of Health (ROZ, 2004) yet it is not known by most health workers outside the Zambia Correctional Service. This is unfortunate because, during the formulation and review of this document, MoH was not one of the major key stakeholders. This could have affected ownership of the Prisons Act by MoH and consequently, overall implementation of the Act. This is in line with Mukanu *et al*., (2016) and Zulu *et al*., (2013) in their analysis of government's health policy response to non-communicable diseases in Zambia and the development process of the community health worker strategy in Zambia respectively. This can also be applied to inmates who according to the informants were not consulted during the formation of the Prisons Act.

The alluded to lack of involvement of inmates who are one of the key stakeholders in the formulation of legal provisions for inmates was cited as one of the reasons that inmate's health-care needs have not been met in the Zambia Correctional Service (ibid).

Furthermore, informants expressed how the formation of legal provisions should start from bottom to top. They added that inmates, as well as officers, need to participate in the formulation of the aforesaid provisions and once the document is out, it is supposed to be disseminated to them as well so that they are able to read and understand what is in the document (Koduah *et al*., 2015; Zulu *et al*., 2013; Mukanu *et al*., 2017). They further stated that this is the only way inmates can understand the gaps and demand for what they are entitled to.

The importance of stakeholder participation is shown by Etiaba's (2015) findings that revealed that the Oral Health Policy was a success because all the key stakeholders where involved in the policy formulation process. The level at which stakeholders participate also matters and affects ownership. Therefore, attention should be paid to the extent of key stakeholder participation or else efficiency and effectiveness in implementation is affected. This is supported by Walt and Gilson (1994) who state that focus on the content of policy neglecting the other proportions of the process such as actors and context can make the

difference between effective and ineffective policy choice and implementation (Agyepong and Adjei, 2008).

Additionally, as Romdhane (2004) emphasises, the importance of sensitisation, this study findings showed that if vigorous sensitisation was embarked on after using top-down approach and not consulting key stakeholders, the implementation of the law on inmates' health would have not been much of a problem. They further noted that Zambia has about 70 per cent of the population leaving in poverty meaning most of these people are illiterate and they only want prisoners to be punished. These need to be sensitised so that they see the value of rehabilitation that reduces the prison population and helps inmates to know their basic rights, in particular, right to health so they can claim it and hold people accountable.

5.2.2 Delayed Court Hearing

During the process of the implementation of the content of the legal provision on inmate health, the study has revealed that one of the strategies that the Zambia Correctional Service is using is building more correctional centres. This is in an effort to reduce the spread of diseases that result from overcrowding (Habeenzu *et al.*, 2007; Stern, 2001). Some informants stated that they applaud the government for building more prisons to reduce congestion that is notorious for spreading diseases but it is not a complete panacea to the problem. They added that the new prisons will be filled up so long as other criminal justice systems do not address the critical role they play in congesting the correctional centres. Therefore, this study suggested as did Topp *et al.*, (2016), that there is need for a holistic approach that will engage other stakeholders such as the Police, Drug Enforcement Commission and the Ministry of Justice.

5.2.3 Lack of Correctional Training at ZCS Training School

It was revealed by informants that in the process of trying to implement and align with international standards of prison care and translate the law accordingly, the Constitution was amended to change Zambia Prisons to Zambia Correctional Service (Topp *et al.*, 2016). This move was highly praised but not as easy as a lot of changes in the service have to take place to leave up to the

correctional service. The study found that the curriculum at the Zambia Correctional Service training school had not changed to training officers in evidence-based corrections and how to respect inmates' rights that included the right to health (Listwan *et al.*, 2006, MacKenzie, 2000). The Prisons Act also needs to be amended so that a person without a medical background should not be the one to decide whether a prisoner should seek medical attention or not.

5.2.5 Accountability and Reporting on Inmates Health

This study further showed that there is a lack of accountability by people responsible for ensuring the implementation of the legal provision on inmates' health is taking place (Brinkerhoff, 2004). The Zambia Correctional Service does not answer to the Ministry of Health about activities to do with the health of inmates. Moreover, the study revealed that the Zambia Correctional Service Officers often want to give a positive report even when the health condition is not good. This makes the superiors to give a false report on the health condition of inmates, therefore, making the Minister think all is well (Ferguson and Malouff, 2016). Therefore, the study suggested that there is need for a system that will ensure that there is monitoring and evaluation and reporting is done according to the true situation on the ground.

5.2.6 Strength of Some Legal Documents

Informants reported that the formation of some documents such as the Zambia Prison Health Strategic Plan (ZCHSP) was very consultative (Crase *et al*., 2005, Gauthier *et al*., 2011). They expressed how the process was inclusive and representative. The robust engagement of offenders during the formulation of the ZCHSP might enable it to be successfully implemented because key stakeholders will own the documents and ensure its success. The only problem it might face is missing some important action plans that are captured in the National Health Policy, the National Health Strategic Plan and the Sixth National Development Plan because it was formulated when all these documents had expired.

5.3 Context

This study analysed the political, economic, social or cultural factors, both national and international which have been affecting translation of the legal provisions that exist on inmates' health (May *et al.*, 2014). The study found out the approach that was used in the formulation of the Legislative Acts and policy and how they have influenced implementation. Community attitude towards inmates and how it affects the implementation of the Legislative Acts and policy was assessed. Furthermore, the external factors such as international bodies, among others, Mandela Rules, were also assessed (UNODC, 2015). The analysis of the context alluded to showed the following; favourable political environment, lack of implementation of the law on community sentencing, resource inadequacies, Open Door Policy, inequalities in public health care delivery, lack of accountability, no strong Inter-Ministerial Collaboration and overcrowding have negatively affected the implementation of legal provisions on inmates' health as expounded below.

5.3.1 Lack of Implementation of the Law on Community Sentencing

Overcrowding is one of the hurdles to the effective implementation of the legal provision on inmates' health. Therefore, this study revealed that there is a need to reduce overcrowding by measures such as non-custodial sentencing options. The study findings were similar to those by Todrys *et al.*, (2011) that stated that non-custodial sentencing is provided in the law but not utilised because of the lack of personnel to supervise those sentenced on such. Therefore, the study suggested that there is a need to utilise the law on community sentencing.

5.3.2 Inequalities in Public Health Care Delivery

It is imperative for every citizen to have access to adequate health services that is of acceptable quality in order to achieve universal health coverage (Mills, 2012). Inmates, in terms of health, should not be looked at as prisoners but as patients. The study reported that sick inmates were being treated differently from patients in the general community. This is tandem with findings by Phiri and Ataguba (2014). Furthermore, informants reported that just like any other patient, if an inmate is sick, they need to be treated the way a person who is not in a correctional facility is treated (Elger, 2008). One of the factors that this

study attributed inequality of treatment of sick inmates to be, was the lack of officers' training and knowledge.

However, this study commended the Mandela Rules that does not focus on inmates solely, but staff as well. Mandela Rules have made some Cooperating Partners to change their programming to concentrate on the Zambia Correctional Service staff as well. Cooperating Partners have been holding training to unpack the Mandela Rules so that they are understood and correctional staff become aware of their rights and as well as inmates' rights (UNODC, 2015). They further noted that these training had made staff realise that inmates' health and their health were inter-dependent. They hope this will break the barrier of translation of the law on the equivalence of care for inmates as that of the general community (Lines, 2006).

5.3.3 Resource Inadequacies

In relation to resources, this study findings like previous studies revealed that there was inadequate funding to implement strategies and guidelines on inmates' health (Maggard, 2015; Topp, 2016; Todrys, 2011). The study further showed that the health directorate in ZCS is not funded, therefore, it has been difficult to discharge the required health services to inmates efficiently and effectively. They depend on other vaults to carry out activities and provide health services to inmates.

Findings also attributed insufficient correctional health centres at the Zambia Correctional Service to inadequate resources. In tandem with the findings by Topp *et al*., (2018) this study suggested that inadequate health centres (25 health centres with clinics out of the 88 correctional centres) were also a barrier to translation of the law on inmate's health. Few health centres means inmates' access to health is limited because of transport and manpower challenges to take them to the nearest clinic or hospital. This implies that the well-documented laws on inmates/prisoners access to health to be like that of the general population will just be on paper (Elger *et al*., 2008; Lines, 2006).

Furthermore, the understaffing of health personnel in prisons is experienced in a lot of countries (Finn, 2000). Zambia has not been spared from this problem.

The study showed that this was due to inadequate funding. Findings from this study revealed that the Zambia Correctional Service only has 88 nurses against a population of about 21, 200 which excludes correctional staff and when correctional staff are added the population is 25-26 thousand (Topp *et al*., 2016). This is similar to the study by Nicholas (2012) that reported inadequate health-care provision in correctional facilities due to understaffing and severe overcrowding.

Finally, resources are dependent on the economic performance of a country. Zambia is one of the African countries that are not doing well economically (York, 2018). The study reported that resources are never adequate and there are various competing needs that usually supersede inmates' health-care demands especially with the fact that access to the health index is still below internationally accepted levels in Zambia (Stiftung, 2018).

5.3.4 Political Environment

Political will is cardinal to the successful implementation of legal provisions, this is evidenced by Etiaba *et al*., (2015) findings that recognised political will as one of the reasons the Oral Health Policy was actualised in Nigeria. Correspondingly, this study showed a favourable political environment in which the Act could have easily been implemented. As alluded to above, this was evidenced by the President assenting to the Constitution on 5January 2016 that changed the name from prisons and the retributive modal to a correctional modal (the Republic of Zambia, 2016). This change opened doors for many more Civil Society Organisations and interested groups, but the implementation of inmate's health legal provision had been slow. Some informants claimed that it could be because one of the key stakeholder, the Ministry of Health has no deliberate strategies that specifically benefit inmates, instead, the activities are targeted at all citizens.

The findings also suggested that the Zambia Correctional Service needs to open the doors more than they are, especially after the amendment of the Constitution alluded to earlier. This is the best way to collaborate in solving health problems in the Correctional Facilities (Orr, 1978).

5.3.5 No strong Inter-Ministerial Collaboration

In consistence with Mukanu's (2016) study results that showed that inter-sectoral collaboration is cardinal in policy formulation process, this study added that translation of law on inmates health is interlinked with other ministries such as the Ministry of Justice and others in the Criminal Justice System. For example, attempt to eradicate Tuberculosis (TB) as stated in the Prisons Act is being made by cooperating partners and implementers (ZCS), but as is the case, all offences even misdemeanour ones end up in correctional facilities causing overcrowding that hastens the spread of TB. Additionally, delay of cases and mishandling of cases by police prosecutors also makes remands to overstay in correctional centre, therefore, contributing to overcrowding.

5.3.6 Overcrowding

Overcrowding in prisons continues to rise, often without a parallel increase in space available and has a negative impact on health care (Warmsley, 2005). With overcrowding, it means that airborne and diarrhoea diseases are difficult to control. Informants in this study cited overcrowding as one of the major hurdles in controlling disease and implementing what the Act states on a prisoner's health. The aforesaid findings are akin Topp *et al*., (2016) finding that confirmed high rates of overcrowding with associated negative effects on both inmates' and officers' physical and mental health.

According to informants, the government in conjunction with stakeholders are in the process of building modern correctional facilities which will have a higher holding capacity. They further added that this will not be a solution to overcrowding that affects implementation of policies that deal with inmates health because without proper rehabilitation, inmates will keep re-offending hence increasing the correctional facilities population (Clark, 1994).

The informants suggested policies and strategies that will support correctional programmes especially following the transformation from punitive to Zambia Correctional Services after His Excellence, President Lungu assented to the constitution in 2016 (Republic of Zambia, 2016). The correctional programmes

will reduce re-offending which will mean a reduction in overcrowding that will enable strategies to address inmate's health to be implemented successfully.

5.4 Policy Actors

In order to provide health-care to inmates, the Zambia Correctional Service has been working in collaboration with cooperating partners (Topp, 2016; Todrys, 2011). These collaborating partners formed a platform which used to be called Prisons AIDS Advisory Committee (PAAC) but was rebranded not just to look at AIDS but health in totality hence the change to Prisons Health Advisory Committee (PHAC). This is where all the partners that are supporting the prisoner's health in whatever aspect come together with the correctional service to discuss how services are going to be provided in the correctional facilities (ShareII, 2015-2019). Unfortunately, it emerged from informants that the platforms' full potential is not tapped due to lack of funding and it has no legal backing.

According to the findings, the Ministry of Health (MoH) is charged with the responsibility for health for all, therefore, the Ministry is expected to take up the supervisory role. They added that they expect MoH to take the first step in collaborating with the Zambia Correctional Service (ZCS) not vice-versa as the status quo is (Lines, 2006).

Informants revealed that cooperating partners had done a lot and made a lot of effort to address the health problems in correctional facilities/prisons. They further noted that to achieve what is prescribed in the legal documents and policy on inmates' health, stakeholders had been providing different services such as; comprehensive care, legal and, nutritional support, sensitisation on the available guidelines, education, spiritual support, counselling, hygiene, and health-care. The active partners providing the mentioned support are; VSO, CELIM, CIDRZ, UNODC, USAID DISCOVER-Health, PRISCCA, PFF, ZLDC, IN BUT FREE and UBUMI.

Overall, this study is in agreement with the study by Agyepong and Adjei (2008) which concluded that the complex interactions of context with actors and

processes including political power have effects on agenda setting, decision making and policy and programme content.

5.5 Limitations

Note that the author declared an interest as she is an employee at the institution under study. To this effect, intense guidance was sought from independent ethics experts during the formulation of the interview guide and a research assistant was engaged to neutralise the interviews. This type of bias is called Reflexivity. The author was aware of such biases, values, and experiences that the study would encounter due to reflexivity (Hammersley and Atkinson, 1995). Therefore, the study design had a reflexive journal where the researcher was logging the details of how she influenced the results of each interview (Roller, 2012).

Conversely, some of the key informants were responsible for policy implementation and some wanted to defend their profession, therefore, there was some bias in giving information on the formulation of policies and other legal and non-legal documents that are supposed to be translated and enhance the health of inmates in correctional centres. Some health professionals expressed how fair they were in the treatment of inmates and how fair all other health professionals were when it came to treatment of inmate, while others felt otherwise. This bias was countered by stakeholders who were not directly responsible for the implementation of these documents but were knowledgeable and other key stakeholders who were directly involved in the inmate's health but were not health professionals.

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study was guided by the policy triangle framework and study has shown that both local and international legal documents have provided for inmates' health. The approach used in the formulation of these documents was found to be top-down apart from the Zambia Prisons Health Strategic Plan (ZPHSP). On the downside, the ZPHSP was formulated when the cardinal legal documents the Seventh National Development Plan and the National Health Strategic Plan had expired. Most of the key stakeholders were not involved in the formulation process and it is for this reason the study revealed that most of the key stakeholders did not own the documents and were not aware of the content. To this effect, the study revealed that the process of implementation has been a challenge because it is the same stakeholders that are ignorant and lack ownership that are expected to implement the legal provision on inmates' health. Furthermore, the study found that the context in which the legal provisions on inmates' health are supposed to be implemented are not conducive. Firstly, the economic situation is not good which makes inmates' health needs to come second to that of the community, health personnel are not adequate to take care of inmates' health needs and not all correctional centres have health facilities within.

Secondly, the community that the inmate returns to is not sensitised on accepting and helping an ex-inmate with health issues. The only favourable contextual factor according to this study is political will that prevails. The study has also revealed that although there is political will, the implementation is mainly left to the Zambia Correctional Service whose mandate is not to provide health but to only supplement the Ministry of Health. Evidence from this study has also shown that implementing health intervention is a challenge due to the lack of resources and capacity within the Zambia Correctional Service. There is also a need to domesticate international frameworks on inmates' health to match the resources and capacities in the local context if the implementation is to be practical and measurable.

6.2 Recommendations

Below are the recommendations on the translation of laws on inmates' health in Zambia arising from the study:

6.1.1 Zambia Correctional Service

i. Zambia Correctional Service (ZCS) needs to ensure that the process of domesticating international guidelines is commenced and should do it adequately.
ii. Zambia Correctional Service (ZCS) needs to engage more with MOH and other key stakeholders.
iii. Zambia Correctional Service should facilitate amendment of old legislation.
iv. Zambia Correctional Service needs to come up with its own policy.

6.1.2 Ministry of Health

i. Currently, the National Health Policy mentions key population but does not specify inmates' health, therefore, the Ministry of Health should consider expanding on inmate's health policy and other guidelines.
ii. Ministry of Health needs to take up the upper role of facilitating health-care provision for inmates'. It needs to make a deliberate effort to visit prisons not only when approached. This will only be possible if they come up with guidelines for their staff on health provision for inmates. This means they need to mainstream inmates' health in the Ministry of Health.
iii. Ministry of Health should monitor and evaluate health provision by the Zambia Correctional Health Personnel.
iv. Ministry of Health should come up with policies that will provide for a group of nurses and doctors to be carrying out visitations to correctional facilities than inmates to be taken to the hospital which requires manpower and transport.
v. The Ministry of Health should consider allocating resources to building health facilities in all Zambia Correctional Centres.

6.1.3 Zambia Correctional Service and Ministry of Health

i. There is need to carry out vigorous sensitisation on inmates and their right to health-care, most Zambians are ignorant of the law.

ii. They should ensure that the Prison Health Advisory Committee's full potential is realised by supporting it financially and legalising it.
iii. Outside clinic and hospitals to be only used as referrals.

6.1.4 Cooperating Partners

i. Cooperating Partners need to help the Zambia Correctional Service and the Ministry of Health to monitor and evaluate health provision for inmates.
ii. Health provision for inmates should be more coordinated and should ensure the PHAC is financed and advocate for it to be made legal.

6.1.5 Political Will

i. Political will should continue but there is need to show more commitment by supporting the implementation of legal provisions for inmates by allocating sufficient resources required for effective and efficient implementation

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APPENDICES

Appendix 1: Information Sheet

THE UNIVERSITY OF ZAMBIA: SCHOOL OF PUBLIC HEALTH

Study title: Barriers to the translation of the legislative Acts that deal with health for inmates in correctional facilities.

Principle investigator: Elizabeth K. Muchinda

Introduction: You have been purposively selected to participate in my study with the above title, therefore, am requesting for your participation. But before participating, I would like to explain to you the purpose of the study, why you were picked, procedure, risks/discomforts, benefits, payment, protecting data confidentiality, what happens if you leave the study and who you can call when you have questions.

Purpose of the Research Project

I am a Master of Public Health student at the University of Zambia. I am carrying out a qualitative case study research to examine the barriers to translation of the legislative Acts and policies that deal with health for inmates in correctional facilities. This will involve interviewing participants from the Ministry of Health, the Ministry of Home Affairs, Prisons Care and Counselling Association (PRISCCA), Centre for Infectious Disease Research in Zambia (CIDRZ), United Nations Office on Drugs Crime (UNODC) and USAID DISCOVER-Health with knowledge of the legislative acts and policies that address prisoner's health and how they are translated. Furthermore, I will ask how Legislative Acts and policies were formulated so that I can understand why there are barriers to the translation of these documents to benefit inmates in correctional facilities.

The results of this study will be shared with the participants and the public in general. This study will help understand where the hurdle is in the translation of the law and policies and this will be useful for the policy makers to ensure that the health of inmates are taking care of as that of the general public.

Why you are being asked to participate

I am interviewing participants with knowledge of the acts and policies that are supposed to address prisoners health and health practitioners who are directly involved in taking care of prisoners. This is so because those who are knowledgeable about policies will give me information as to what acts and policies address the prisoner's health and how they were formulated. The health practitioners will tell me what they know about policies pertaining to prisoners and what their perceptions are about treating prisoners.

In a nutshell, you have been invited to take part in this research because you are in a necessary office with cardinal information for this study.

Procedure after you agree to take part in this study

After you have had all your questions answered and feel you understand what you will have to do, you will be asked to sign on a consent form. You are not obliged to have someone present. You will then be given a number which is unique to you and will ensure that your answers remain private. The interview will take about one (1) hour, it will be taken in a private place which if you prefer can be in your office. If you permit us we will tape record the interviews to help capture all that you will say, if not, I will ask if writing notes of the interview will be ok. The information from the take or notes will be typed in full to help us understand what you will say but your name will not be included in any of the documents.

Risks/discomforts

We do not expect you to have any problems in participation in this study although you might find some questions sensitive. However, this should not worry you as the anonymity of participants' record files will be maintained by not using names but instead, codes or unique identification numbers will be used on data which will be collected. The information will be kept on a laptop and no unauthorised persons will have access to the data and information. Furthermore, names and positions will be withheld, that is, when writing the report you will not be identified by your profession, for example, stating what the doctor or permanent secretary said.

Benefits

There are no direct benefits to you in participating in this study. However, by taking part in this study you will have contributed to the body of knowledge in the development of the research towards improving the quality of health care in correctional facilities by in investigating the barriers to translation of legislative acts and policies that deal with health for inmates.

Payment

There is no enumeration of any kind in participating in this research

Protecting data confidentiality

All information collected in this study will be taken as highly confidential and used only for research purposes. It will be locked in a safe place and your identity will not be reviewed under any circumstance.

What happens if I leave the study?

Your participation is completely voluntary. It is up to you to decide whether you want to be in this study or not, and you are free not to answer any question you are not comfortable with. You can also withdraw from the study at any time without any consequences.

Who do I call if I have questions?

Call the principal investigator, Elizabeth K. Muchinda

Cell: +260-976086471; Email: ingrafufu@yahoo.com OR ekmafonko@gmail.com

The Chairperson, the University of Zambia Biomedical Research Ethics Committee, P.O Box, 50110, Lusaka. **Tel: +260-1-256067**

What does your signature or mark on this consent form mean?

- You have been informed about the project's purpose, procedure and possible benefits and risks.
- You have been given the chance to ask questions before signing.
- You have voluntarily agreed to take part in this study.

Appendix 2: Consent Form

The purpose of this study has been explained to me and I understand the purpose why I have been picked, the benefits, procedure, risks/discomforts and confidentiality of the study. I further understand that if I agree to take part in this study, I can withdraw at any time without having to give an explanation and taking part in this study is purely voluntary. I also understand that I am free not to answer any questions that I may feel uncomfortable with, personal or otherwise.

I………………………………………………………………………… (Names)

Agree to take part in this study designed to investigate barriers to translation of the legislative acts that deal with health for inmates in correctional facilities.

Signed……………………………….Date………………………… (Participant)

Signed……………………………… Date…………………………… (Witness)

For more information you may contact;

The principal investigator Elizabeth K. Muchinda on Cell: +260976086471 or Email: ingrafufu@yahoo.com / ekmafonko@gmail OR

The Chairperson, the University of Zambia Biomedical Research Ethics Committee, P.O Box, 50110, Lusaka. Tel: +260-1-256067

Appendix 3: Key Informant Interview Guides

i. Interview guide for ministries and cooperating partners

Research title: Barriers to the translation of the legislative acts that deal with health for inmates in correctional facilities.

Organisation:____

Position in the organisation:_________________________________

Date of interview:____

Introductory information

I want to thank you for taking the time to meet with me today. My name is Elizabeth K. Muchinda Mafonko. I am pursuing a Master of Public Health majoring in Health Policy at the University of Zambia, Ridgeway Campus. This research is a prerequisite to the completion of my programme. My study is as titled above. I would like to interview you about your experiences and knowledge about the law, policies and strategies that address inmate/prisoners health. The research has been approved by the University of Zambia Biomedical Research Ethics Committee. With your permission, the interview will be recorded.

OBJECTIVES	MAIN QUESTIONS	FOLLOW-UP QUESTIONS
1. To review the extent to which content of the legislative Acts and health policies address the health needs of inmates in correctional facilities.	-What do you think about the existing law pertaining to a prisoner's health? - What do you think about the existing Policy pertaining to a prisoner's health? - What are the contents of these acts and policies that talk about prisoner's health -Do you think they adequately address inmate/prisoners health needs?	-Do you think they are being implemented accordingly? -What has been your experience in implementing these laws and policies? -What guidelines are prepared by the Ministry of Home Affairs /Zambia Correctional Services and Ministry of Health to translate legislation on inmate's health into organizational policy?
2. To assess the process of translation of Legislative Acts and health policies in the delivery of health services in correctional facilities.	-Do you have an idea of how these laws, policies and strategies were formulated? -How do you operationalize legislation? How are budget line items made?	-In the formulation of these laws and policies what do you think were the strengths and weakness at the different levels of formulation? -What advice would you give if you were given a chance to advise on the policy formulation process?
3. To explore the context in which the Legislative Acts and policies are translated to meet the health needs of inmates in correctional facilities.	-What resources from non-governmental partners/ actors are brought to facility inmates' healthcare? -What factors influence the development of policies and laws?	-How does the government coordinate this process?
4. To investigate the nature of collaboration among the key actors involved in prisoners health services.	-Which organizations do you involve in planning for inmates? -Can you mention who you think were the key players in the formulation of the policy and the Acts pertaining to prisoner's health? -Do you coordinate with stakeholders on issues to do with prisoner's health?	-What measures have you put in place to ensure that there is a collaboration with stakeholders? -What role did each key player have at different stages of policy and act formulation and who were the key influencers. -How often do you meet with stakeholders to plan for inmates/prisoner health? -What kind of laws, policies and strategies would you suggest that can ensure equivalence of healthcare access?

ii. Interview guide for health professionals

Research title: **Barriers to the translation of the legislative acts that deal with health for inmates in correctional facilities**

Organisation:____

Position in the organisation:___________________________________

Date of interview:____

Introductory information

I want to thank you for taking the time to meet with me today. My name is Elizabeth K. Muchinda Mafonko. I am pursuing a Master of Public Health majoring in Health Policy at the University of Zambia, Ridgeway Campus. This research is a prerequisite to the completion of my programme. My study is as titled above. I would like to interview you about your experiences and knowledge about the law, policies and strategies that address inmate/prisoners health. The research has been approved by the University of Zambia Biomedical Research Ethics Committee. With your permission, the interview will be recorded.

OBJECTIVES	MAIN QUESTIONS	FOLLOW-UP QUESTIONS
1. To review the extent to which content of the Legislative Acts and health policies address the health needs of inmates in correctional facilities	-What do you think about the existing law and policy pertaining to a prisoner's health? -What is the content of these acts and policies that talk about prisoner's health? Doesn't have to be exactly as stated in the document? -Do you think they adequately address inmate/prisoners health needs?	-Do you think they are being implemented accordingly? -What has been your experience in implementing these laws and policies? -What specific strategy or guidelines has the government put in place to ensure that the disease burden in correctional facilities is reduced?
2. To assess the process of translation of Legislative Acts and health policies in the delivery of health services in correctional facilities. 3. To explore the context in which the Legislative Acts and policies are translated to meet the health needs of inmates in correctional facilities. 4. To investigate the nature of collaboration among the key actors involved in prisoners health services	-Do you have an idea of how these laws, policies and strategies were formulated? -How often are you in contact with inmates? -What factors influenced the development of these policies and laws? -What factors influenced the implementation of these policies and laws? -How often are you invited to participate in planning for inmate's health-care? How do you feel about providing health-care for inmates? -Can you mention who you think were the key players in the formulation of the policy and the Acts pertaining to prisoner's health?	-Do you think there is any difference between a patient from the correctional facility and a patient from the general population inmate? -Do you see it necessary for inmates/prisoners to have access to health equivalent to that of the community as stated by international bodies that Zambia is a signatory to? -What kind of laws, policies and strategies would you suggest can ensure equivalence of healthcare access? -Who do you think should be lead influencers in the process of formulating inmate's health policy?

Appendix 4: Data extraction matrix for document review

Summary of Inmate/Prisoner health relevant policy/Act:	
Source Document:	
Background Information on the source document:	
Regulatory body/Department/Agency:	
Regulation/Statutory Instrument:	
Actors	
Context	
Process	
Content	