Participation in decision-making within prison settings as a tool for enhancing the enjoyment of the right to health: The case of women inmates in Zambia

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DECLARATION

I, Chipo Mushota Nkhata, hereby declare that the work on which this thesis is based is my original work (except where acknowledgments indicate otherwise) and that neither the whole work nor any part of it has been, is being or is to be submitted for another degree in this or any other university. I authorize the University to reproduce for the purposes of research either the whole or any portion of the contents in any manner whatsoever.

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ABSTRACT

The number of women inmates is growing exponentially globally, with sub-Saharan Africa experiencing an annual growth rate in the prison population of 22%. Many correctional facilities and prisons were not designed or built with women in mind. This has seen women excluded in many aspects of correctional and penal systems including in correctional health systems. The situation is no different for Zambian women inmates who have limited access to health facilities, goods, services, and programmes. Women inmates in Zambia have one of the lowest citizenship status' in the country owing to the multiple levels of discrimination that they experience including discrimination based on their gender and their legal status as inmates. For many years, women inmates were rendered invisible in the Zambian correctional and penal system and in the general population and treated as non-existent. The growing recognition of women's rights, the paradigm shifts from punitive to a hybrid of a punitive and correctional system, and the growing involvement of citizens in governance in Zambia, present an opportunity to re-evaluate the situation of women inmates and put in place measures that effectively integrate them as full members of the Zambian society, entitled to enjoy fundamental rights and freedoms such as health and citizenship.

This thesis sets out to establish whether participation in health-related decision-making and programmes by women inmates would enhance their enjoyment of the right to health. Existing literature shows that citizenship participation is an appropriate vehicle for fostering citizens' effective participation in governance for the attainment of their rights and interests. While most interventions focus on citizenship participation as a political tool, I leverage the argument that citizenship participation is equally useful in advancing social rights and interests such as health. I use a qualitative research methodology to engage key stakeholders such as women inmates, their representative institutions, and governmental and quasi-governmental institutions to ascertain the desirability and feasibility of using the citizenship participation model to enhance women inmates' health rights. This methodology is also used to ascertain the role of the Zambian regulatory framework in realising such participation.

Many study respondents in this study stated that women inmates' participation in health-related decision-making and programmes is cardinal to the realisation of their right to health as envisaged under international and human rights frameworks. However, for women inmates to participate effectively in health governance, I argue that it is necessary to employ a model to

citizenship participation that ensures their effective integration in health governance systems of the Zambia Correctional Service. Through the study respondents' views, I establish that traditional approaches to governance, including the rights-based and feminist approaches offer an entry point for women inmates' participation in health governance but are not entirely suitable for responding to their health needs and experiences. To address this gap, I propose a model that I term "a woman-centred citizenship participation model" for health. Through this model, the State should seek to solicit women inmates' effective and active participation in health governance in their correctional centres in Zambia.

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LIST OF ABBREVIATIONS

ACHPR	AFRICAN CHARTER ON HUMAN AND PEOPLE'S RIGHTS
CEDAW	CONVENTION ON THE ELIMINATION OF ALL FORMS OF DISCRIMINATION AGAINST WOMEN
GEEA	GENDER EQUITY AND EQUALITY ACT
ICCPR	INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS
ICESCR	INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS
NGP	NATIONAL GENDER POLICY
NHP	NATIONAL HEALTH POLICY
NMR	NELSON MANDELA RULES
UDHR	UNIVERSAL DECLARATION FOR HUMAN RIGHTS
UNCESCR	UNITED NATIONS COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS
ZCS	ZAMBIA CORRECTIONAL SERVICE
ZCSA	ZAMBIA CORRECTIONAL SERVICE ACT

CONTENTS

CHAPTER ONE

INTRODUCTION

1.0 INTRODUCTION

The aim of this thesis is two-pronged: Firstly, to examine the role of participation of women inmates in health-related decisions for enhancing their enjoyment of the right to health and their health interests. Secondly, to examine how the Zambian regulatory framework can effectively guarantee women inmates' participation in health decisions and programmes. I argue that if women inmates effectively participate in key areas of health governance such as decision-making and shaping of the regulatory framework applicable to correctional settings in Zambia, they would have better access to health goods and services and thus better enjoy their right to health. I further argue that legal guarantees of effective participation of women inmates can create a platform, which enhances the profile of social issues that women inmates experience that prevent them from enjoying their right to health on an equal basis as others in Zambia.

Women inmates in the Zambian correctional facilities are relatively fewer compared to their male counterparts. The Zambian correctional facilities have an official occupancy capacity of 9150.[1] However, they collectively host an estimate of 26 150 occupants.[2] The overcrowding in Zambia's correctional facilities creates a health hazard for inmates. A report by the Human Rights Watch and Prisons Care and Counselling Association shows that overcrowding coupled with other poor living conditions in the Zambian correctional facilities exposes inmates, correctional staff and other prison occupants to serious health risks, most common among them being tuberculosis (TB) and various skin diseases.[3] The report identifies poor sanitation, imbalanced and insufficient food, little or no access to clean and running water as some of the factors contributing to poor living conditions in correctional settings.[4] Efforts by the Zambian Correctional Services (ZCS) to address these problems are negatively affected by four main structural

[1] Republic of Zambia *Prisons and Correctional Centres Audit Report* (2023) vi
[2] Ibid
[3] Human Rights Watch *Report on Zambia: Unjust and unhealthy* (2010) 48
[4] Ibid

factors: inadequate health financing, poor planning and coordination of health-related human resources, weak health governance and old prison structures.[5]

Whereas some of the factors that affect inmates' health are biological, others depend on the inmates' socio-economic status. Inmates in Zambia do not enjoy health rights, at least not to the same extent as the general population in Zambia.[6] This is especially true for women inmates who have limited access to health goods and services including sexual and reproductive health goods and services and services for addressing physical, psychological, and sexual violence.[7] This coupled with the low social status of being an incarcerated woman exacerbate their health-rights violations. The healthcare system and regulatory system applicable to correctional settings in Zambia determine how various social, political and economic positions of inmates, such as gender, age, disability, social origins, geographical location, civic awareness and economic stability impact on the health of inmates. These are referred to as social determinants of health. The World Health Organisation defines social determinants of health as:

> "[T]he conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities.[8]

Michael Marmot et al exemplify the definition of social determinants of health as including a healthcare system, education, income, occupation, place of residence, gender and ethnicity.[9] The healthcare system in Zambian correctional settings disproportionately affect women inmates.[10] Although all inmates in the Zambian context live in dire conditions that negatively impact on their health, women inmates experience challenges differently based on their social and economic factors and therefore require unique responses as shown in chapters 5 and 6 of this thesis. Inmates occupy one of the lowest

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[5] Stephanie M. Topp, Clement N. Moonga, Nkandu Luo, Michael Kaingu, Chisela Chileshe, George Magwende, S. Jody Heymann and German Henostroza 'Mapping the Zambian prison health system: An analysis of key structural determinants.'(2017) 12:7 *Global Public Health* at 858-75

[6] Katherine W Todrys and Joseph J Amon 'Health and human rights of women imprisoned in Zambia' available at *http://www.ncbi.nlm.nih.gov/pmc/articles* accessed on 10 July 2017at 6

[7] Ibid at 6

[8] World Health Oraganisation, www.who.int>sdh_definition accessed on 4th August 2018

[9] Michael Marmot, Sharon Friel , Ruth Bell, AJ Houweling, Sebastian Taylor 'Closing the gap in a generation: Health equity through action on the social determinants of health' (2008) 372 *The Lancet* 1664

[10] Jo Baker and DIGNITY 'Conditions for women in detention in Zambia: Needs, vulnerabilities and good practices' (2015) *DIGNITY Publication series on Torture and Organised Violence Study Number 12* at 40

socio-economic statuses in Zambian society,[11] thereby making them vulnerable to health risks.[12] Marmot et al argue that the lower a person's socioeconomic position, the worse their health is.[13] Similarly, women inmates' low social status often disempowers them from making decisions effectively managing their health.[14]

Interventions aimed at facilitating participation in decision-making for women inmates must consider their heterogeneity and how historical and current social and economic factors in and out of correctional settings impact on their health. The Fourth World Conference on Women-Platform for Action and the Beijing Declaration noted that social and economic factors affect the health of women of all ages, but little is known about "the provision of health services to girls and women and the patterns of their use of such services, and about the value of disease prevention and health promotion programmes for women."[15] It further states that most health research is based on male dominated values and male research participants and the findings are often assumed to also apply to women.[16] These views expressed at the Fourth World Conference on Women attest to the extent of women's exclusion from health research and programmes and/or failure to prioritise women's health interests in health research agendas and activities, a key motivating factor for undertaking this research project.

The ZCS needs to evaluate how the structural factors and the social determinants of health negatively impact on the health of women inmates and implement strategies to address them. The social and economic factors that impact on the health of women inmates can only be properly understood and addressed with the participation of women inmates. Failure to understand and address the social determinants of health for women inmates negatively impacts on the attainment of health equity in correctional settings and the ability to better guarantee health rights for women inmates. The consequence of this is that healthcare systems and the regulatory framework applicable to correctional settings in Zambia maintain the status quo of implementing inequitable health policies and practices

[11] Republic of Zambia Central Statistics Office *Selected Socio-economic Indicators* Report (2015) 2-6 available at www.zamstats.gov.zm accessed on 4th April 2018 at 2
[12] Marmot et al op cit note 9 at 1664
[13] Ibid
[14] Nichola Douglas, Emma Plugge and Ray Fitzpatrick. 'The impact of imprisonment on health: What do women prisoners say?' (2009) 63 *J Epidemiology Community Health* at 749-5
[15] United Nations Platform for Action and Beijing Declaration (1996) at 61
[16] Ibid

to the detriment of women inmates. There is a need for information which not only links the law to lived realities of women inmates, but also demonstrates how the linkages can achieves a specific outcome. My research study seeks to achieve this. The next section provides the context of the research is provided followed by the problem statement, research questions, and research objectives. Thereafter, I discuss the significance of this study and examine the existing literature to show the gaps that my research endeavours to fill.

1.1 RESEARCH CONTEXT

Zambia has a hybrid prison system in which punitive sanctions are implemented alongside correctional services for offenders. This is demonstrated by the existence of stand-alone correctional facilities and facilities that are a hybrid of correctional centres and prison facilities. Thus, in this thesis, reference to '"correctional centres" or "correctional facilities" includes "prisons" and "prison facilities". Similarly, the word "prisoner" is used interchangeably with the words "inmate" or its plural as determined by the context. Zambia has 52 standard correctional centres, 33 open air farm prison facilities and two maximum security prisons which hosted about 26 150 inmates as of May 2023.[17] A 2010 study by Todrys and Amon reveals that there were 250 women inmates in Zambian correctional facilities, representing approximately 1.5 percent of the total prison population.[18] Although there are relatively fewer women inmates in sub-Saharan Africa, they "represent the fastest growing incarcerated population globally and have seen a 22% increase in sub-Saharan prisons since 2000."[19]

Women in correctional settings have the right to the highest attainable standard of physical and mental health, like all other human beings.[20] However, women in Zambian correctional centres have limited access to health goods and services and in some cases do

[17] Republic of Zambia op cit note 1
[18] Todrys and Amon op cit note 6
[19] Stephanie M Topp, Clement N Moonga, Constance Mudenda, Nkandu Luo, Michael Kaingu, Chisela Chileshe, George Magwende, Jody S Heymann and German Henostroza 'Health and healthcare access among Zambia's female prisoners: A health systems analysis' (2017) *International Journal for Equity in Health* at 2
[20] Article 12 of the International Covenant on Economic, Social and Cultural Rights as read together with the Rules 24-35 of the Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and Note (1) of the Preliminary Observations to the United National Rules for the Treatment of Women Prisoners and non-custodial Measures for Women Offenders (the Bangkok Rules).

not enjoy their right to healthcare on an equal basis with others.[21] This can be attributed to a number of reasons discussed below.

Firstly, the Zambian correctional system has historically not fully taken into account the peculiar circumstances and needs of women in correctional centres.[22] The prison infrastructure, which was largely designed in the colonial era, has not responded to the growing numbers and unique needs of women inmates, making it difficult to comply with internationally recognised standards for humane detention as stipulated in the Nelson Mandela Rules. The system was largely designed for men and managed by men and thus tends to exclude women's needs.[23] For example, some correctional facilities which were originally "male-only" facilities now contain makeshift accommodation to house female inmates, but have not been modified to ensure their access to other services, such as health services.[24] One of the social determinants of health for women in prisons is their status as a parent and caregiver. The health of women inmates, particularly mothers incarcerated with their infant children, pregnant mothers and those who have left children and dependents in the general population, is closely related to the health of their children and their dependents. When they are in prison, women inmates worry about how their care-giving roles will be fulfilled. Women inmates experience stress and anxiety over their failure to adequately provide for and protect their children and dependents.[25] Many of the correctional facilities do not provide for the accommodation of pregnant women inmates or children who accompany their mothers to prison for lack of alternative care.[26]

Women inmates also have unique challenges related to their biological makeup that directly impact on their health, including their sexual and reproductive health. The failure to provide clothing, soap, detergent, and sanitary wear to incarcerated women places them at greater physical and psychological health risk. Their susceptibility to violence and abuse from male inmates and correctional officials also puts their physical and psychological health at risk.[27] Women inmates are therefore disproportionately affected by the failure of

[21] Topp et al op cit note 19 at 3
[22] Ibid
[23] Baker and DIGNITY op cit note 10
[24] Ibid
[25] Topp et al op cit note 19 at 11 of 14
[26] Human Rights Commission and Child Justice Forum 2013-2014 Monitoring visits' report on children in prison and police detention facilities in Zambia at 17
[27] Todrys and Amon op cit note 6

the ZCS to protect their bodily autonomy and to meet their accommodation, nutritional and hygiene needs. They are thus more likely, than their male counterparts, to suffer psychosocial and physical illness because of their incarceration.[28]

Since the peculiar needs of women inmates are seldom met in Zambian prisons, many are at risk of poor health. They therefore require health and health-related services, like information, routine medical check-ups and psychological support to address and avert poor health. Unfortunately, because many of the prisons in Zambia were designed and established for men, these services were not included for women and women continue to be excluded from the correctional health services. Research by Topp et al reveals that "basic availability of health services for female inmates [in Zambian prisons] was weak due to the absence of internal health services in any of the women's facilities."[29] The ZCS does not provide child and maternal-friendly health services even though the Zambia Correctional Service Act permits mothers to be admitted to correctional facilities with their children.[30] The ZCS also fails to provide routine psychosocial counselling and sexual and reproductive health services for women inmates despite the fact that women inmates are subjected to sexual, psychological, and physical violence and exploitation within correctional centres.[31]

The second factor that fuels the inadequate response to the health needs of women inmates is the severe financial limitations experienced by the ZCS.[32] This often means that the ZCS must ration resources. The process of rationing resources involves various levels of decision-making and prioritisation of needs.[33] The current health governance[34] system does not provide for the participation of inmates in health-related decision-making. This, coupled with the fact that the Zambian correctional centres offer a limited range of health

[28] Ronald L Braithwaite, Henrie M. Treadwell and Kimberly R. J. Arriola 'Health disparities and incarcerated women: A population ignored' (October 2005) 95:10. *American Journal of Public Health* 1679 at 1680
[29] M Topp et al op cit note 19 at 12 of 14
[30] Zambia Correctional Service Act, no. 37 of 2021, section 30
[31] Braithwaite et al opcit note 29
[32] Topp et al op cit note 5 at 860
[33] Baker and DIGNITY op cit note 10
[34] In this thesis, I adapt the conceptualization of health governance by Tata Chantwidze and Konrad Obermann (2016) as "structures and processes by which the health system is regulated, directed and controlled." They further identify five components of such governance to include coherent decision-making structures; stakeholder participation; transparency and information; supervision and regulation and lastly consistency and stability. Such components must be achieved through culturally appropriate means. A detailed analysis of the components of governance in the context of prisons are discussed in chapter 2 of this thesis.

services for women, means that the health needs and interests of women inmates tend to be overlooked.

The third factor is that the Zambia correctional centres are marred with administrative biases and weak health systems that disproportionately affect women inmates.[35] For example, most prisons in Zambia do not have inbuilt prison clinics or hospitals.[36] As a result, the ZCS has to transport sick inmates to Ministry of Health-regulated health institutions accessible by the general community.[37] Decisions concerning who can access these services and when the services are accessed are often at the discretion of those in positions of power, and in most cases without consulting a medical officer. Many inmates, especially female inmates, do not have the opportunity to influence health-related decisions unless they possess the requisite power. Power structures within the prisons are dictated by a hierarchical system by the ZCS officers appointing cell captains and ranking inmates based on their good behaviour and duration of sentence served. This enables inmates to be promoted thereby gaining a higher social status over other inmates. The highest stage that an inmate can attain is that of special stage:

> Special stagers are responsible for deputising 'cell captains' who maintain discipline within individual cell blocks and who have the authority to report 'cases' of indiscipline. Cell captains are also responsible for the management of illness within their cell including identifying of sick inmates and facilitating referrals to clinics. Cell captains typically have sleeping privileges and greater freedom of movement including to easier access to internal health services (where they exist). However, these are by arrangement with the special stage rather than formalised rights.[38]

A privileged class of inmates is created by the health system in the Zambian correctional facilities, which allows only a small group of inmates to enjoy their health rights and related social benefits. The creation of special classes of inmates makes women inmates vulnerable to risky survival and health-seeking behaviours.[39] They indulge in relationships and social networks to have access to healthcare and other social needs and

[35] Stephanie M. Topp, Clement N. Moonga, Nkandu Luo, Michael Kaingu, Chisela Chileshe, George Magwende, S. Jody Heymann and German Henostroza 'Exploring the drivers of health and healthcare access in Zambian prisons: A health systems approach' (2016) 31 Health Policy and Planning Journal at 1255
[36] Topp et al op cit note 5 at 862-63
[37] Topp et al op cit note 35 at 1255
[38] Ibid
[39] Topp et al op cit note 19 at 6

do not meaningfully participate in determining matters that impact on their health. Topp et al write: "inmate health and health seeking behaviours were influenced by a range of social and relational factors. Primary among these was an inmate ranking system, which afforded some female inmates significant privileges and power over others." [40] The Zambian correctional system therefore exacerbates exclusion of some inmates, thereby disadvantaging them from accessing health services. Topp et al further show how women are disproportionately affected by the prison hierarchy system:

> Women's access to health services [in Zambian correctional centres] was shaped by a combination of prison resourcing, administrative bias and inmate-officer relationships…Compounding these barriers, women reported varied and often ad hoc officer responsiveness to requests to access healthcare, with positive responses often based on inmates' wealth or long-term relationship with the officer. Women prisoners with no visible physical symptoms of ill-health, as well as those looking after children, reported particular difficulties in persuading officers to commit resources to helping them access services.[41]

From the above, additional social determinants of health for women inmates include their access to resources and access to social relationships and networks within the correctional settings. Social relationships and networks in correctional settings determine an inmate's ability to access healthcare goods and services. A biased correctional system exacerbates already strained relationships and creates an environment where health inequity thrives, leaving the most vulnerable women to bear the heaviest burden of poor health.

Fourth, the Zambian regulatory framework does not contain comprehensive laws that guarantee health rights of women inmates. The Constitution of Zambia[42] is the highest law of the country and it does not guarantee comprehensive rights specific to women inmates. It contains a Bill of Rights that guarantees civil and political rights to persons in Zambia. These rights apply to prisoners by necessary implication. The Constitution does not expressly guarantee economic and social rights. The right to health is, therefore, not explicitly included in the Zambian Constitution. The Constitution's failure to guarantee health rights worsens the *de facto* health status of many women in correctional settings as

[40] Ibid
[41] Ibid at 12
[42] Constitution of Zambia, 1991 as amended by Act no. 18 of 1996 and Act. No. 1 and 2 of 2016.

they have limited legal claims for the protection of their right to health. This is particularly true as their access to healthcare goods and services is mostly made at the State's expense.

The fifth and final factor is that many women inmates are not aware of their legal and human rights and are unable to challenge human rights abuses that place their health at risk.[43]As a result, women inmates are unable to seek legal redress when their rights are violated as they neither know their rights nor the procedures to follow to enforce them.[44] The lack of information by women inmates often disempowers them from responding to threats on their health.[45] The women inmates' inability to demand their rights is also influenced by their low social and economic status.[46] Women inmates' low social and economic status can be enhanced by empowering them to lodge complaints and obtain redress for health-related violations that they experience in correctional settings. The Government of Zambia realises the importance of raising awareness among women inmates on their legal and human rights, but in reality not much has been done to achieve this thus perpetuating the status quo for women inmates.[47].

It is evident from the above discussion that women inmates do not enjoy their right to health to the same extent as male inmates and women in the general population in Zambia. This is mainly due to limited access to sexual and reproductive health and psychosocial goods and services, their low socio-economic and political status making them susceptible to exploitation through prison social networks and relationships and detrimental prison practices. Women inmates' position is compounded by weak prison health systems and laws that do not consider the special needs and interests of women inmates. The next section analyses the problem that these issues create for women inmates' equal enjoyment of health rights and interests.

1.2 PROBLEM STATEMENT

Zambia's prison legislation has not contributed much to alleviating the vulnerabilities of women inmates to health-rights' violations or to the promotion of their health interests. Many laws applicable to correctional settings are outdated and were drafted without due

[43] Republic of Zambia op cit note 1 at 107
[44] United Nations supra note 15 at 61
[45] Ibid at 61-62
[46] Ibid at 124-125
[47] Bureau of Democracy, Human Rights and Labor *Country reports on human rights practices* (2016) 3-10 available at https://www.state.gov/j/drl/rlaccessed on 4 April 2018

consideration to the experiences of women in correctional settings.[48] For example, until the recent 2021 Zambia Correctional Service Act, Zambian correctional facilities were regulated by the Prisons Act of 1965. Other archaic laws applicable to the correctional settings include the Probation of Offender Act,[49] which was enacted in 1953, and the Penal Code [50] and Criminal Procedure Code, [51] which were enacted in 1930 and 1922 respectively. These pieces of legislation were drafted at a time when the focus of correctional facilities was on custody and control of prisoners and the implementation of a purely punitive system.[52] Thus, the laws sought to regulate the custody and control of prisoners devoid of rehabilitation services. Furthermore, many of these laws contain negligible provisions on the welfare of women inmates.[53] The legal framework applicable to Zambian Correctional Service (ZCS) does not guarantee gender-specific healthcare, does not respond to social factors that make women inmates vulnerable to health violations, and fails to provide access to health-related complaint mechanisms to empower women inmates to claim remedies for health-rights violations. It therefore does not directly address the experiences of women inmates' access to healthcare.

The failure of the legal framework to adequately respond to the health needs of female inmates has contributed to their health needs being excluded, thereby violating their right to health. Health governance laws, policies, and practice in correctional settings have limited impact on women's health needs due to gender bias, exclusion, and the assumption of gender neutrality in the laws, policies, and practice.[54] Although many of the barriers to enjoyment of health rights, including access to healthcare for women inmates have been documented, there has not been an equal response to documentation of possible solutions to such barriers. Women inmates are almost invisible in the Zambian correctional system. This invisibility makes women inmates susceptible to health rights violations, among others. The situation of women inmates in Zambian correctional facilities necessitates this inquire into women inmates' participation in health governance

[48] Baker and DIGNITY op cit note 10 at 20-1
[49] Chapter 93 of the Laws of Zambia
[50] Chapter 87 of the Laws of Zambia
[51] Chapter 88 of the Laws of Zambia
[52] Baker and DIGNITY op cit note 10 at 21
[53] Ibid at 22
[54] Ibid at 21

and the role of ZCS and its regulatory framework in facilitating the effective integration of women in correctional health system.

1.3 RESEARCH QUESTIONS AND OBJECTIVES

The following research question is considered: "How can participation of women inmates in decision-making enhance their right to health and what is the role of the Zambian regulatory framework in facilitating such participation?" To answer the above question, the following sub-set of research questions are addressed:

a) What does participation in health-related decision-making entail?
b) What is the role of participation in realising the right to health?
c) What standards and norms exist within prison management and prison health governance for the participation of women inmates in health-related decision-making?
d) How does the current Zambian regulatory framework impact on women's participation in correctional settings for better realisation of their health rights?
e) How is the health of women inmates affected by the failure of the correctional healthcare system to provide for the peculiar needs of women inmates in Zambia?
f) How can women inmates participate in decision-making that impacts on their health in the Zambian context?
g) What is the role of the Zambian legal framework in guaranteeing the participation of women inmates in decision-making and in shaping the regulatory framework applicable to correctional settings in Zambia?

In addressing the above questions, the following are the objectives of my proposed research:

a) To examine the link between women inmates' participation in decision-making in correctional settings and their access to health.
b) To determine how the participation of women inmates can address the factors that impact on access to healthcare for women inmates and their interaction with social and institutional factors in correctional facilities.
c) To analyse the role of law in supporting women's participation in decision-making in correctional settings.
d) To consider how situating Zambia's legal response to health needs and challenges of women inmates in the participatory rights framework can enhance their access to healthcare.
e) To consider how the health governance system in the Zambian correctional facilities can be enhanced by the participation of women inmates.

1.4 SIGNIFICANCE OF THE STUDY

My study is important as it makes three key contributions. First, it provides a model for improving the regulatory framework for promoting and protecting the right to health for women inmates which is anchored in a participatory-rights framework. This would greatly input into the ongoing legal reforms of the Zambian Correctional System. The constitutional amendments created the Zambia Correctional Service (ZCS),[55] which replaced the Zambia Prison Service. This was done as part of its aimed at transforming the prison system to a hybrid of a prison and correctional system. It was also done to reform rather than punish criminal offenders.[56] There is seemingly a move to completely abolish the penal system and create a purely correctional system, with the Republican President pronouncing the abolition of the death penalty in December 2022 and making some legislative amendments to this effect.[57] The constitutional amendments of 2016 also constitutionally established the Gender Equity and Equality Commission, a body that was first created by the Gender Equity and Equality Act 2015 (GEEA). One of the objectives of the GEEA is to provide for the making of strategic decisions that guarantee gender equity and equality as well as to integrate both sexes in society. The Act also seeks to "prohibit harassment, victimisation and harmful social, cultural and religious practices … [and] provide for the elimination of all forms of discrimination against women, empower women and achieve gender equity and equality."[58] This research study makes key recommendations that could improve the legal and administrative environment for addressing some of the health rights and citizenship challenges experienced by women inmates in Zambia.

The second key contribution of this research study is that it documents the unique experiences of women inmates on how they are affected by the existing healthcare system in Zambian prisons, the social determinants that affect their participation in accessing health, and their recommendations for improving the regulatory and administrative

[55] Supra note 42, Article 193
[56] Supra note 31, Preamble
[57] World Coalition Against the Death Penalty "Zambia is the 25th African Country to abolish the death penalty" available at https://worldcoalition.org/2023/01/06/zambia-abolishes-the-death-penalty/
[58] Ibid

systems to enable them to enforce their right to health. This study is important as it provided an opportunity for women inmates to express their views about their health rights and interests and proposals for improvement of the healthcare system through their participation in this research.

The third contribution of the study is that it contributes to the nascent literature on prison health for women inmates in Zambia by proposing practical solutions for addressing the health rights-related violations experienced by women in correctional settings in Zambia, which incorporates the views of women inmates. As I demonstrate in literature review section below, research on the health rights of women inmates in Zambia is limited. The existing literature has tended to describe the health challenges of prisoners and in is in most instances based on male prisons. My research explores the value of situating Zambia's administrative and legal response to the health needs and challenges of women inmates in the participatory-rights framework to enhancing women inmates' right to health.

1.5 LITERATURE REVIEW

To situate my research in the body of existing literature, I conducted internet searches on Zambialii, PRIMO and Sabinet with the view to assess the state of knowledge on approaches to enforcement of health rights, including the rights of women in correctional facilities. The search area included literature on the realisation of health rights for women inmates in Zambia and similar contexts, citizenship, participation, and human rights generally. The search criteria were informed by my research questions and a preliminary review of literature which revealed that there is limited research on women in prisons in general and on approaches for improving the right to health for women in correctional facilities. The little literature that exists on the subject has tended to focus on male prisoners and is then generalised to all people within correctional systems.

Existing literature on the approaches to enforcing health rights can be grouped under four thematic areas. The first theme describes research on the enforcement of health rights in general. The second comprises of literature on enforcing health rights and interest in prisons. The third is literature that discusses citizenship as a tool for realising health

rights. The forth thematic area discusses the influence of gender, rights, and citizenship on women inmates' health rights. I discuss these below.

1.5.1 Enforcing Health Rights

With regards to the enforcement of health rights, researchers have identified litigation as a key method for enforcing health rights.[59] Those who advocate for litigation anchor their arguments in the existing international, regional and national human rights instruments on the right to health, such as the International Covenant on Economic, Social and Cultural Rights (ICESCR)[60] and the African Charter on Human and Peoples Rights (ACHPR) [61]which enable citizens of States Parties to enforce their rights through litigation.[62]

Ebenezer Durojaye[63]notes the increase in health-related litigation globally focusing on issues such as the denial of emergency medical treatment, life-saving medication, access to health goods and services such as contraception, and denial of healthcare services based on age, sex, HIV status, or marital status.[64] He attributes the increase in health rights litigation across Africa to recent developments and clarifications on the right to health at international and regional levels.[65] Durojaye identifies litigation as a means by which rights-holders actively seek to assert their rights but emphasises the obligation of the State in fulfilling this right by creating"an enabling, supportive, legal and social environment that empowers women to be in a position to fully and freely realise their right to self-protection and to be protected."[66] This position on States' obligations is echoed by

[59] Ebenezer Durojaye 'Litigating the right to health in Africa' available at https://southernafricalitigationcentre.org/wp-content/uploads/2017/08/Durojaye-Ebenezer.pdf, accessible 10th May 2021; Sandra Liebenberg 'Rights, needs and transformation: Adjudicating social rights'(2006) 17 *Stellenbosch Law Rev* 5-36.

[60] UN General Assembly, International Covenant on Economic, Social and Cultural Rights, 16 December 1966, United Nations, Treaty Series Vol 993 P.3 available at http://www.refworld.org/docid/3ae6b36c0.html accessed pm 30 April 2018, Article 2

[61] Organisation of African Unity (OAU) African Charter on Human and Peoples Rights (Banjul Charter) 27th June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M 58 (1982) available at http://www.refworld.org/docid/3ae6b3630.html accessed on 10th July 2019 , Article 55

[62] International Commission of Jurists 'Courts and the legal enforcement of economic, social and cultural rights: Comparative experiences of justiciability' (2008) *Human Rights and Rule of Law* Series no. 2 at 16

[63] Ebenezer Durojaye 'Litigating the right to health in Africa' available at https://southernafricalitigationcentre.org/wp-content/uploads/2017/08/Durojaye-Ebenezer.pdf, accessible 10th May 2021

[64] Ibid at 104

[65] Ibid

[66] Ibid

Zahara Nampewo, Jennifer Heaven Mike & Jonathan Wolff who argue that States must ensure that health-rights interventions are inclusive, equitable, and accountable to rights-holders.[67]

Although litigation offers a useful means for holding States accountable to their obligations under international and regional human rights instrument, it is limited when it comes to realising the rights of marginalised populations. One such limitation is the standard of "reasonableness" which courts apply in ascertaining the extent to which the State has fulfilled its obligation to provide the highest attainable standard of health.[68]Sandra Liebenberg argues that litigation is effective when it is complemented by equitable and inclusive legislative and administrative interventions such as the formulation and implementation of a national strategy and plan of action which is formulated and periodically reviewed in a participatory and transparent process.[69] In the context of South Africa, participatory law making is viewed as a constitutional imperative within the context of the right to participation.[70]

In the context of Zambia, where the Constitution does not provide for a justiciable right to participation, the government has attempted to implement some of its obligations to realise the right to health for its citizens by developing development plans, strategies and programmes. These comprise the Eighth National Development Plan,[71] Vision 2030,[72] National Community Health Strategy,[73] Community Health Workers' Strategy,[74] National Gender Policy,[75] National Health Policy,[76] National Health Strategic Plan,[77] National

[67] Zahara Nampewo, Jennifer Heaven Mike & Jonathan Wolff 'Respecting, protecting and fulfilling the human right to health' (2022)21 *International Journal of Equity in Health* 36 available at http://doi.org/10.1186/s12939-022-01634-3, accessed on 10th May 2022

[68] Sandra Liebenberg 'Rights, needs and transformation: Adjudicating social rights'(2006) 17 *Stellenbosch Law Rev* at 5

[69] Ibid

[70] Moses Retselisitsoe Phooko 'What should be the form of public participation in the law-making process? An analysis of South African cases' 2014 *Obiter Journal* 39-59; Linda Nyati 'Public participation: What has the constitutional court given the public?' (2008) 12 *Law, Democracy and Development* 102-110 available at www.saflii.org/za/journals/LDD/2008/15 accessed on 30 September 2017

[71] Available at http://www.zda.org.zm/wp-content/uploads/2022/09/08th-NDP-2-22-2026.pdf accessed 17th October 2023

[72] Available at https://www.nor.gov.zm/?wpfp_dl=44 accessed on 17th October 2023

[73] Ministry of Health 'National Community Health Strategy 2019-2021' Available at https://chwcentral.org/resources/zambia-national-communicty-health-strategy-2019-2021/# accessed on 17th October 2023

[74] Available at https://www.advancingpartners.org/sites/default/files/cadres/policies/zambia_nchw_strategy-august_2010_final.pdf accessed on 17th October 2023

[75] Available at https://www.gender.gov.zm/?page_id=1629 accessed on 17th October 2023

Child Policy,[78] National Social Protection Policy,[79] the Integrated Framework of Basic Social Protection Programmes,[80] National HIV/AIDS/TB Policy[81] and the National Strategic Framework on HIV and AIDS.[82] A 2019 report by the Ministry of Gender documenting the progress of implementation of the Beijing Declaration and Platform for Action shows that the Zambian government has implemented measures to promote women's access to health services, including sexual and reproductive health and mental health services, through expansion of universal health coverage or public health services. It also shows that the government has implemented gender-specific public awareness interventions.[83] This study assesses how women inmates' participation in health governance can enhance the visibility of their health needs and interests in national agenda and inspire a responsive regulatory framework for their health rights.

1.5.2 Enforcing health rights and interests in prisons

Existing literature on the enforcement of health rights and interests in prisons often describes healthcare models in prisons and the attendant challenges that they have produced on inmates in general and women inmates in particular. For example in the study by Vaugh and Smith, they argue that the Penal Harm Framework, which regulates the manner in which correctional services establish health systems for inmates, negatively impacts on inmates' enjoyment of health rights.[84] This framework views inmates as deserving of a lower standard of enjoyment of health rights because of their criminal actions.[85] This framework often reflects the general population's view about inmates' entitlements to health rights and promotion of their health interests. It could explain, for

[76] Republic of Zambia 'National Health Policy: A nation of healthy and productive people' August 2012
[77] Republic of Zambia Ministry of Health '2022-2026 National Health Strategic Plan: Towards attainment of quality universal health coverage through decentralisation."
[78] Republic of Zambia Ministry of Community Development, Mother and Child Health *National Child Policy 2015-2021* 2015
[79] Republic of Zambia Ministry of Community Development, Mother and Child Health National Social Protection Policy June 2014
[80] Republic of Zambia Integrated Framework of Basic Social Protection Programmes
[81] Republic of Zambia Ministry of Health National HIV/AIDS/TB Policy February 2002
[82] Republic of Zambia Ministry of Health National HIV/AIDS Strategic Framework 2017-2021
[83] Republic of Zambia *Progress report on the implementaiton of the Beijing Declaration and Platform of action(1995) and The Outcomes of the Twenty -Third Special Session of the General Assembly(2000)* 2019 at 23-25
[84] Ken Kerle, Stan Stojkovic, Richard Kierkbusch and Joe Rowan 'A rejoinder to Vaughn and Smith's "Practicing penal harm medicine in the United States: Prisoners' voices from jail' (1999) 16:4 *Justice Quarterly*
[85] Ibid

instance, why the Zambian national budget for prisons and correctional services is low, with inadequate funding for prison health.[86] The low priority given to prisons indiscriminately affects women inmates who suffer multiple and intersectional levels of health-related discrimination based on their sex, gender roles, disability, health, and legal status.

Another scholar, Catrin Smith critiques the "fundamental philosophies underpinning current models of prison healthcare [in the UK] where the benevolent aims of health promotion may become extremely punitive."[87] Smith discusses inherent contradictions between health and law enforcement from the UK prison system which claim to promote health initiatives. Smith finds that the major health problems of mental illness, HIV/AIDS, and drug abuse "illustrate not only the inherent contradictions between health and law enforcement, but also that preventive measures in prisons may, in fact, become extremely punitive, doing more harm than good."[88] Smith attributes identifies participation by inmates as being key to success of health promotion initiatives in the UK prison system.

Existing literature in Zambia emphasises the challenges of implementing a healthcare model that tends to overlook the health needs of women inmates. Despite the high burden of disease among Zambian prisoners, the issue of prison health has historically received low priority by policy makers and health programmers. Inmates are often stigmatised and the public is often ambivalent about providing quality care to those accused or convicted, particularly given that the public sector financing is already limited.[89] Coupled with women inmates' low social standing in Zambia, the limited funding to prisons negatively impacts their access to public goods and services that impact on their health. Michael Marmot et al, link the position of a person on a social gradient to their health.[90] They argue that the lower a person's socio-economic position, the worse their health is.[91] Marmot et al identify several social determinants of health including misdistribution of healthcare goods and services, the healthcare system itself, unequal

[86] Topp et al op cit note 19
[87] Catrin Smith '"Healthy prisons": A contradiction in terms?'(2000) 39: 4 *The Howard Journal* 339
[88] Ibid at 348-49
[89] Jeremy Sarkin 'An overview of human rights in prison worldwide' in Jeremy Sarkin (ed) *Human Rights in African Prisons*(2008) at 21
[90] Marmot et al op cit note 9 at 1661-69
[91] Ibid at 1661

power relations and gender inequalities.[92] Although the authors do not go into detail about how each of these determinants can be addressed in the context of women, they identify among others, empowerment, inclusion, and redistribution of power as means of reducing health inequities.

This literature is limited in addressing the challenges of women inmates in realising their health rights three ways. Firstly, the literature is generalised and does not describe the unique experiences of women who are disproportionately affected by the implementation of the healthcare models that the literature has criticised. Secondly, this literature hardly explores possible solutions to the various challenges that it has identified in the existing healthcare models that are implemented in prisons. Thirdly, although some of this literature identifies the importance of participation in the enforcement of health rights, it rarely interrogates the role of participation in realising health rights for women inmates. Let us now consider some insights from scholarship on citizenship as a tool for realising health rights.

1.5.3 Citizenship as a tool for realising health rights

Much of the mainstream literature on citizenship has tended to discuss the concept within the context of democracy and participation in political and social spaces. For instance, Bryan S. Turner states that "it [citizenship] is the democratic apparatus, which prevents the agencies of power, law and knowledge from fusing into a single leading organ."[93] The active participation of the masses ensures that State powers are not abused and that rights are guaranteed. The literature also makes the link between participation and the realisation of rights including economic, social, and cultural rights.[94]

In emphasising the importance of the participation of the masses in democratic governance, John Gaventa uses the emerging work of researchers at the Development Research Centre to showcase the need to rethink and recast the debate on participation, inclusion, and accountability in a rights-based and citizenship-centred approach.[95] Gaventa argues that changes in the understanding of rights and spaces for participation demand a

[92] Ibid
[93] Ibid at 190
[94] Clare Ferguson *Global Social Policy Principles: Human rights and Social Justice* (1999) 1-49
[95] John Gaventa 'Introduction: Exploring citizenship, participation and accountability.' (2002) 33: 2 *IDS Bulletin*1-11.

rethink of the traditional relationships of accountability and responsibility among different stakeholders. Gaventa's analysis particularly focuses on how participation, inclusion, and accountability are related to citizenship in the context of developing countries.

With regards to relationships and spaces for participation, Helen Potts argues that one of the problems of participation is that it is deeply contextual.[96] Augmenting this, Andrea Cornwall states that many discussions on participation are often theorised. They do not pay attention to how participation would work in practice. She argues that to make participation a reality, particularly for marginalised groups, it must be situated in their lived realities and experiences, that is to say where marginalised groups ordinarily have spaces for participation.[97] Cornwall argues that evidence of forms of participation that have worked in a particular location should not be transferred to all locations.[98]

The arguments on citizenship in context are relevant to my research study which seeks to interrogate how citizen participation would work for female inmates and to establish how the Zambian regulatory framework can facilitate their active participation in health decisions and programmes. My research draws on this body of literature to assess the different forms of participation that have worked in the Zambian context to formulate a women-centered model for citizenship participation in health for women inmates as discussed in Chapter 7 of this thesis. The next section discusses the existing literature on gender, rights and citizenship and their influence on inmates' health rights.

1.5.4 Gender, rights, and citizenship's influence on women inmates' health rights

As a means of locating participation within people's lived realities, some authors articulate the need to examine and document how women experience citizenship.[99] It is key to acknowledge that just as participation is a situated practice, gender is a relevant factor in situating one's participation in all spheres. Julia Preece analyses the concepts of

[96] University of Essex Monograph on Participation and the right to health available at https://documents-dds-ny-un.org/doc/UNODC/GEN/NO8/456/47/PDF The Right To Health 11 August 2008 A/63/263 UNGA at 2 of 40
[97] Andrea Cornwall 'Locating citizen participation' (2002) *IDS Bulletin* 1-10 available at https://opendocs.ids.ac.uk accessed on 20th February 2018
[98] Ibid at 1-2
[99] Nira Yuval-Davis 'Women, citizenship and difference' (1997) 57(1) Feminist Review 4-27 available at https://journals.sagepub.com/doi/abs/10.1080/014177897339632 accessed on 19th Octber 2023; Ann Kangas, Huma Haider, Erika Fraser, Evie Browne 'Gender and Citizenship' Topic Guide July 2015 accessed on 19th October 2023

citizenship and governance using a gender lens. She states that contemporary discourse on gender and citizenship are informed by the following feminist theories:

a) Liberal feminism, which is concerned with "equal democratic rights with men and free choice within existing social structures."
b) Radical feminism, which "identifies the specific historical role of male domination over women …but does not challenge the categories of gender power differentials."
c) Socialist feminism, which recognises differences between men and women "but primarily explores the ways in which gender is socially, rather than biologically constructed."
d) Postmodern or poststructuralist theory, which "shifts the focus of difference onto the relationship between language and power." [100]

Preece uses the above feminist theories of citizenship to analyse the post-structuralist theory, which focuses on pluralism and change. She looks at the relationship between power and discourse in the European construction of citizenship and governance.[101]

Gay W. Seidman uses the experiences of feminists and gender activists in South Africa, during their transition to democracy, to demonstrate how their activities impacted on the development of new democratic institutions that represented women's experiences of citizenship. She states that citizenship must not be treated as a universal relationship between individuals and the State but rather acknowledge the impact of gender dynamics on individuals' ability to participate in political discussion and the effect of State polices on individuals.[102] Seidman argues that South Africa's attention to gender issues during its transition to democracy offered a unique perspective on the construction of engendered democratic institutions. She discusses the impact of new democratic institutions on men and women. She argues that women experience democratic institutions differently from men and this factor should not be ignored when determining women's participation in public life.[103]

[100] Julia Preece 'Feminist perspectives on the learning of citizenship and governance' (2002) 32: 1 *Compare: A Journal of Comparative and International Education*
[101] Ibid at 22
[102] Gay W. Seidman 'Gendered citizenship: South Africa's democratic transition and the construction of a gendered state' (June 1999) 13:3 *Gender and Society*
[103] Ibid at 302

In her article, Seidman demonstrates how women in South Africa were able to mobilise themselves and ensure that they were made a big part of the agenda in the transition to democracy.[104] Seidman's work demonstrates how participation can be realised by locating it within the context of people's lived experiences, as argued by Cornwall. Her contribution also gives practical examples of how women in apartheid South Africa were, despite their marginalisation, able to mobilise themselves and play an important role in communicating their interests to and through various political and governance structures.

Another complexity of participation that Potts identifies is that participation is dependent on other rights, for example, rights to information, association and assembly.[105] Human rights however are contested as they are often used against the very people they are meant to protect. They are often used by more wealthy and affluent members of society to oppress the poor.[106] Thus, if safeguards for the realisation of rights are weak, chances are that active citizenship will not be realised. However, where fundamental rights are well protected and accessible to vulnerable and marginalised groups, an enabling environment may be created for active and effective participation in social and political spheres. The fact that social and political participation are dependent on other rights provides justification for using the hybrid approach of rights-based approach and citizenship to collectively mitigate or curb the power of "traditional elites that are likely to resist the active and informed participation of disadvantaged individuals and communities and populations in health-related sectors" [107] and ensure the realisation of active citizenship.

The article by Douglas et al articulates the challenges that female inmates in the UK experience.[108] In discussing the implication of their research findings, Douglas et al highlight the effect of disempowerment for women inmates and how this is exacerbated by women's histories of sexual and physical abuse. They argue that self-empowerment and control are "central tenets of health promotion theory and practice."[109] They argue further

[104] Ibid at 290-298
[105] University of Essex op cit note 96
[106] Carol Smart 'The Problem of Rights' in *Feminism and the Power of Law* (1986) at 144-146
[107] University of Essex op cit note 96
[108] Douglas, Plugge and Fitzpatrick op cit note 14
[109] Ibid at 752

that freedom is essential for one to effectively manage one's health. If a person does not have control over their lives, they cannot take responsibility for their health.[110] They conclude that many of the experiences of disempowerment by female inmates were based on factors that are inherent in the process of imprisonment.[111] Douglas et al do not discuss factors that female inmates can control that impact on their health. They do not discuss how women's participation in health-related decision-making in correctional facilities and in the shaping of their regulatory frameworks can alleviate feelings of disempowerment, enhance good health behaviour and increase access to health goods and services. Moreover, they do not discuss how the law can help address some of the experiences of disempowerment for women inmates. These are some of the points of departure in my research study. Health needs and experiences of women inmates in the African context are unique from male inmates and women in the general population. It is thus necessary to understand the experiences of women inmates as we formulate participatory health governance systems and procedures for women inmates.

Similarly, women inmates in Zambia are exposed to health risks and experience numerous challenges in accessing healthcare goods and services as a result of the current correctional health systems and regulatory frameworks. Many factors impact on access to healthcare for women inmates in Zambia including lack of control over their health maintenance in prison settings, anxiety over their children and dependents, exposure to violence, lack of access to friends and family and other support systems, and lack of financial resources to meet their health and other basic needs.[112] Topp et al discuss how the system in correctional facilities implicitly prioritizes the health needs of male prisoners.[113] They also discuss the prevalence of inmate-led and officer-led discrimination against women prisoners and how this negatively impacts on the health of women prisoners.[114] The article concludes with a statement that there is a need to address the following issues within the correctional health system to curb the challenges that women inmates experience in accessing healthcare:[115]

[110] Ibid
[111] Ibid
[112] Topp et al op cit note 19
[113] Ibid at 11 of 14
[114] Ibid
[115] Ibid at 13

a) Administrative biases against women;
b) Inefficient delivery of health services; and
c) Prison governance practices aimed at changing "the organisational culture which shapes officers' understanding and responsiveness to women prisoners' health needs." [116]

In their discussion on how the correctional health system can be improved, Topp et al identify the above three stated interventions but do not articulate the role of women inmates in achieving the necessary reforms. While the identified determinants of health for women inmates can be addressed by investing in structural improvements in the provision of women-friendly health services for women inmates, others require "interventions to reform the organisational culture which shapes officers' understanding and responsiveness to female prisoners' health needs."[117] It is argued in this thesis that the solutions offered by Topp et al require the participation and involvement of women inmates for them to achieve the desired impact. The identification of participation of women inmates in health governance of correctional facilities in Zambia as a necessary vehicle for realisation of their health rights is justified by the findings of another study conducted by Topp et al. The latter study focuses on the key structural determinants of health in Zambian correctional settings. Topp et al identify weak health governance and poor health information systems as two of the four key structural barriers to health that make the Zambian prison health system ineffective.[118] They note that there is a discrepancy between the legal commitments of the Zambia Correctional Services to provide timely and responsive healthcare to prisoners and the reality of poor access to healthcare by prisoners.[119]

Most available literature on health promotion interventions in correctional and prison settings are devoid of human rights-based approaches and thus do not adhere to international and regional human rights standards of the highest or best attainable standard of physical and mental health. While there is relatively little written on approaches to enforcement of health rights for women inmates, there is even less written about women inmates' effective participation in health-related decision-making and programming globally and particularly in Zambia. The United Nations Special Rapporteur on the Right

[116] Ibid at 13
[117] Ibid at 13 of 14
[118] Topp et al op cit note 5 at 858-75
[119] Ibid at 859

to Health, in 2008, acknowledged the dearth of information on participation and the right to the highest attainable standard of health in his foreword to the flagship study conducted by Helen Potts.[120] Potts produces an introductory study to participation and the right to the highest attainable standard of health. She focuses on participation in relation to health policy development by States. She describes various methods of participation and introduces an instructive framework for a fair and transparent participatory process. She also identifies some indicators that can be used to monitor and evaluate participation and pre-conditions for the incorporation of participation in health systems.[121] She argues that the right to the highest attainable standard of health cannot be delivered without a responsive, integrated health system that is accessible to all.[122]

Potts also acknowledges that insufficient attention is paid to the role of participation and what it means in practice and seeks to fill this literature gap through her publication. By placing participation at the centre of health systems and prioritizing the well-being of people, groups, communities and populations, implementation of the right to health ensures that "a health system is neither dominated by experts nor removed from the people it is meant to service."[123]

In the Zambian context, except for the article by Topp et al,[124] seemingly no other literature on health governance has been published in the last two decades. Globally, most existing literature on health governance has been necessitated by paradigm shifts in governance that extended to social spheres of governance through interventions such as decentralisation programmes.[125] Countries that pioneered devolving interventions of health goods and services from central government level to community level had opportunities to monitor and evaluate what works and what does not work thereby perfecting the community participation and State accountability.[126] Countries such as Portugal[127] and Burkina Faso[128]have undertaken such evaluations.

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[120] University of Essex Op cit note 96
[121] Ibid
[122] Ibid at 2
[123] Ibid at 4
[124] Stephanie Topp, Anjali Sharma, Chisela Chileshe, George Magwende, German Henostroza and Clement N Moonga 'The health system accountability impact of prison health committees in Zambia' (2018) 17:74 *International Journal of Equity in Health* available at http://doi.org/10.1186/s/2939-018-0783-3
[125] Ana Lorena Ruano 'The role of social participation in municipal-level health systems: the case of Palencia, Guatemala' *Global Health Action* 2013 available at http://dx.doi.org/10.3402/gha.v6i0.20786
[126] Ibid

The Zambian regulatory framework on health and governance has over the years expanded to promote the shift from central to community control of health interventions.[129] From 2006, Zambia embarked on a programme to decentralise many functions of central government including health.[130] As mentioned previously, Zambia also experienced a paradigm shift from a purely retributive and punitive justice system to a corrective system. This, coupled with the Constitutional amendments of 2016 that promote equity, transparency and participation, create a conducive environment for examining the role of participation in enhancing health rights of women inmates as guaranteed in international and regional human rights instruments. Considering that no express right to health and no express inmates' rights exist for women inmates in Zambia's regulatory framework, a factor that sets Zambia apart from other countries in the region, I examine the role of women inmates' participation in health governance through a women-inclusive lens that integrates a human rights approach and a citizenship participation approach. I test this participatory model thorough the review of the relevant normative frameworks and empirical interviews as discussed in the next section.

1.6 RESEARCH METHOD

Desk-based and empirical methodologies were employed to conduct this study. In relation to desk-based research, access to library facilities and use of internet research accounted for the bulk of data collected. The literature reviewed included primary and secondary sources. Primary sources include books, articles, research reports and internet publications on the subject matter under study. Empirical research involved semi-structured individual interviews with women inmates, correctional officers, and NGOs working on prison issues, health or women's issues, and in-depth individual interviews with relevant government-based institutions. A detailed methodology is provided in Chapter four of this thesis.

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[127] Paulo Ferrinho, Claudia Conceicao, Andre Rosa Biscaia, Ines Fronteira and Ana Rita Antunes 'Sixty years of reform in the Portuguese health system: What is the situation with regard to decentralisation?' 2006 available at https://www.cairn.info/revue-francaise-des-affaires-sociales-2006-6-page-297.htm

[128] Strategic Purchasing for Primary healthcare 'Devolution of the health sector to communes: A misfit in the national health system governance framework and management shortfalls in Burkina Faso' April 2022 available at https://thinkwell.global.wp-content/uploads/2022/04/Burkina-Faso-Case-Study-April-2022.pdf

[129] Government of the Republic of Zambia supra note 72 at 14-17

[130] Ibid at 17

1.7 CONCLUSION

The literature demonstrates that the citizenship and human rights concepts of participation in decision-making and programming by persons most affected by the subject requiring a decision to be made has the potential of better protecting their rights. For example, one can infer from the literature that if women inmates can control factors that put their health at risk, they stand a chance of better enjoying their right to health in prison settings. This requires them to be empowered to make decisions about their lifestyles and choices that impact on their health. Participation in decision-making therefore becomes an important tool for such empowerment.

Another empowering tool for the enjoyment of health rights by women inmates is their meaningful involvement in determining when they need to access health services and the determination of treatment options. The Zambian prison system has inherent barriers that prevent women inmates from accessing health services when they need them. Women inmates must therefore be empowered to openly discuss their health status with correctional medical officers and other health professionals for optimal enjoyment of health goods and services. The literature also shows that another important way in which women's participation can guarantee their fundamental rights is by getting involved in the creation of conducive regulatory environments that affect their situations and ensure that regulatory frameworks reflect or address their unique and collective needs. Thus, women inmates can enhance their enjoyment of the right to health by contributing to the enactment of laws and policies that impact on their health in correctional settings. For all of these to be realised women inmates must be recognised as citizens with full rights and claims upon the State (except for the loss of their liberty) and empowered to act as self-agents. It is evident that while there is vast information on participation and its ability to guarantee rights for various groups of people in varying circumstances, there is insufficient literature on the participation of female inmates as a means for protecting their right to health. My research study endeavours to contribute to existing literature by ascertaining the role of participation of women inmates in decision-making to better realise their right to health, and to show how the Zambian regulatory framework can facilitate such participation.

CHAPTER TWO
THE THEORETICAL AND CONCEPTUAL FRAMEWORK OF PARTICIPATION

2.0 INTRODUCTION

This Chapter presents the conceptual and theoretical framework of my study. The Chapter lays a foundation for examining the extent to which citizenship participation can be used as a tool for guaranteeing women's rights generally, and more specifically their right to health. Several legal and social theories discuss the concept of 'participation' as a tool of empowerment for citizens, particularly marginalised groups.[131] These include the theories of citizenship, democratic governance, rights-based approach, legal empowerment. The concept of 'participation' often takes on many different and contested meanings and experiences.[132]Therefore, no single theory exists that holistically addresses the concept of participation or focuses solely on 'participation'. As this Chapter demonstrates, the theory that most appeals to my study is the theory of citizenship, specifically the feminist theory of citizenship. I perceive the theory of citizenship as a double-edged sword, which cuts across the cloth of status and identity on the one hand, and rights and entitlements on the other.

Citizenship operates both as a status and as a lived practice.[133] Once bestowed with the cloth of citizenship, persons are not only recognised as belonging to a particular group or society, but are also entitled to participate in their activities and to contribute to their development and governance. On this premise, it is relevant to consider the theory of

[131] See Ann Shola Orloff 'Gender and the social rights of citizenship: The comparative analysis of gender relations and welfare states' (1993) 58:3 *American Sociological Review* 309; Andrea Cornwall 'Locating citizen participation' (2002) *IDS Bulletin* 1 available at https://opendocs.ids.ac.uk accessed on 20th February 2018; Ned Crosby, Janet M Kelly, and Paul Schaefer 'Citizen panels: A new approach to citizen participation' (1986) 46:2 *Public Administration Review* available at www.jstor.org/stable accessed on 24th August 2017 at 171-172; Renee A Irvin and John Stansbury 'Citizenship participation in decision making: Is it worth the effort?' (2004) 64:1 *Public Administration Review* at 56-57; Joann Mcnutt and Mary K. Totten 'Women in governance: A Savvy strategy for advancing community health' (2016) 69:1 *Trustee* 25-28; Doina Popescu Ljungholm 'Citizen participation in organizational decision making' (2015) 14 at 138

[132] Ann Shola Orloff 'Gender and the social rights of citizenship: The comparative analysis of gender relations and welfare states' (1993) 58:3 *American Sociological Review* 309; Fiona LehHoonChuah, Astha Srivastava, Shweta Rajkumar Singh, Victoria Haldane, Gerald Choon Huat Koh, Chia Kee Seng, David McCoy, Helena Legido-Quigley 'Community participation in general health initiatives in high and upper middle income countries: A systematic review exploring the nature of participation, use of theories, contextual drivers and power relations in community participation.' (2018) *Social Science and Medicine* 107

[133] Ruth Lister 'Citizenship: Towards a feminist synthesis' (1997) 57*Feminist Review* 28-48 at 29

citizenship in addressing women inmates' low social standing in Zambia and their ability to make claims on the State for their health rights and health determinants. Being mindful that women inmates in Zambia experience multiple-tier barriers that inhibit their participation in the governance system of the Zambia Correctional Service and at the national level, I considered the feminist theory of citizenship as cardinal for anchoring my study. The feminist theory of citizenship not only examines the barriers that women experience in the mainstream theory of citizenship but also explains how best to establish women's participation in governance in such a way as to topple the inequality and social exclusion. To fully understand the relevance of the feminist theory of citizenship, there is a need to understand the tenets of the mainstream theory of citizenship.

The Chapter commences with a brief examination of the theory of citizenship focusing types of citizenship types of citizenship. Here, different conceptualisations of citizenship are presented. Further, an analysis of the advantages and disadvantages of citizenship participation is done. The Chapter also presents key considerations for the effective implementation of citizenship. Citizenship participation is a hybrid of 'participation' and 'governance',[134] hence it is sometimes referred to as "participatory governance" or "participatory citizenship."[135] The Chapter ends with an analysis of the of citizenship participation from a human rights perspective and from a feminist perspective.

2.1 THE THEORY OF CITIZENSHIP

Citizenship can be defined from a global perspective or from a nation-State perspective.[136] TH Marshall understood it as "a set of juridical, political, economic and cultural practices which define a person as a competent member of society, and which as a consequence shape the flow of resources to persons and social groups."[137] In his analysis of Marshall's conceptualisation of citizenship, Turner states that the idea of 'practices' helps to expand the concept of citizenship beyond rights and obligations.[138] He posits that the word 'practices' entails that the "social construction of citizenship" changes over time in

[134] Gaventa op cit note 95
[135] Ibid
[136] Bryan S. Turner 'Contemporary Citizenship: Four Types' 2017 *Journal of Citizenship and Globalisation Studies*12-13
[137] Bryan S. Turner. Ed. Citizenship and Social Theory (1993) 2
[138] Ibid

response to societal conflicts and struggles.[139] On the premise of Marshall's definition, citizenship can be civil, political, economic, social or cultural as all these constitute different types of "practices". Whereas a foreign national may not be permitted to vote in an election, they may still be entitled to claim certain benefits from the government under whose care they are for example, access to healthcare[140] and protection from arbitrary deprivation of life. The political practice of voting in an election is distinct from the social practice of accessing certain goods and services or seeking protection of other fundamental rights. The foreign national is not deemed as a "competent member of society" for enjoying the benefit of participating in an election. However, they are seen as a "competent member of society" for accessing health goods and services and seeking protection from arbitrary deprivation of life. Further, Marshall's account of citizenship development and enjoyment of rights is that the expansion of citizenship was possible because of how society was structured and its dependence on the State as the sole provider of development and rights.[141]

Marshall's definition of citizenship entails that citizenship is about inequality, power differences, social class as well as advantages and disadvantages that flow from these.[142] A person may be defined as a competent member of society whereas another may not, thus creating inequality between them. Since rights and privileges flow from being a competent member of society, such a person is ascribed power in comparison to the person without citizenship. The fact that a person may also be considered a competent member of society in one area and not another may also create inequality, impact their social status, and ascribe power, all of which may have advantages or disadvantages for the person or group of people. Citizenship is a key determinant for how resources are distributed by the State.[143] Public goods and services may be availed or denied to a person on account of

[139] Ibid

[140] This thesis adopts the description of "healthcare" by Van Hout and Mhlanga-Gunda (2018) in which "healthcare" for women inmates is understood as "standards for management of incarcerated women's specific health needs on an equal basis as standards available in the community". They argue that healthcare is about equitable quality and access to health needs, where prison health services are provided in tandem with (and not isolated from) public health services in a way that results in compromised service delivery, quality and access for women prisoners. This aligns with my analysis on the right to health contained in chapter 3 of this thesis.

[141]Bryan Turner 'Outline of a theory of citizenship' *Sociology* (May 1990) 24:2 at 194

[142]Ibid

[143]Ibid

their citizenship status. It is therefore important to understand the nature and extent of citizenship for one to appreciate how societal resources are shared.

According to Turner, in understanding 'citizenship', citizenship theorists have to address the following questions in any given societal context:[144]

a) What is the content and form of social rights and obligations of the competent members of a society?
b) What are the social determinants of the practices that define a person as a competent member of society?
c) What determines the social arrangements for allocation of resources to different sectors of society?

Citizenship differs from context to context and across societies over time. It is therefore not static.[145] To determine who a citizen is, the above questions must be answered each time society formally or informally changes its rules on membership and benefits to members. Turner argues that citizenship is expanded when there is 'social conflict' and 'social struggle' in a particular social setting.[146] Social conflicts and struggles compel social groups to compete over access to resources. This means that social struggles and conflict arising from insufficient resources compel groups to make decisions about how the available resources are utilised.[147] The participation of social groups in governance and decision-making under Marshall's theory of citizenship is thus dependent on whether the members of the group are competent members of society and whether there exists a social conflict or struggle for resources.

Gaventa criticises Marshall's conceptualisation of citizenship as the "individual legal equality accompanied by a set of rights and responsibilities bestowed by a State on its citizens."[148]Gaventa argues that such conceptualisation of citizenship is typical of the traditional Western thought advocated by liberal theorists who principally believe that citizens are dependent on the State for enjoyment and exercise of their rights and

[144]Ibid
[145] Gaventa op cit note 95
[146] Turner op cit note 141 at 194
[147] Ibid
[148] Gaventa op cit note 95

duties.[149]Gaventa differentiates this liberal thought of citizenship from those that do not focus on the nation-State as the authority that determines citizenship, but instead depend on "the agency of citizens themselves, based on their diverse sets of identities."[150]Bryan Turner also argues for a broader conceptualisation of citizenship beyond the relationship of individuals in society and the nation-State. He posits that in a modern society, citizenship cannot be confined to specificities of the relationship between citizens and their nation-States akin to those of families or tribes as the demands of a modern society have outgrown this unsophisticated model of citizenship.[151] Turner thus defines citizenship as "a set of social practices which define membership in a society which is highly differentiated both on its culture and social institutions, and where social solidarity can only be based upon general and universalistic standards." [152] By defining citizenship in this way, Turner theorises citizenship in terms of interactions and association between people irrespective of where they are, as opposed to the enjoyment of a shared community life among people in a particular location.[153] Thus, citizenship should not be dependent on the State as the sole provider of its development and the sole determiner of citizenship rights.

While there are many theories of citizenship, including those deliberated by African scholars, the principles enunciated above concerning the liberal theory of citizenship underpin the conceptualisation of a prisoner as a citizen in Zambia. This is because Zambian prisons are highly regulated with little to no room for inmates to act as self-advocates. As a result, the rights and interests of inmates as citizens have received little recognition in the Constitution and consequently in all the seven constitutional review processes in Zambia where the status and practice of citizenship is largely shaped by the general population. Jeremy Sarkin argues that the lack of resources in many African countries entails that African prisons are not a priority for funding as "[m]any believe that there are needs more pressing than prison improvement. Often the attitude towards the appropriate function of penal institutions is that they are simply facilities for detention,

[149] Ibid
[150] Ibid
[151] Turner op cit note 137 at 5
[152] Ibid
[153] Ibid

punishment and crime prevention." [154] The State's exclusion of inmates from the constitution-review processes has the effect of disregarding the views of inmates and leaving them at the State's mercy. The citizenship rights and obligations of inmates is determined by the State through Acts of Parliament, signifying that the State determines the nature and extent of citizenship of inmates akin to the unsophisticated society envisaged by Marshall. This makes the practice of citizenship by inmates' minimalist and for the most part, inmates are not viewed as citizens worthy of the status and practice of citizenship.

The status and practice in present-day Zambia have changed over time with more non-State actors determining the growth of citizenship. Development actors as well as citizens have taken a prominent role in shaping the changes in citizenship. Sometimes development actors come with their own expectations of citizenship, which influence how citizens participate and enjoy their rights. [155] At other times, citizens transform their relationships, creating "networks of resistance as well as power that stretch into new spaces within as well as beyond the nation-State."[156] In both scenarios, the State is not the sole or even the most important determiner of citizenship. For the experience of citizenship to be extended to inmates, spaces for their participation in governance must be created by not only the State, but also the inmates and development actors. Through this research, I collected women inmates' views about the need for women inmates to claim and shape their practice of citizenship, and allowed their views and voices to inform an appropriate model to citizenship relevant to women inmates. This is on the understanding that even among women inmates, there are different classes of citizens ascribed with different powers, inequalities, status, and consequential advantages and disadvantages. The next section explores the different types of citizenship that exist in citizenship theory.

2.1.1Types of citizenship

Citizenship theorists allude to several forms and consequences of citizenship. According to Turner, different types of citizenship developed from different political and social circumstances in society. [157] He argues that citizenship types are informed by various

[154] Sarkin op cit note 90 at 21
[155] Cornwall op cit note 97
[156] Ibid
[157] Turner op cit note 137 at 11

modern processes occurring in law, culture, politics, and society generally.[158] This section briefly describes the different forms of citizenship, which include active, passive, inclusive, and exclusive types of citizenship. Below I juxtapose active and passive citizenship against inclusive and exclusive citizenship.

a) Active and Passive Citizenship

The concept of active and passive citizenship is concerned with the level of participation or involvement in championing one's interests. Participation may occur in the public space where individuals interact with institutions of democracy to advance individual and organisational interests.[159] The predominant focus of public participation is the relationship between the State and individuals which allows for engagement on common areas of interest. Participation may also occur in the social space where individuals engage each other to formulate and implement collective interventions for their mutual benefit in society.[160] Here, the principal focus of participation is the relationship among members of a community or organisation to the exclusion of the State. Individual participation occurs in a person's daily life. It allows individuals to make decisions and take actions concerning matters that affect them, including decisions and actions that shape how they live in their communities and society and how society is governed.[161] Participation thus creates relational and self-interest spaces in which participants may contribute to the shaping of their lives, communities and society. Participation need not strictly apply in the three distinct spaces, i.e. public, social and individual. Often, these spaces for participation overlap. The description of the different forms of participation emphasize the involvement of a person with a State, institution or self. It is possible for one to participate socially to further their personal interests or to improve their relationship with the State. It is also possible for one to participate in activities that further their self-interest as well as their social interests and relationship with the State.

[158] Ibid at 12
[159] Briefing Paper No. 1-*What is participation? Towards a round-earth view of participation*.pathwaysthroughparticipation.org.uk. Accessed on 16th August 2017 at 10hrs. 1
[160] Ibid
[161] Ibid

The determination of whether citizenship is active or passive depends on political, legal, and social entitlements ascribed to citizens at a given time.[162] Ray Pahl defines active citizenship as "local people working together to improve their own quality of life and to provide conditions for others to enjoy the fruits of more affluent society."[163] Thus, active citizenship is about how assertive citizens are in claiming their rights and benefiting from public resources.[164] The goal of active participation from the governance perspective is to improve the implementation of development policies by involving citizens in governance structures and processes.[165]Active citizenship guarantees democracy that is a "continuous interplay between the State, intermediary groups and individual rights."[166] Thus, if citizens are able to make demands on the State for their legal, political, and social entitlements, they are considered to be active citizens.[167] In the case of women inmates, for example, any woman inmate who complains about poor health services or denial of health rights by officials of correctional facilities or health practitioners is an active citizen. A woman inmate may rely on a law or laws containing provisions guaranteeing their right to health to lodge her complaint. A woman inmate may also be considered an active citizen if she utilises available women-friendly health services in public health and correctional facilities and other governance structures to assert her health rights.

By contrast, one who does not make any health-rights claims on the State or utilise governance structures to assert their health or other rights despite these rights being violated, is a passive citizen. Similarly, if a State grants decision-making power to women inmates without addressing barriers to their exercise of such power, women inmates remain unable to participate in decision-making thereby promoting a passive model of citizenship. Turner describes passive citizens as "apolitical and isolated".[168] They do not hold the State or civil society accountable, instead they either forgo their rights or interests

[162] Ibid at 2-3
[163] Lister op cit note 133 at 32
[164] AfriMAP and Open Society Foundation for South Africa *South Africa: Democracy and Political Participation* (2006) 3
[165] Jakob Kirkemann Hansen and Hans-Otto Sano *The Implications and Value Added of a Rights Based Approach* In *Development as a Human Right: Legal, Political and Economic Dimensions* Bard A Andreassen and Stephen P Marks (2006) 48-49
[166] Bernard Crick (2002) cited in AfriMAP and Open Society Foundation for South Africa. South Africa: *Democracy and Political Participation* (2006) 4
[167] Turner op cit note 137 at 22
[168] Ibid at 11

or seek to provide for themselves regardless of the actions or inactions of the State or civil society.

A governance system that does not provide for "devolution of authority"[169] to citizens is likely to produce passive citizens. A person can thus be a passive citizen if they fail to participate in activities that require collective involvement such as community discussions or if they fail to participate in activities that require individual action such as voting in an election. Thus, the issue of 'active-passive citizenship' has to do with whether a citizen exercises agency over their entitlements and opportunities or are complacent with whatever services the State provides them.

b) Inclusive and Exclusive citizenship

Inclusive and exclusive citizenship has to do with the extent to which individuals or groups of citizens are enabled to participate in claiming their rights, particularly on an equal basis to others. The State, civil society, or other development actors may develop criteria for recognising some individuals or groups as worthy of rights and participation in governance, thereby declaring others as unworthy of such participation. Naila Kabeer defines inclusive citizenship as "people's ability to claim their legally recognised rights on an equal basis as well as to the extent to which the law deals with them in a way that guarantees their equality."[170] Thus, once citizens are included in the list of eligible citizens for participation in governance, they must have equal opportunities, resources, and capacities to participate. An included citizen can either be active or passive. An excluded citizen is one who is prohibited from participating in governance and so they seldom can be said to be active. An excluded citizen may however lobby the State, civil society, and development actors to be included among the citizens who are legally recognised as eligible to participate in governance.

Several factors affect the practice of inclusive citizenship. One such factor is the dependency of women inmates on correctional officers and other State officials. Women inmates are wholly or substantially dependent on the State to meet their basic needs. This dependency coupled with the negative attitude of State officials consigns women inmates

[169] AfriMAP and Open Society Foundation for South Africa op cit note 164 at 4

[170] Naila Kabeer 'Citizenship, affiliation and exclusion: Perspectives from the South'(September 2006) 37:4 *IDS Bulletin* 91

to recipients of charity. This produces a passive citizenry who fail to hold the State accountable and are unable to claim basic necessities, such as healthcare, as of right. Conversely, the State largely ignores the needs and interests of women inmates as it views the bare provisions to women as charity. Further, poverty and political contestation were identified by Kabeer as barriers to inclusive citizenship. Kabeer argues that when one is poor, they tend to attach a lower value to formal guarantees of rights and forego rights' enforcement.[171] Regarding political contestation as a barrier to inclusive citizenship, Kabeer envisages a situation where a change in societal set-up fails to address pre-existing barriers to participation thereby perpetuating social exclusion. Discriminatory approaches to citizenship equally present barriers for inclusion. Efforts to include minority groups in governance that treat such groups as homogeneous risk excluding their unique needs, thereby creating an exclusionary form of citizenship. Fraser and Nicholson also illustrate exclusionary tendencies that arise by treating minorities as a homogeneous group. They argue that dominant groups of women ignore and subsume less dominant groups of women by ignoring their identities and interests in ways akin to how men ignore and subsume women as shown through dominant theories of citizenship.[172] Thus, just as identities are important to the practice of active citizenship, they are important for inclusive citizenship.

Policy changes are key to ensuring that as citizenship evolves, policies also evolve to support systems that facilitate new forms of citizenship. Although they do not address all the barriers to inclusive citizenship, they are a site of power that cannot be ignored. One factor that inhibits inclusive citizenship is the failure of political systems to create the time and space for those with competing identities and interests to engage in dialogue over their positions.[173] Lister opines that 'politics of difference' can pave way to a new way of realising rights referred to as "dialectical and relational rights", which enable excluded groups to be given a voice and listened to in the course of decision-making.[174] In Kabeer's view, political conflicts about the nature and boundaries of citizenship arise from attempts to address pre-existing differences while trying to balance local and national interests and

[171] Ibid
[172] Lister op cit note 133 at 38
[173] Ibid at 39
[174] Ibid at 40

individual and collective rights.[175] In the case of women inmates in Zambia, a major contestation exists concerning the ethos of the correctional system as a place of punishment for wrong-doing versus the modern view that the correctional system must be a place of rehabilitation and reformation to enable the reintegration of inmates into society. While it is quite clear what the former entails, there is neither consensus nor publicly available data, in the Zambian context, of what constitutes a correctional model and its goals. Increasingly, scholars and legal systems are making a case for correctional models that recognise the citizenship rights of inmates and their entitlement to an active participation as citizen. As argued by Stern, many correctional facilities still operate under the labyrinths of the 19th century ethos of punishment, with offender behaviour programmes taking centre-stage to the exclusion of more effective citizenship approaches.[176] A truly reformatory correctional model for prisons must pursue the goals of inclusive citizenship, identifying areas in which citizenship can be actively practiced in correctional facilities and ensuring a prison model that "accords more properly with the 21st century view of democracy and human rights."[177]

The foregoing discussion supports the need to review regulations and practices of citizenship that fuel social inequality and reinforce passive and exclusionary forms of citizenship.[178] Although inmates, as a class of citizens, are generally excluded from practicing citizenship in Zambia, there are more spaces opening up for their practice of citizenship. For example, at regional level, key documents such as the Kampala Declaration on Prison Conditions in Africa; the Fourth Conference of the Central, Eastern and Southern African Heads of Correctional Services; the Arusha Declaration on Good Prison Practice and the Ouagadougou Plan of Action have been formulated to improve prison governance systems.[179] At national level, the State has recognised and legally protected inmates' right to vote, upheld their right to food and promoted inmates' access to education. It should be noted, however, that citizenship must be shaped by affected persons who are given space and resources to participate in governance. How such

[175] Kabeer op cit note 170 at 97-98
[176] Baroness Vivien Stern 'Prisoners as citizens: A comparative view' 2002 at 9 available at https://journals.sagepub.com accessed on 10th October 2018
[177] Ibid
[178] Kabeer op cit note 170 at 98
[179] Sarkin op cit note 90

participation is effected will depend on the context and position of the citizens, but must certainly be determined by all parties that are directly affected including women inmates, the State, civil society, and development actors. In the next section, I examine the options that citizenship participation offers for facilitating active and inclusive forms of citizenship.

2.2 CITIZENSHIP PARTICIPATION

'Citizenship participation' is concerned with citizens' involvement in government beyond mere political participation.[180]Brynard J. Dirk notes that although citizen participation is synonymous with political participation, the two are distinct in that the former emphasizes the role of the citizen whereas the latter emphasizes the role of the State in the participatory relationship.[181] Dirk further differentiates citizen participation from public participation, which he states is wider than, and may include, citizen participation.[182] Public participation focuses on involvement of the public as a whole and not just individuals.[183] Thus, whereas some scholars use the words interchangeably, there are some nuanced differences that impact on the understanding of the concept of 'citizenship participation'.

Citizenship participation can be defined as "involvement of citizens in autonomous forms of action through which they create their own opportunities and terms for engagement" which in turn "bridges the gap between 'social' and 'political' participation but offers new ways of configuring the space in between."[184] This definition entails that citizens have opportunities and resources to mobilize themselves in both social and political issues that affect their lives and that they find creative ways of solving their social and political problems. The definition emphasizes the subject matter for citizenship participation and the need for citizens' agency in determining how they resolve their issues. Doina Popescu Ljungholm states that citizenship participation is a means by which citizens claim "democratic control" [185] over governance. He also emphasizes the

[180] Cornwall op cit note 97 at 2
[181] Koos Bekker (ed) *Citizen Participation in Local Government* (1996) at 134
[182] Ibid
[183] Ibid
[184] Cornwall op cite note 97
[185] Douglas, Plugge and Fitzpatrick op cit note 14 at 630

relationship between the citizen and the State. The sharing of democratic control between citizens and government helps them both to effectively contribute to policies and practice related to citizens' rights. Thus, for citizen involvement to qualify as 'citizenship participation', citizens must be involved meaningfully in a form of governance that reconciles their political interests with social, economic, and cultural interests.[186]

There are many ways in which citizens participate in public affairs that do not amount to citizenship participation. For instance, citizens who provide services akin to those of the State that are aimed at reconciling citizens' various interests cannot be said to be practicing citizenship participation even if they are expressly permitted by the State. Thus, individuals and civil society organisations offering health, education, legal, and other such services to the public are not promoting citizenship participation. Instead, they are offering services that are typically viewed as part of the States' responsibility. The lack of partnership between the State and the citizens in such service provision removes these interventions from the realm of citizenship participation. Similarly, citizens engaged by the State to develop and implement various policies, laws, and programmes cannot be said to be practicing citizenship participation. They are agents of the State. Another form of participation that does not amount to citizenship participate is when citizens carry out work pursuant to an imprisonment sentence. There may be citizen-State involvement in such work, but this does not qualify as a practice of citizenship participation since inmates are under the control and direction of the State. The work carried out pursuant to an imprisonment sentence is in a similar position to work carried out by inmates who are given special responsibilities as part of a rewards system of a correctional facility. Such work may assign powers and responsibilities to the inmate. The correctional officers are expected to ensure that the powers and responsibilities exercised by the inmate are within the limits granted. The control of the use of power by the correctional officers over the inmate makes the latter an agent of the State. Any involvement carried out pursuant to such a reward system also does not qualify as a practice of citizenship participation.

The joint exercise of "authority and control" by the State and citizens in determining and implementing policy solutions is a major determining factor of

[186] Ibid

citizenship participation.[187]Cibuka defines governance as "the exercise of authority and control."[188] This means citizens must be involved in governance if they are to be said to be practicing citizenship participation. The most prominent form of governance the world over is political governance.[189]

However, societal changes across the globe have expanded governance beyond a focus on politics.[190] There is now greater emphasis on other forms of governance such as "social, corporate and community-based governance".[191] These have, in turn, expanded citizenship thereby enabling citizens to have greater involvement in governance. For example, Lister refers to two main ways in which groups of women increasingly assert their citizenship. Firstly, women's development as citizens in the 20th century has been fueled by their participation in shaping and determining the nature of social rights and the partnership with State institutions to ensure realisation of such rights. The greater interaction of social and political citizenship has provided many women with relatively more authority and control thus expanding their experience of citizenship.[192] Secondly, bearing in mind that not all women are able to participate in the construction of social rights on an individual basis, Lister identifies community action as a means of expanding citizenship for both groups and individual members of those groups. She avers that many women find the participation in community organisations more personally fulfilling and relevant to their needs, rights, and interests than participation in formal politics.[193] Through such participation, they become advocates of social change in that they experience empowerment that enables them to engage with the State as partners in development and governance and not solely as beneficiaries of State programmes and policies.

[187] James G Cibulka. 'Citizen participation in the governance of community mental health centres.' (1981) 17:1 *Community Mental Health Journal* available at accessed on 23rd September 2018 at 19
[188] Ibid
[189] Henry Steiner 'Political participation as a human right' (1988) 1 *Harvard Human Rights Year Book* 77-134

[190] Cornwall op cit note 97
[191] Cibulka op cit note 187 at 20
[192] Lister op cit note 133 at 35
[193] Ibid at 33

The report on 'Gender and Governance in Africa: A conceptual framework for research and policy analysis and monitoring'[194] augments Lister's assertion by stating that the expansion and strengthening of women's citizenship can be achieved by transforming present relationships in society to reconstruct how society perceives women, re-organising community life and conceptualising power and decision-making as applicable in the home and other social settings.[195]

2.2.1 Key Considerations of citizenship participation

The expansion of governance and citizenship makes government policies and programmes more effective as they allow for inclusive and active forms of citizenship that are based on a collaborative response to rights, needs and interests of the people.[196] As a result of such expansion, institutions that are established to implement government policies and laws also function better.[197] In this respect, Gaventa observes that a complimentary relationship exists between effective citizens' participation and good governance when participatory approaches are imbedded in policies.[198]

Citizenship participation therefore has the potential benefit of making governance more effective thereby enabling institutions to provide better and relevant services to citizens. The form and effectiveness of citizenship participation may differ from context to context hence it is necessary to establish the nature of and extent to which it will apply in a particular setting. Citizenship participation may also have the benefit of enhancing the relationship between the State and its citizens by creating opportunities for dialogue and collaboration.[199] A healthy citizen-State relationship may be achieved by, among others, balancing "technical expertise of what is possible with citizen views about what is desirable."[200] Thus, the State may have all the expertise they require to implement various laws and policies, but if these are not reflective of the desires of the citizens, they will

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[194] Olu Tola Pearce *Gender and governance in Africa: A conceptual framework for research and policy analysis and monitoring* In a paper presented at the African Knowledge Networks Forum Preparatory Workshop (2000)
[195] Ibid
[196] Renee A Irvin and John Stansbury 'Citizenship participation in decision making: Is it worth the effort?' (2004) 64:1 *Public Administration Review* at 56
[197] Ned Crosby, Janet M Kelly, and Paul Schaefer 'Citizen panels: A new approach to citizen participation' (1986) 46:2 *Public Administration Review* at 171-172
[198] Gaventa op cit note 95
[199] Irvin & Stansbury op cit note 196 at 56-57
[200] Rose D. Douglas 'Citizen participation in public decision making by Jack DeSario and Stuart Langton' *American Political Science Review* (1988) 82: 2 at 630-631

encounter difficulties with their implementation. The possibility of a cooperative citizenry and consequential good relations between the State and its citizens provides one of the strongest motivations for the State to share its decision-making powers in the different forms of citizenship participation.[201] Irwin and Stansbury argue that citizens are more accepting of government programmes that are participatory.[202] Citizenship participation fosters legitimacy of government actions and efficiency, what Ljungholm refers to as "better management of public economy".[203]

Another advantage of citizenship participation is that it creates opportunities for citizens to be involved in governance. Through citizenship participation, citizens can identify solutions to the problems they face.[204] If citizenship participation is effectively implemented, citizens become knowledgeable about their situations and are empowered to find solutions to issues that affect their lives.[205] This creates active citizenship.[206] By fostering efficiency in use of public resources, citizenship participation also saves resources such as time and money. Resources are saved by ensuring that government policies and programmes are well designed and implemented from inception. If citizens are involved from inception, they are able to express their views in support or against a government programme timeously. This would prevent or minimize the expenditure of resources on unsupported programmes[207]

Critics of citizenship participation raise several concerns about its efficacy in meeting citizens' needs and interests. One of the reasons why citizen participation fails is that it is irrelevant to the context and issues of which citizens are involved. Many discussions on participation are often theoretical.[208] In order to make participation a reality, particularly for marginalised groups, it must be situated in their lived realities and experiences. In other words, where marginalised groups ordinarily have spaces for participation.[209] Cornwall argues that evidence of forms of participation that have worked

[201] Irvin & Stansbury op cit note 196 at 56
[202] Ibid at 55
[203] Doina Popescu Ljungholm 'Citizen participation in organizational decision making' (2015) 14 at 140
[204] Ibid at 140-141
[205] Irvin & Stansbury op cit note 196 at 56-57
[206] Ljungholm op cit note 203 at 140-141
[207] Irvin & Stansbury op cit note 196
[208] Cornwall op cit note 97
[209] Ibid at 1-2

in a particular location should not be generalised to all locations.[210] Certain forms of participation may work well for one or with a particular group of people but not for all. She states that it is important to identify factors that influence people's participation and to assess which spaces are available for their participation.[211] It would thus necessary to identify factors that inhibit citizens' participation and to determine how these can be addressed to enable people to participate in matters that affect their lives.

Another disadvantage of citizenship participation in practice is that it is often riddled with inequality among participants who advance personal interests thereby defeating the whole purpose of engaging in participation.[212] Further, and a closely related disadvantage of citizenship participation is that it sometimes attracts participation of citizens who are not representative of the people most affected by government decisions.[213] This prevents the outcomes of such citizenship participation from being legitimate and accepted by citizens who are most affected by government actions. Crosby et al suggest that a careful selection of participants and the establishment of fair procedures for such participation can address the concerns of power relations between participants, vested interests, and lack of representation.[214]

Sometimes citizenship participation is unsuccessful because the citizens are not knowledgeable about the area of discussion and are "not able to articulate their voice in these areas" or they make uninformed decisions.[215] In response to this concern, Colby et al contend that citizenship participation can be successful if it is packaged in a user-friendly format, the method of engagement is flexible to adapt to settings and different tasks, and citizens are "provided with accurate and meaningful information" to enable them to participate effectively in public policy matters.[216] Therefore, there is need to put in place a variety of measures that aim at empowering disadvantaged individuals and groups to participate in complex discussions using their lived experiences, desires, needs, and rights. The procedure for holding these discussions is just as important as the conversations held.

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[210] Ibid at 2
[211] Ibid at 3
[212] Irvin & Stansbury op cit note 196 at 59
[213] Ibid
[214] Crosby, Kelly & Schafer op cit note 197 at 171-2
[215] Gaventa op cit note 95
[216] Crosby, Kelly & Schafer op cit note 197 at 171-3

Gaventa emphasizes the importance of citizens claiming their citizenship. He argues that for citizenship participation to be effective, citizens must not wait for the State to create opportunities for them to participate.[217] Citizens must hold the State accountable and "demand public scrutiny and transparency."[218] At the same time, civil society organisations must also be held to account.[219] Citizens have a right to know, for example, what civil society organisations are doing to build agency and promote citizen participation and other forms of active citizenship.

While citizen participation can yield many benefits, it is a time-consuming and costly process to undertake.[220] Irwin and Stansbury argue that "the low end of the per decision cost of citizen participation groups is arguably more expensive than the decision-making of a single agency administrator, even if the citizen's time costs are ignored."[221] They, however, acknowledge that there is a social-capital value that is attached to citizens' involvement in decision-making inherent in citizenship participation, which is absent when a single agency administrator makes a decision that the community would have approved.[222] Getting citizens to participate in governance is therefore important for building and advancing social capital, but citizens may not always be willing to participate in public processes. The time and costs of citizenship participation are felt by citizens immediately whereas the benefits of such participation are often only felt in the long term. This may discourage citizens from engaging in participatory activities.[223] It may therefore seem worthwhile to educate citizens on the importance of participation as well as the processes envisaged to manage expectations and keep them involved.

The lack of resources for engagement processes may also discourage citizens from participating in public spaces.[224] It is therefore important for administrators to ensure that there are sufficient resources for the process before embarking on it. To be efficient, administrators must weigh the cost of the preferred mode of participation against other

[217] Gaventa op cit note 95 at *1-2 and* 9
[218] Ibid at 9
[219] Ibid
[220] Koos Bekker op cit note 181 at 72
[221] Irvin & Stansbury op cit note 196 at 58
[222] Ibid
[223] Ibid
[224] Ibid

forms of participation, with a justification given for selecting the more expensive form.[225] They should then secure the resources needed for the preferred mode of participation and further engage citizens if this proves problematic.

2.2.3 Types of participatory decision-making for citizens

Citizens can participate in several types of participatory decision-making processes. One such approach is through direct participation of a representative number of citizens on citizen panels.[226] This entails that citizens select a representative among their own to be part of a decision-making body where they can communicate their views on issues affecting them and make decisions on possible solutions for addressing those issues.[227] Another participatory decision-making model is through community discussions. Fiona Leh Hoon Chuah et al refer to this model as "deliberative approaches to community engagement"[228] They describe community discussions as "characterised by a process of reasoning, where community members are given opportunity to reflect, discuss, question and think."[229] Citizens may also use direct forms of submitting their views to decision makers as a mode of participating in governance.[230] Direct modes of submission can be done on an individual level or as a group. They may also be done orally or in writing. Other participatory decision-making models include the use of interest and pressure groups.[231] The difference between these two groups is contested mostly because they present themselves as two sides of the same coin. Bekker acknowledges the difficulty that many scholars and theorists have in defining or describing 'interest group' and 'pressure group'. He argues that whatever the differences between the two, both aim at "primarily promoting the interests of their members, through their actions they may also affect the lives of other members of the community."[232]

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[225] Crosby, Kelly & Schaefer op cit note 197 at 172
[226] Ibid at 170-77
[227] Ibid
[228] Fiona Leh Hoon Chuah, Astha Srivastava, Shweta Rajkumar Singh, Victoria Haldane, Gerald Choon Huat Koh, Chia Kee Seng, David McCoy, Helena Legido-Quigley 'Community participation in general health initiatives in high and upper middle income countries: A systematic review exploring the nature of participation, use of theories, contextual drivers and power relations in community participation.' (2018) *Social Science and Medicine* 111
[229] Ibid
[230] Moses Retselisitsoe Phooko 'What should be the form of public participation in the law-making process? An analysis of South African cases' (2014) *Obiter Journal* 40
[231] Bekker op cit note 181 at 29
[232] Ibid at 31

Bekker further notes the importance of the relationship between the local authority and a community group in determining what qualifies as an interest group or a pressure group. He avers that this largely depends on the response of the local authority to the demands of the group.[233] Interestingly, Bekker's view suggests that the partnership between the State and citizens that is required for citizenship participation can be created from a relationship that did not start out with the intention of creating a partnership. It is thus safe to conclude that independent or parallel actions of citizens through which they seek to communicate their claims to the State are capable of forming a form of citizenship participation if they eventually create a partnership with the State with the aim of resolving the issues of concern. Whatever form of citizenship participation is employed, it is important to ascertain how citizens want to influence changes. The impact of citizenship participation may be affected by the underpinning values and principles upon which it is anchored.

The next two sections examine two lenses through which citizenship participation may be practiced, that is, the rights-based approach to citizenship participation and the feminist approach to citizenship participation.

2.2.3 Rights-based approach to citizenship participation

This section discusses the relationship between citizenship participation and the rights-based approach to governance and development. I argue that the rights-based approach to citizenship participation uses the principles of human rights to justify not only how citizenship participation must be practiced, but also how the practice of citizenship participation can advance the realisation of human rights. I also examine the limitations of the rights-based approach in advancing citizenship participation and realising human rights.

'Human rights' is a contested concept.[234] It is mostly contested because the words 'human' and 'rights' that make up the concept are themselves contested. History shows that different phases of society the world over considered different classes of natural persons as being 'human' while others were not considered as being 'human'.[235] For

[233] Ibid
[234] Jerome J. Shestack 'The Philosophical Foundations of Human Rights' in Janusz Symonides *Human Rights: Concepts and Standards* (2000) at 33-35
[235] Jim Ife *Human Rights From Below: Achieving Rights Through Community Development* (2010) at 69-70

example, women, children, prisoners, persons with disabilities, persons of racial minorities, and indigenous people were at different times in human history not considered to be human beings worthy of rights and liberties protected by society.[236] On the other hand, the term 'rights' is contested because, among others, it bares at least more than one meaning.[237] 'Rights' can mean 'rectitude' or 'entitlement'.[238] Since rectitude is based on a moral standard, it is subjective. Further, when the word 'right' is used in the sense of an entitlement, it has a political character that allows it to take on various meanings. For example, a right can be recognised as valid even if it is not enshrined in national legislation.

In Zambia, inmates' right to vote is not expressly guaranteed in the legislation. The courts, however, recognise this right through interpretation of the constitutional provision of citizens' right to vote.[239] In other contexts, a right may not be recognised because it is not enshrined in national legislation. Inmates' right to social protection is not expressly recognised in any Zambian legislation and therefore not protected. Furthermore, rights are often considered as tools that can be used to trump actions of others and yet they too can be trumped by more weighty considerations.[240] The process of determining whether rights are tools to prevent violations by others or factors that justify violations is also contested.[241]

In the case of human rights, the composition of human rights has historically been a source of contestation.[242]Janusz Symonides observes that "intuitive moral philosophers claim that definitions of human rights are futile because they involve moral judgement which must be self-evident and are not further explicable."[243] Human rights are, however, not always self-evident and in many cases there is a need to justify why a right should be categorised as fundamental and thus belong to the bracket of rights referred to as human rights. Rights may be in various categories and have implications inherent in those categories. For example, civil and political rights such as the right to life, right to dignity

[236] Ibid at 69-70
[237] Shestack op cit note 234 at 34
[238] Jack Donnelly *Universal Human Rights in Theory and Practice.* 3ed.(2013) at 7
[239] Supra note 20
[240] Ibid
[241] Ibid
[242] Shestack op cit note 234 at 33-34
[243] Ibid

and the right to political participation are said to be negative rights, requiring a "hands off" approach from the State. [244] This means that the State is not expected to expend any resources for one to enjoy the right to life, dignity or right to political participation. On the other hand, economic and social rights such as the right to health or right to food are said to be "hands on" rights in which the State must invest resources to ensure that its citizens enjoy such rights.[245]

Rights-based approaches to governance and development arose through at least three major factors namely, the growth of international legal human rights framework, increase in social and political struggles, and "an evolution from clientelism to citizenship".[246] Rosalind argues that the growth of the international legal human rights framework created obligations on States to adhere to human rights standards and report their performance to international human rights monitoring bodies. The inclusion of independent or parallel reporting by civil society organisations (CSOs) increased pressure on States to adhere to international human rights standards.[247] Rosalind further argues that the increase in social and political struggles led to the development of rights-based approaches because the struggles encouraged vulnerable groups to mobilise themselves and demand participation in decisions that affected their lives.[248] As argued earlier, social and political struggles or conflicts galvanise citizens to demand accountability from their leaders thereby enabling them to be actively involved in governance.[249] In linking rights to struggles, Shivji argues that rights should be seen as a means of struggle.[250]"Seen as a means of struggle, a 'right' is not a standard granted as charity from above, but a standard-bearer around which people rally for the struggle from below."[251]

Lastly, Rosalind's reference to the evolution from "clientelism to citizenship" as a basis for the development of rights-based approaches is closely related to the increase in social and political struggles. It is concerned with change from passive citizenship to

[244] Carlson Anyangwe *Universal Human Rights and Humanitarian Law* (2006) at 25
[245] Ibid
[246] Eyben Rosalind *The Rise of Rights* IDS Policy Briefing 17 (2003) at 1
[247] Ibid
[248] Ibid
[249] Turner op cit note 137 at 2
[250] Shivji I *The Pitfalls of the Debate on Democracy* CODESRIA Bulletin 2 cited in Harsh Mander *Rights as Struggle-Towards a More Just and Humane World* in Paul Gready and Jonathan Ensor (eds) *Re-inventing Development?: Translating Rights-based Approaches from Theory to Practice* (2005) at 238
[251] Ibid.

active citizenship. This change demands that public goods and services are not imposed on the people but are made available so that if they are not provided, then people are able to make demands for their provision from their leaders.[252] Mander emphasises the value of agency by stating that "'sustainable' or enduring justice that addresses and reverses the causes of their rights denials cannot be achieved" without their participation.[253]

In Turner's recount of the growth of citizenship, he discusses how the world economic recession of the 1980s threatened the existence of the welfare State.[254] This prompted critical theorists to "re-examine the issues of distributive justice, equality and individual rights."[255] Although the welfare system met some of the needs of vulnerable and marginalised groups, it was not successful because it took a top-down approach in identifying their needs and not giving them opportunities for doing so.[256] As noted earlier, the identification of needs by vulnerable groups is an important factor for sustainable and effective service delivery. The participation of vulnerable groups in this process cannot therefore be dispensed with. Similarly, citizen participation is cardinal in deciding which rights are most important and require priority funding.[257] In this respect, Rosalind argues that "deciding which rights are most important and require priority funding in relation to the State's resources, becomes a political debate in which all citizens have a right to participate."[258]

The concepts of human rights, democracy, and good governance are mutually beneficial.[259]Gudmundur Alfredsson states that "the purposes of human rights, democracy and good governance may differ, but they share the overall desire of improving national societies and the quality of life for the people living there."[260] One cross-cutting issue that human rights, democracy and good governance emphasise is 'citizenship participation'. Turner uses the concept of citizen participation to illustrate one way in which the three

[252] Rosalind op cit note 246 at 3-4
[253] Harsh Mander 'Rights as Struggle-Towards a More Just and Humane World' in Paul Gready and Jonathan Ensor (eds) *Re-inventing Development?: Translating Rights-based Approaches from Theory to Practice* (2005) 243
[254] Turner op cit note 141
[255] Ibid
[256] Mander op cit note 253 at 236
[257] Rosalind op cit note 246 at 2
[258] Ibid
[259] David Beetham *Human Rights and Democracy: A Multifaceted Relationship* in *Democracy and Human Rights* (1995)
[260] Gudmundur Alfredsson 'The Usefulness of Human Rights for Democracy and Good Governance' *in* Hans-Otto Sano and Gudmundur Alfredsson (eds) *Human Rights and Good Governance: Building Bridges (2002) 23*

concepts advance the common goal of accountability by the State to the citizens. He states that democracy provides the vehicle for the protection of fundamental rights, which in turn prevents the abuse of power by the State. By this, Turner acknowledges the importance of citizen participation in holding the State accountable for the power it exercises and ensuring that human rights are protected.[261]

Ferguson argues that people's participation in decision-making on the provision of health services is so important to their enjoyment of health rights that without such participation, people cannot enjoy their right to health.[262] Citizenship participation is crucial for the realisation of rights because it facilitates individuals' claims on the government and other organisations.[263] Human rights also guarantee social participation, that is, one's right to participate in social activities that determine how the governor must distribute public resources. Social participation is equally cardinal in addressing factors that cause vulnerability and curtail personal and societal development.[264]

Just as human rights and democracy do not always work in the same domains, rights-based approaches are not always suited for all developmental agendas. Although rights-based approaches enable human rights principles to be mainstreamed in public activities and institutions, they "are not and should not be applied to all economic, social, political and institutional change" because human rights would not have a major impact in certain areas of development.[265] Certain locations or activities are not well suited for participatory methods as such methods would not yield the intended result.[266] Cornwall argues that spaces in which participation occurs have their own dynamics.[267] Thus, it is important to acknowledge these dynamics and consciously decide whether implementing participatory methods carried out in one location in the same manner as a different location will yield the same outcomes. This is indicative of the fact that in certain locations, certain forms of participation will not be as suitable as in other locations.

A rights-based approach to governance offers viable means of achieving citizenship participation but it is not always suitable for this purpose. Some of the reasons

[261] Turner. Op cit note 141
[262] Ferguson op cit note 94 at 7-11
[263] Ibid at11-14
[264] Hansen & Sano op cit note 165 at 36 and 38
[265] Ibid at 36
[266] Irvin & Stansbury op cit note 196 at 60-2
[267] Cornwall op cit note 97

concern the purpose and location of the intervention whereas others relate to the foundational problem of a concept of human rights that is contested. Citizenship participation practiced within a rights-based approach has the potential to realise fundamental rights such as the right to health, but without considering exclusionary tendencies of citizenship and having due regard to one's context, the realisation of rights may be limited. For women inmates, consideration of their unique circumstances as inmates and more specifically as women inmates requires a different perspective. Feminism offers valuable insights.

2.2.4 Citizenship participation from the feminist perspective

Women's experiences of citizenship are relevant for reviewing and reforming the systems needed for creating an enabling environment for their participation.[268] They experience governance and citizenship differently when they have no control over the subject-matter for participation and even when they are not recognised as eligible to participate in governance. Citizenship participation, including that underpinned by a rights-based approach, is presented mostly from a patriarchal view because forms of participation often capture the ways in which men envisaged and experienced citizenship participation. Feminists recognise that women have been and continue to be excluded in many spheres of life to the extent that they do not often participate in decision-making on issues that affect their lives. According to Ashwanee Budoo, "feminist as a 'group' seek the empowerment of women and the transformation of institutions dominated by men."[269]However, the concept of feminism extends beyond the broad classification of the fight for equality between women and men. Since feminists from the global north have been accused of imploring advocacy strategies for equality that "reflect the world as viewed through the eyes of white middle class women, Black/Diaspora feminists have introduced race and class as important factors in understanding their situation."[270]

Mainstream theories of democracy, citizenship, and human rights, among others, are dominated by men and other privileged groups in that they obscure or ignore women's

[268] Madeleine Arnot 'Gendered Citizenry': New Feminist Perspectives on Education and Citizenship (1997) 23:3 *British Educational Research Journal*
[269] Ashwanee Budoo 'The role of gender budgeting in implementing the obligation to provide resources to realise women's human rights in Africa' University of Pretoria 2016
[270] Fareda Banda *Women, Law and Human Rights* (2005) at 7-8

(including minority women's) experiences and views thereby making them invisible. Feminism, whilst recognising and celebrating women's heterogeneity, calls for the re-conceptualisation and creation of theories such as democracy, citizenship, and human rights from a 'women's perspective'.[271] Feminists' argument that women experience governance and citizenship differently from men and other "better-placed" women is exemplified by the spaces and democratic institutions which are entrenched in patriarchal and elitist values, norms, and practices.[272] Preece states in this regard that "the way men and women learn what is valued in terms of active citizenship and participation in decision-making determines their identity as citizens, their perceived entitlements as members of a given society and their perceived role within society."[273]

Many issues affecting women are viewed as private as opposed to those affecting men which dominate the public arena.[274] Ruth Lister argues that the failure to recognise women's needs as genuine political issues warrant the need to deconstruct the "patriarchal separation between the public and the domestic 'private' which underpin the very (gendered) meaning of citizenship".[275] Akiyode-Afolabi augments this view by arguing that separating women and men's interests on account of private and public domains is artificial since "public spaces reach people's homes from political power positions."[276] On this account, women must not be excluded from public spaces and more importantly, the private-public divide that fuels women's differential experience of citizenship must be dismantled.

Another way in which women experience governance and citizenship differently from men and privileged women is in respect of the eligibility criteria. Who gets to participate in governance is often affected by a person's status in society for example, women versus men, poor versus rich, old versus young, educated versus uneducated, able-bodied versus persons with disabilities, incarcerated versus free persons and so on.

[271] Arnot op cit note 268 at 146
[272] Ibid
[273] Julia Preece op cit note 100 at 21
[274] Abiola Akiyode-Afolabi *Feminist reflections: Political participation, feminist organising and creation of inclusive democratic spaces* (Dec 2020) at 11
[275] Lister op cite note 133
[276] Akiyode-Afolabi op cit note 274

Feminists take an inclusive approach to participation based on equal recognition of all human beings regardless of their gender, identities and status.[277]

Feminists also argue that women's ability to participate in decision-making may shift depending on the times and prevailing circumstances.[278] They recognise that "the idea of increased participation in decision-making is grounded in a number of concepts which are still evolving and require closer scrutiny."[279] Therefore, what may constitute participation at a particular time may change along with women's experiences of such participation. The constant refining of democratic spaces also warrants a constant review of women's experiences to ensure that historical exclusion is addressed and that sites, issues, and eligibility for participating in decision-making are reflective of the needs, interests, and rights of women.

In as much as society shapes how citizens experience citizenship, citizens can shape how society is governed.[280] For many women, this has been unachievable due to factors such as inequality on the basis of sex, gender, age, and legal status that affect their ability to participate meaningfully in public activities and decision-making. Inequality must therefore be addressed to enable women to participate effectively in governance. Society's attempt to address women's inequality was to grant them universal suffrage "with the assumption that inequality ends with this right".[281] This, however, served to reinforce inequality and curtail participation. As a result, many women are seen to take a passive role in their exercise of citizenship. Akiyode-Afolabi argues that many African countries resorted to a quota system as a means of increasing the number of women in political leadership. This approach is not effective in creating inclusive democratic spaces for women as women do not have the necessary power to influence agenda-setting and championing of their interests. Women in leadership positions most often fulfil symbolic functions, thereby being subjected to implementing a patriarchal agenda.[282]

Attempts to facilitate active citizenship by women must be cognisant of women's historical context and use this as a basis for planning and implementing their inclusion in

[277] Pearce op cit note 194 at 7
[278] Smart op cit note 175
[279] Pearce op cit note 194
[280] Ibid at 24
[281] Ibid at 26
[282] Afolabi op cit note 274

governance. In the case of Zambia, a study by the British Council revealed that to promote female participation in politics, the following barriers need to be addressed: patriarchal values and norms in the political and social system that do not support women, the structure of the legal system that limits its promotion of gender equality to formal equality, and lack of personal wealth.[283] On this premise, the National Women's Lobby, a civil society organisation in Zambia with the mandate to promote women's participation in governance, designed capacity-building interventions to support women political candidates by meeting their individual needs, to advocate for reforms in Zambia's regulatory framework and to promote gender equality in the country's governance structures.[284] This approach has contributed to ensuring greater access of women to various governance structures and national agenda.

As earlier argued, women inmates in Zambia occupy a low social standing which negatively impacts their enjoyment of their human rights, including citizenship rights and health rights. They are treated generally by the correctional authorities and society as "criminals" and not "incarcerated citizens".[285] By virtue of this identity ascribed to women inmates, many governments, through their correctional systems and the broader criminal justice systems, neglect their responsibilities in ensuring that women inmates enjoy their citizenship rights to the fullest extent possible.[286] The only legitimate limitations on the enjoyment of citizenship rights by women inmates must be those aspects directly impacted by their imprisonment such as their freedom of movement. Vivien Stern argues that correctional facilities can recognise the citizenship status of an incarcerated person and facilitate their enjoyment of citizenship "without jeopardising security or lessening the importance of prison as a punishment in the eyes of the judicial system and the public."[287]

Negative social attitudes, discrimination, and other human rights violations against inmates should be addressed to enhance the low social standing of women prisoners. Some scholars argue that although it is difficult to measure the extent of enjoyment of inmates' citizenship rights, such measurement is nonetheless possible by examining factors such as

[283] British Council 'Encouraging female participation in Zambian politics'available at https://www.britishcouncil.org
[284] Ibid
[285] Stern op cit note 207
[286] Ken Kerle, Stan Stojkovic, Richard Kiebusch and Joe Rowan 'Rejoinder to Vaughn and Smith's "practicing penal harm medicine in the United States: Prisoners' voices from jail" *Justice Quaterely* 4 (1999) at 897
[287] Ibid

inmates human rights status, humane containment and the decency of the treatment they are subjected to, the legitimacy of State and societal actions towards inmates, and inmates' personal responsibility and civic duty for their own social inclusion.[288] Bird and Albertson identify the ability to make choice on how inmates spend their time, retain personal identity and interact with prison officials as some of the factors that can be considered for measuring the citizenship of inmates.[289] As argued by Preece, "equality of opportunity within existing definitions and social structures" cannot address gender differences without interrogating the existing power relationships that preserve the exclusion of women.[290] The review of institutions of democracy is necessary to challenge the power relations and sites that perpetuate exclusion of women. Gaventa augments this by stating that "participation can only become effective as it engages with issues of institutional change."[291]

To ensure effective citizenship participation that advances the rights and interests of women, women need to be active citizens and mobilise the change they want. Changes in social structures are most effective when they do more than rely on legal and policy changes that can mostly guarantee formal equality. There is a need to position women, especially vulnerable women, to participate actively in all areas of public life to the same extent as men and other better-placed women. Raday argues that law and philosophy alone are insufficient to bring about equality unless they are translated into political, economic and social action."[292]

Another issue of concern regarding women's experience of citizenship participation, is the motivation for such participation. Whereas authors such as Gaventa identify citizenship participation as a means of realising rights,[293] Carol Smart warns about the use of citizenship participation for the realisation of rights. Smart identifies four reasons why rights are problematic. First, she argues that "rights oversimplify complex power relations".[294] She argues that social problems may continue to exist even if laws are

[288] Hayden Bird and Katherine E. Albertson 'Prisoners as citizens: 'Big society' and the 'rehabilitation revolution'- Truly revolutionary?' (2011) 9 *British Journal of Community Justice* at 96
[289] Ibid at 97
[290] Preece op cit note 100 at 29
[291] Gaventa op cit note 95
[292] Frances Raday 'Gender and Democratic Citizenship' (2012) *I.CON* 10:2 at 1
[293] John Gaventa op cit note 95
[294] Carol Smart op cit note 107 at 144

enacted to address them because the law is not a panacea for all problems.[295] Some women fail to enforce rights because doing so would put them in a worse position than they were in before seeking to enforce their rights.[296] It should, however, be noted that feminists generally agree that regardless of the shortcomings in the law, the legal recognition of women is a goal in its own right, considering that women's rights were historically not recognised.[297]

The second problem Smart identifies with rights is that they are granted to everyone including victims and perpetrators, and thus "a resort to rights can be effectively countered by the resort to competing rights."[298] For marginalized and vulnerable women, this presents major problems as they often lack resources and the required skills and support to prove their claims or counter-competing claims. Feminists recognise the need to build women's resistance to patriarchy by organising, which builds communities that advocate for their collective interests, builds pressure for their inclusion in social structures and system and engages in intersectional activism while exploring feminist alternatives to social struggles.[299] It must, however, be acknowledged that in many ways, the rights-based approach creates a vehicle by which this feminist agenda can be achieved. As argued by Budoo, the human rights discourse facilitates the enjoyment of women's rights in ways that did not exist previously.[300]

A third problem with rights is that they place the burden of proving a violation on the victim for whom they are intended to protect.[301]This makes it difficult for women who do not have the capacity to prove a rights violation. The last problem that Smart identifies is that rights that are intended to protect the weaker members from the stronger members of society are often used by the latter.[302]

The above four problems of the rights-framework have the potential of exacerbating vulnerability of women therefore negating the effective implementation of

[295] Ibid
[296] Ibid
[297] Ashwanee Budoo 'The role of gender budgeting in implementing the obligation to provide resources to realise women's human rights in Africa' 2016 University of Pretoria at 134
[298] Smart op cit note 107 at 145
[299] Abiola op cit note 214 at 11
[300] Ashwanee Budoo op cit note 387 at 117
[301] Smart op cit note 107 at 145
[302] Ibid

citizenship participation. Even though rights are largely individualist, the feminist approach allows marginalised women to mobilise in ways that allow them to satisfy their collective and individual interests.

It is evident from the above discussion that solutions targeted at women must reflect a women's perspective as these could be radically different from solutions offered from the male perspective. Further, differently placed women experience citizenship differently and thus the power differences that exist among women of different backgrounds must be fully understood and addressed when seeking to engage in citizenship participation. To be effective, systems and structures meant to address women's citizenship rights and their interests must be informed by the affected women. The weaknesses that have been identified in the rights-based approaches could be strengthened by a feminist approach to citizenship participation, which allows women to meaningfully participate in matters that affect their lives.

2.5 CONCLUSION: KEY CONSIDERATIONS FOR THIS RESEARCH STUDY

This Chapter lays a foundation for using the concept of 'citizenship participation' for recognising rights and citizenship of women inmates. It justifies the choice of citizenship participation as the relevant analytical lens for challenging the exclusion of vulnerable and marginalised groups like women inmates who are often passive recipients of health systems in their places of detention. Citizenship participation creates an environment for social learning that flows from citizens' engagement in activities and decisions, which help them to identify their political interests and the social values that affect such interests with the aim of subjecting political interests and social values to debate.[303] Citizens' participation in debates on their social values and political interest informs strategic decisions.[304] Although neither citizenship participation nor the rights-based approach are a panacea for addressing challenges that women face in exercising active citizenship and asserting their rights, they have the potential to address some challenges faced by women. Feminism offers a useful lens for responding to women's social exclusion from the public sphere as feminists build resistance against exclusionary practices in society, advocate for

[303] Czapansky K, Syma Karen and Rashida Manjoo *The Right to Public Participation in the Law Making Process and the Role of the Legislature in the Promotion of this Righ*t (2008) at 15
[304] Ibid

alternative ways of participating in politics, and explore and create new democratic spaces for women's participation.

Using a feminist's approach, this research explores how the participation of women inmates in health-related decision-making and programming can foster the realisation of their health rights in correctional settings in Zambia. In this research, the term 'citizenship participation' or 'citizen participation' is used to emphasise the involvement of women inmates as citizens, individually or jointly, in advancing their interests, rights, and claims against the State and in communicating with the State on matters that affect their health. The next Chapter examines human rights norms at international, regional and national levels for the promotion and protection of women inmates' health rights.

CHAPTER THREE
ZAMBIA'S INTERNATIONAL, REGIONAL, AND NATIONAL LEGAL FRAMEWORKS FOR REALISING WOMEN INMATES' HEALTH RIGHTS

3.0 INTRODUCTION

This Chapter has two objectives. Firstly, it seeks to examine the applicable international and regional human rights standards for responding to women inmates' health determinants and for their participation in health-related decision making. The Chapter demonstrates that international and regional human rights treaties applicable to Zambia consider 'health' as constituting more than one's medical needs, but a holistic state of physical and mental health. The Chapter further shows that international and regional human rights treaties establish a link between participation in health-related decision-making and programming and enjoyment of the right to health. Examining the role of participation in advancing health rights shows the weaknesses in a medical-based approach (such as the one used by the Zambia Correctional Service) to correctional health. This justifies the formulation of a women-centred citizenship participation model for health which enhances women inmates' health rights and interests, while conforming to Zambia's international and regional human rights obligations. The human rights instruments applicable to Zambia provide the minimum standards of how rights must be guaranteed. The minimum standards thus set the foundation upon which States may construct their own normative standards for responding to citizens' health needs and interests. This Chapter will examine the standards set by international and regional human rights treaties applicable to Zambia on the right to health and the right to participate in governance as a way of promoting health interests.

The second objective of this Chapter seeks to analyse Zambia's national legal framework on women's right to health and participation in health-related decisions and programmes. Through this analysis, the Chapter presents how the national laws promote women's health rights, the existing gaps and the opportunities for using the law to promote women inmates' health rights.

This Chapter starts with a discussion on that the link between participation and health rights. International and regional human rights systems on the right to health and the conceptualisation of health-related participation for women are then examined. The Chapter then presents an analysis of international and regional systems on social and political participation and how they can potentially advance women's health rights and interests. Using this information, a reflection on the suitability of international and regional human rights standards for fostering women inmates' participation in health governance is considered. Thereafter, Zambia's national legal frameworks for the promotion of women's heath right are analysed, showing the implications of Zambia's national laws on enjoyment of health rights by women inmates. The Chapter ends by summarising the findings on legal approaches to addressing women inmates' health rights.

3.1 THE LINK BETWEEN PARTICIPATION AND HEALTH RIGHTS IN INTERNATIONAL AND REGIONAL HUMAN RIGHTS SYSTEMS

Zambia has signed and ratified international and regional human rights instruments that guarantee the right to health and the right to social and political participation. These international and regional human rights frameworks provide evidence that health rights and interests can be enhanced through the participation of those most affected as illustrated below.

3.1.1 The role of participation in international and regional human rights instruments on health

Participation has the potential to empower women inmates to determine health priorities for themselves and to influence the formulation and content of health laws, policies and practices. An examination of the international and regional human rights mechanisms conducted below is relevant to illustrate the role of citizenship participation in the enjoyment of health rights.

a) Guaranteeing women's participation through the highest/best attainable standard of health

Zambia ratified the International Covenant on Economic, Social and Cultural rights (ICESCR), which is arguably the first and most comprehensive international treaty on economic, social and cultural rights that was developed after the Universal Declaration of

Human Right (UDHR).[305] It guarantees the right to health by recognising everyone's right "to the enjoyment of the highest attainable standard of physical and mental health."[306] It also provides a guide on steps that States Parties to the Covenant should take to achieve this standard of health.[307]

The right to health as stipulated in Article 12(1) of the ICESCR guarantees the right to "the highest attainable standard of physical and mental health." It may be interpreted as guaranteeing not only a high-quality package of health, but also ensuring the enjoyment of the best health status. The right to health does not guarantee freedom from disease, but entails that when a person does fall ill, they should be entitled to the highest attainable standard of healthcare.[308] It also entails that every person is entitled to the best attainable preventive measures for safeguarding their physical and mental health.[309] Other international human rights mechanisms that conceptualise the right to health as guaranteeing the right to highest attainable standard of health are the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD)[310] and the United Nations Convention on the Rights of the Child (UNCRC).[311] At regional level, human rights instruments in Africa guarantee "the right to the best attainable state of physical and mental health."[312] The African Charter on the Rights and Welfare of the Child and the Protocol to the African Charter on the Rights of Persons with Disabilities also guarantee the right to the *best* attainable standard of health.[313] [Own emphasis]

[305] Carlson Anyangwe *Introduction to human rights and humanitarian law* (2003) at 34
[306] UN Supra note 61, Article 12
[307] Article 12(2)
[308] United Nations Economic and Social Council 'General Comment no. 14 (2000)' Para 8 and 9 available at General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant) | Refworld accessed on 14th February 2024
[309] Southern African Litigation Centre *Using complaints to address healthcare violations: A guide for healthcare users and community-based organisations* August (2016) at 1
[310] UN General Assembly, Convention on the Rights of Persons with Disabilities: Resolution/adopted by the General Assembly 24 January 2007 A/RES/61/106 available at http://www.refworld.org/docid/45f973632.html accessed pm 30 April 2018, Article 25
[311] Ibid, Article 24
[312] Supra note 62, Article 16
[313] See Article 14 of the Protocol to the African Charter on the Rights of the Child and Article 17 of the Protocol to the African Charter on the Rights of Persons with Disabilities

Considering that the UDHR inspired the drafting of the ICESCR, the right to health must be understood to include the enjoyment of social and economic factors that affect the enjoyment of health rights.[314] Article 25 of the UDHR provides:

> 1. Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and other necessary social services, and the right to security in the event of unemployment, in sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.
> 2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection.[315]

The UDHR expressly anchors the right to health in the broad area of social and economic factors that affect the enjoyment of health rights. The UDHR recognises that one's living standards impacts on their health and explicitly creates the relationship between the right to health and social determinants of health.[316] The UDHR further recognises that women and children are particularly vulnerable to violations of their socio-economic rights, including their health-rights and thus are entitled to special protection.[317]

The United Nations Committee on Economic, Social and Cultural Rights (UNCESCR) is the independent body of experts established under the ICESCR to monitor the implementation of the ICESCR. The UNCESCR has interpreted Article 12 of the ICESCR as requiring the participation of rights-holders in attaining the highest attainable standard of health.[318] Firstly, it has recognised that "the participation of the population in all health-related decision-making at community, national and international levels is an important aspect of Article 12(1) of the ICESCR." [319] Participation plays an important role in defining what is meant by health, identifying health needs and determining and prioritizing health resources. The attainment of the best possible standard of health requires consideration of a person's biological and socio-economic status as well as an assessment of the State's available resources for health. In other words, a fusion of a people-centred and systems-centred approach to health is cardinal in realising the best

[314] Supra note 308, Para 3
[315] Universal Declaration of Human Rights 1948 217 (III) A. Paris, 10th December 1948 available at https://www.refworld.org/docid/3ae6b36c0.html accessed on 10th July 2019, Article 25
[316] Supra note 308, Para 4 and 9 of General Comment 14 of 2000
[317] Supra note 315, Article 25(2)
[318] Para 10, 11, 17 and 21 of General Comment 14 of 2000
[319] Ibid at Para 11

attainable standard of health. The State is not privy to the biological and socio-economic status of its citizens, neither are citizens privy to the State's available resources for health.[320] This means that the State and citizens must work together to ensure the enjoyment of the highest attainable standard of health. Secondly, the UNCESCR states that to give effect to Article 12(2)(d) of the ICESCR which requires States Parties to formulate conditions necessary for guaranteeing medical services and attention for sick people, States Parties must ensure:

> the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.[321]

The UNCESCR further acknowledges that 'health' is not a static concept. It shifts over time, requiring periodic reviews of what it means to a person or group of people at different times and spaces. 'Health' is influenced by time, geographical location and political and socio-economic environments, among others.[322] The provision of health services is dependent on the conceptualisation of 'health' in any given setting. Health systems and programmes can facilitate the attainment of the highest attainable standard of health if they effectively involve their users in health rights programming and governance.[323]

The Declaration of Alma Ata[324] also recognises the importance of participation in the attainment of the highest attainable standard of health. It is not a legally binding human rights instrument but has significant persuasive value for interpreting and modelling countries' adherence to international human rights standards for primary healthcare.[325] The Declaration of Alma Ata was a call to action for primary healthcare made to governmental and non-governmental bodies. It was instrumental in calling for a paradigm shift of healthcare from "hospital-based and curative" (herein referred to as a

[320] Ibid at Para 14
[321] Ibid Para 17
[322] Ibid Para 10
[323] Ibid
[324] WHO, Microsoft Word - almaata_declaration_en.doc (who.int)
[325] Audrey R Chapman. *Alma Ata at 40: Revisiting the Declaration*. Health and Human Rights Journal. 10th September 2018. Available at www.hhrjournal.org accessed on 8th September 2021.

medical-based approach to health) to a healthcare approach which was community-based (herein referred to as a citizen-centred approach to health) thereby calling for an increase in the number of people accessing healthcare.[326] Although the Declaration of Alma Ata was enacted over 40 years ago, it is relevant to current day discourse on primary healthcare as a means of advancing the best attainable standard of health for all. It provides guidance in achieving universal health coverage under target 3.8 of the Sustainable Development Goals.[327] It has also been influential in the interpretation of Article 12(1) of the ICESCR "as an inclusive right extending not only to timely and appropriate healthcare but also to underlying determinants of health. The list of the underlying determinants of health in General Comment No. 14 reflects the influence of the Declaration of Alma Ata."[328] The influence that the Declaration of Alma Ata has had on the enjoyment of the right to health to date evidences its authoritativeness.

The Declaration of Alma Ata describes participation in health as a right and duty of individuals and groups.[329] Further, it states that the health of the people is the responsibility of government and links primary healthcare to social and economic development of a country.[330] The Declaration of Alma Ata expressly recognises the importance of locating health within one's living conditions and taking a holistic approach to primary healthcare.[331] Like the ICESCR, it describes health as the "highest level of health possible."[332] These provisions do not only inspire a supportive environment for a participatory approach to health, but contribute to the attainment of the standard of health envisaged in international and regional human rights instruments.

The UNCESCR and the African Commission recognise that the highest attainable standard of health is affected by a State's available resources.The ICESCR requires States Parties to "take steps to the maximum of its available resources with a view to achieving progressively the full realisation of the rights recognised in the present covenant".[333] Further, the African Commission notes that meaningful participation by targeted

[326] J.H.Bryant and J.B.Richmond *Alma Ata and primary healthcare: An evolving story* (2008)
[327] Chapman op cit note 325
[328] Supra note 324
[329] Ibid, para IV
[330] Ibid, para VI
[331] Ibid, para VII
[332] Ibid, para I
[333] Supra note 61, Article 12(2)

populations of health interventions must be promoted for the State to fulfil its obligations in "adopting all necessary and appropriate positive measures to the maximum of its available resources to promote, provide and facilitate" health rights.[334] Different types of resources are required for different health needs. States must identify what types of resources they require to meet the health needs of different populations under their care. Considering that health needs and resources evolve along with the concept of health and are affected by various health determinants, health experts cannot adequately identify required health resources without the participation of affected populations.

Furthermore, to guarantee efficiency in the use of State resources and aspire for the highest attainable standard of health, it is necessary to involve affected populations in determining and prioritizing health resources. Inefficiency in the use of resources may occur when there is insufficient expenditure or misallocation of public resources due to misplaced priorities or lack of appreciation of health needs or political will to advance health rights leading to misuse of public resources. The UNCESCR describes insufficient expenditure or misallocation of public resources which negatively impact on the people's enjoyment of their right to health as a violation of the right to health under Article 12 of the ICESCR.[335]

b) Standards for women's participation in health deducible from the "equality or anti-discrimination" model.

In this thesis, the equality or anti-discrimination model of health refers to how international and regional human rights systems conceptualise health rights in equality or anti-discrimination provisions. In human rights law, equality constitutes both formal and substantive equality. Formal equality entails the recognition of all persons as equal irrespective of their personal traits and social standing.[336] An example of formal equality is a legal provision that guarantees everyone the right to access healthcare. Substantive equality entails the consideration of one's personal traits and social standing in designing and implementing programmes for the enjoyment of rights. Substantive equality would

[334] ACHPR, Resolution on Access to Health and Needed Medicines in Africa - ACHPR/Res.141(XXXXIV)08 | African Commission on Human and Peoples' Rights (au.int)
[335] Supra note 308, para 52
[336] Equal Rights Trust 'Formal and substantive equality' available at https://www.equalrightstrust.org

therefore consider the fact that women inmates, by virtue of their incarceration, have limited physical access to health facilities and establish a health facility within the correctional centre to ensure their access to healthcare. In this section, international and regional human rights treaties are examined to ascertain the extent to which they promote health equity using the lenses of formal and substantive equality.

The equality and anti-discrimination model acknowledges that discrimination in healthcare is proscribed under international law as it negatively impacts the enjoyment of health rights.[337] When health interventions are generalised to all persons or groups of people, they tend to be discriminatory as the health needs of certain groups of people are inevitably overlooked. Such discrimination, albeit covert, has the same effect as expressly refusing to meet those health needs. The International Covenant on Economic, Social and Cultural Rights (ICESCR) proscribes discrimination in the enjoyments of the right to health on any ground including one's sex, social or legal status.[338] Article 2 of the African Charter on Human and People's Rights contains a similar provision to the anti-discrimination clause of the ICESCR. Further, the ICESCR guarantees equality of women and men in the enjoyment of the right to health and the other rights it guarantees.[339] In recognition of these provisions, the Committee on Economic, Social and Cultural Rights (UNCESCR) recommended that States adopt gender-sensitive approaches "in their health-related policies, planning, programmes and research in order to promote better health for both women and men."[340] Gender-based approaches were recommended by the UNCESCR on account of their ability to respond to biological and socio-cultural factors that play a significant role in influencing the health of men and women.[341] The UNCESCR further identifies the need for the development and implementation of a comprehensive national strategy for promoting women's health rights. It avers that a comprehensive national strategy for promoting women's health is necessary for addressing health-related discrimination against women.[342]

[337] Article 2(2) and article 3 of the ICESCR, Article 2 of the ACHPR, Article 12 of CEDAW and Article of the UNCRPD
[338] Supra note 61, Article 2(2)
[339] Ibid, Article 3
[340] Supra note 308, para 20
[341] Ibid
[342] Ibid, para 21

Human rights mechanisms further recognise the need to protect vulnerable and marginalised groups of people who have historically experienced health-related discrimination. [343] Evidently, Article 12 of CEDAW considers women's unique experiences to identify areas in healthcare that require State intervention for the realisation of women's health rights. It imposes a duty on States to provide women-related health services, particularly sexual and reproductive health services as these "bring into sharp relief the biological differences between men and women."[344] Similarly, several human rights instruments require the consideration of women inmates' unique experiences to inform their access to health-related facilities, goods and services.[345] For instance, the Nelson Mandela Rules proscribe discrimination against prisoners on account of their sex and other status.[346] The Nelson Mandela Rules also require administrators of correctional centres to consider the individual needs of inmates, particularly those most vulnerable to abuse.[347] The UNCESCR asserts the State's special obligation to provide for the health needs of the most vulnerable members of society. By imposing obligations for addressing the health needs of vulnerable members of society on the State, the UNCESCR promotes health equity and provides practical guidance on how to avert discrimination on grounds prohibited under international law including sex, social and legal status.[348]

The Special Rapporteur on the Rights of Women in Africa recognises the importance of removing all barriers that prevent women from accessing health services, education and information.[349] Discriminatory health systems and services present barriers to women's enjoyment of health rights. States are therefore required to oust discriminatory health systems, goods and services and guarantee *de jure* and *de facto* equality to everyone

[343] Article 25 of UNCRPD, Article 12 of CEDAW, the Nelson Mandela Rules; the Bangkok Rules; Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa; the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules)

[344] Mulela Margaret Munalula *Women, Gender Discrimination and the Law: Cases and materials* (2005)

[345] See the Resolutions of the Sixth, Seventh, Eighth and Ninth UN Congress on how to address the needs of women prisoners and the provisions of the Tokyo Rules and Bangkok Rules on the treatment of women prisoners. The body of prison rules established at international law are inspired by the principles contained in various international human rights instruments as stated in their preambular provisions.

[346] United Nations General Assembly, Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) : Resolution/adopted by the General Assembly 8 January 2016 A/RES/70/175 available at *http://www.refworld.org/docid/45f973632.html* accessed pm 30 April 2018, Rule 2

[347] Ibid

[348] Republic of Zambia, op cit note 11

[349] General Comments on Article 14(1)(d) and (e) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa available at *www.achpr.org/instruments/general-comments-rights-women/*, para 46

who needs to access them. For instance, the Mandela Rules read together with the Bangkok Rules provide that women inmates are entitled to healthcare commensurate to that of women in the general population, free from discrimination based on their legal status.[350] Whereas this may meet some health needs of women inmates, it may not meet the highest attainable standard of physical and mental health for women inmates. This is because women inmates may not have as many options for accessing healthcare as do women in the general population. Rather than requiring the same health and social services available to women in the general population to be made available to women inmates, the standard must be that the State ensures that the full range of goods and services for maintaining the highest possible standard of health be made available to women inmates in the same manner that it would for women in the general population. This entails, among other interventions, formulating participatory approaches for women inmates that will ensure substantive equality in accessing healthcare.[351] The African Commission recognises that adopting special measures for women and other marginalised groups and ensuring their participation in governance and decision-making is cardinal for advancing their health and other social rights.[352] Women's participation in health programming and governance is rendered ineffective if they are subjected to exclusionary and discriminatory practices and systems

3.1.2 The relevance of international and regional human rights instruments in promoting health interests of citizens

This section analyses how international and regional human rights treaties use civil and political rights to create platforms for citizens to claim health interests, among others, from the State.

Participation by people most affected by State actions, decisions, laws and polices is important for advancing human rights as well as "achieving things that are important to human life."[353] As argued by Ruger:

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[350] Supra note 346, Rule 24(1)

[351] AU Pretoria Declaration on Economic, Social and Cultural Rights in Africa (2004) available at achprinstrdeclapretoriaescrights2004eng.pdf (au.int), para 11

[352] Ibid

[353] Chipo Mushota Nkhata *An analysis of the right to public participation in governance-The Zambian case* (2010) at 29

> a democratic process can help define a comprehensive package of health benefits to which all should have equal access, and it can help prioritize different types of healthcare in efforts to maintain and improve health with the fewest possible resources.[354]

The African Commission also identifies "citizen participation in government through credible elections…and in the formulation of legislation and policies" as important democratic processes that are necessary for the realisation of social rights such as the right to health.[355] The communal participation of those most affected by government actions has the potential of fostering social learning at individual and communal level, thereby shifting power balance between the governor and the governed and enhancing individual and collective rights and interests.[356] In countries like Zambia, where the right to health is not explicitly guaranteed in the national Constitution, women's participation in democratic processes becomes pertinent in promoting health rights and interests. Democratic processes such as credible elections give citizens an opportunity to negotiate and support aspirations that can promote health outcomes and other social and economic policies.

Similarly, citizens' participation in the formulation of laws and policies that impact on their interests enables citizens to exchange ideas on a variety of issues and to subscribe to a governance regime that advances their interests.[357] Therefore citizens may compare health priorities of different political aspirants and be persuaded to vote for them on account of the interests they hold. This in turn creates a platform for citizens to hold leaders accountable to socio-economic aspirations given through other political processes. Likewise, opportunities for education of the public on national or community health goals and government's social protection agenda as well as formulation of the requisite regulatory framework to support such agenda creates opportunities for citizens to advance their health rights and interests.[358] These opportunities, if effectively harnessed, may lead to the creation of comprehensive health packages as they would be inclusive of the needs of the people who participate in them.

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[354] Jennifer Prah Ruger 'Health and Social Justice' (2004) 364 *Lancet* at 1077
[355] Supra note 351, para 11(a)(x)
[356] Nkhata op cit note 353 at 30
[357] Henry J. Steiner op cit note 189 at 130
[358] Supra note 355

Women inmates can hold the State accountable at national and international levels through their participation in various fora in the democratic space. One such forum is their partnership with civil society organisations that may present an avenue for transmitting women's views and experiences to duty bearers and other rights-monitoring mechanisms. This is achievable in the era of decentralisation of government functions where many services are being provided close to communities and those who need them most.[359]

At international and regional levels human rights standards and mechanisms create a conducive framework for facilitating the participation of women inmates in processes aimed at realising their health interests.[360] International and regional human rights instruments applicable to Zambia guarantee the right of citizens to participate in public affairs,[361] in elections,[362] in accessing public service,[363] public property and services.[364] Although these treaties do not expressly mention women inmates, they are instrumental in realising health rights of women inmates in that they guarantee political rights to women inmates as eligible citizens. Unless expressly curtailed by local legislation, women inmates are able to enjoy political rights embodied in these treaties. Political rights in international and regional human rights instruments are applicable to socially excluded women such as women inmates by virtue of their citizenship status, thereby giving them opportunities to meaningfully participate in matters that affect them.[365] While some of the guaranteed democratic spaces for participation may not be suitable for women inmates, States are expected to take legal and administrative measures within their own contexts to ensure these rights are guaranteed to women inmates.[366] Morris-Jones argues that there is need to create efficient democratic systems that revolutionize spaces for effective participation of marginalised women to ensure improved governance.[367]

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[359] Supra note 77 and 78
[360] Chipo Mushota Nkhata op cit note 353 at 37
[361] see Article 21 of the UDHR, Article 25 of the ICCPR, Article 7 of CEDAW, Article III of the Convention on the Political Rights of Women (CPRW), Article 13 of the ACHPR and the Maputo Protocol.
[362] see Article 21 of the UDHR, Article 25 of ICCPR, article 7 CEDAW and Article III of CPRW. Note that the ACHPRs does not provide an expression right to vote to citizens of its Member States
[363] see the Article 21 of the UDHR, Article 25 of the ICCPR, Article 7 of CEDAW, Article III of CPRW, Article 13 of the ACHPR and the Maputo Protocol.
[364] Supra note 62, Article 13(3)
[365] Chipo Mushota Nkhata op cit note 353 at 39
[366] Supra note 62, Article 1
[367] Birch, A. H. *The Concepts and Theories of Modern Democracy* (1993) at 83

Under international and regional human rights law, the right to participate in public affairs of one's country is equated to the right to participate in government. The right to participate in public affairs entails granting citizens the right to exercise public functions. CEDAW,[368] the Convention on the Political Rights of Women[369] and the Maputo protocol particularly safeguard the rights of women to participate in governance on an equal basis as men. CEDAW Committee also provides for women's right to participate in the formulation and implementation of government policies.[370] The right to participate in elections is a very specific right which entails the right of citizens to vote, to protection of their vote and to contest political power.[371] Failure to protect the right to vote ultimately has negative consequences for women inmates' health. It may disadvantage a political candidate who may have women inmates' health rights as a priority on their political agenda. Thus, even though women inmates in Zambia may not be eligible to contest political power, their interest in free and fair elections must be safeguarded in order to protect their social and other interests that flow from electoral processes. Women inmates' must therefore enjoy their right to vote unencumbered and free of undue influence.

The right to equal access to public services proscribes discrimination in accessing and exercising public functions.[372] This is another avenue through which individuals can participate in the development and implementation of government policies. The ACHPRs, being the only human rights treaty that expressly guarantees equal access to public property and services, guarantees access to State-controlled health goods and services, among others.[373] Thus, women inmates cannot be denied access to such public goods and services necessary for advancing their health rights on account of their legal status. Irrespective of their imprisonment, women inmates have equal political status with men and women who are not imprisoned.[374] Women inmates may thus use the aforementioned provisions on participation to advance their health interests.

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[368] UN General Assembly, Convention on the Elimination of All Forms of Discrimination Against Women, 18 December 1979, United Nations, Treaty Series Vol 1249 P.3 available at http://www.refworld.org/docid/3ae6b3970.html accessed pm 30 April 2018, Article 7
[369] Article III of Convention on Political Rights of Women
[370] Supra note 368
[371] Steiner op cit note at 189
[372] Article 13(3) of the ACHPR
[373] Chipo Mushota Nkhata op cit note 353 at 43
[374] Ibid

The direct connection between participation by citizens and enjoyment of health rights evidences the fact that citizenship is a determinant of health.[375] Citizenship advances health outcomes and promotes health equity as it improves access to and distribution of social determinants of health.[376] Sultana avers that "if ultimately citizenship may have a positive effect, not just on social and economic inclusion, but also on health, it is important to ensure that citizenship is both accessible and widespread."[377] On this premise, one would argue that to address women inmates' health rights and interests, a women-centred model to citizenship participation must be implored to elevate women inmates' citizenship status to enable them to meaningfully contribute to health governance and decision-making that impacts on their lives.[378] Czapansky states that "citizenship is better when citizens are awarded meaningful opportunities to participate in governance and governance is better when citizens are given meaningful opportunities to participate in it." [379] Citizenship elevates people's social standing and promotes their social and economic interests thereby enhancing their political rights. Similarly, political rights enhance citizens' social standing and their social and economic interests. According to Farmer, the interdependence of political rights and social and economic rights is evident when vulnerable and marginalised groups are given opportunities to participate in governance with those who wield political power.[380] This supports the argument that although participation is a political right, it also has significant implications for advancing citizens' socio-economic interests including health interests.[381] Political participation must be harnessed to create opportunities for women inmates to assert their health rights.

International human rights instruments and commentaries of human rights bodies indicate that the right to health is anchored on human dignity and the existence of just institutional arrangements.[382] Health systems are not just apparatuses for delivering goods

[375] Anjum Sultana *Citizenship and health: What role can citizenship play in the social determinants of health?* (June 2017) at 4
[376] Ibid
[377] Ibid at 5
[378] Ibid at 7
[379] Czapansky, Syma and Manjoo op cit note 303 at 21
[380] Paul Farmer *Pathologies of Power: Health, humanity and the new war on the poor* (2004) at 17 available at https://www.ucpress.edu/book
[381] Steiner op cit note 189 at 130-131
[382] Supra note 308, para 55

and services and thus must be built as part of a democratic system.[383] In democratising health institutions, it is important to do so in ways similar to other social and political institutions that are created for the effective running of the State.[384] This forms the basis upon which a government's performance is evaluated by its people in a democracy. Health institutions and health systems are social institutions worthy of scrutiny to determine how government is performing. For health institutions and systems to be transformative and positively impact on the health of its users, the users would have to scrutinize them and measure the government's performance. Health institutions and systems must be subjected to similar levels of scrutiny as social and political institutions that fall squarely under the realm of political governance. According to the Committee on Economic, Social and Cultural Rights (UNCESCR) national regulatory frameworks for health must be based on democratic principles and standards of transparency, accountability and good governance.[385] The UNCESCR further requires health systems to be non-discriminatory in that they should not exclude certain individuals and groups from accessing healthcare on an equal basis as others.[386]

Participation can strengthen citizenship and offer greater protection for health rights particularly for women the world over who have been treated as second-class citizens for many centuries. Despite the many international and national instruments that have been formulated to address discrimination against women, such discrimination persists. The CEDAW acknowledges that "discrimination is an obstacle to the participation of women, on equal terms with men, in the political, social, economic and cultural life of their countries."[387] The consequence of this is that women have the least access to public resources in times of scarcity.[388] Inclusion of women in social and political life does not just recognise their dignity and worth, but enables them to participate in decision-making and programming and facilitates their access to public goods and services.

[383] Alicia Yamin's oral presentation at Global Health Law Conference. University of Cape Town (8th April 2019)
[384] Supra note 308, para 55
[385] Supra note 384
[386] Sultana op cit note 375
[387] Supra note 368, Preamble
[388] Ibid

3.2 A REFLECTION OF INTERNATIONAL AND REGIONAL HUMAN RIGHTS INSTRUMENTS ON CITIZENSHIP PARTICIPATION IN HEALTH

From the examination of international and regional human rights systems, the right to health consists of what I refer to as the three A's and Q. The right to health must be accessible, affordable, acceptable and of good quality.[389] This entails the following:

a) A functioning public health system that has sufficient health institutions, goods, services and programmes;
b) Health institutions, goods, services and programmes that are offered without discrimination on any ground and that adequately respond to barriers to access to such goods and services stemming from economic, information and physical factors among others;
c) Adherence of health institutions, goods, services and programmes to acceptable ethical and cultural standards;
d) Need for good quality healthcare driven by scientifically and medically appropriate health institutions, goods, services and programmes.[390]

Interpretations of international and regional human rights instruments applicable to Zambia reflect the importance of effective participation by rights-holders in health-related decision-making and programming. The interpretations of human rights monitoring bodies such as the UNCESCR do not provide an exhaustive list of the forms of participation necessary for advancing health rights. Further, the human rights instruments themselves do not specifically identify citizenship participation as an effective form of participation for advancing health rights. They provide generic provisions on the right to health which can be adapted to the situation of women inmates in Zambia. However, the fact that international and regional human rights instruments do not expressly recognise effective participation as a means of guaranteeing the right to health lends them open to criticism on at least two fronts:

a) their failure to dispel the misconception that civil and political rights such as citizenship participation cannot be used to guarantee ESCR such as the right to health.
b) their overgeneralisation of the normative contents of the human rights they espouse fosters a closed or narrow understanding of specific rights such as the right to

[389] Supra note 308, para 19
[390] Supra note 61

health and an even narrower understanding of the constituent elements of such rights for marginalised and socially excluded groups such as women inmates.

The classification of human rights in the categories of civil and political rights on one hand and economic, social and cultural rights on the other (mostly perpetuated by the development of the ICCPR and ICESCR) has propelled the notion that these are two separate sets of rights with no bearing on each other. Unlike the right to discrimination which is adequately represented in both the ICCPR and the ICESCR, the right to participate in decision-making is only adequately addressed in treaties that foster civil and political rights. Only through pronouncements of human rights monitoring bodies are there attempts to reconcile the two. This is not very helpful for standard-setting as such rights may be viewed as peripheral even when they are core to the realisation of other rights such as the right to health.

Regarding the criticism on over generalising of normative contents of human rights, it should be acknowledged that overgeneralisation masks women inmates' unique experiences. The consequence of this is that minimum standards are set without considering and adequately reflecting women inmates' experiences as a class of rights-holders. Even when specialised human rights treaties are formulated, drafters must warn themselves of the dangers of overgeneralising provisions and ensure that they strike the right balance between common experiences and unique experiences of members of a target group. The use of optional protocols to address matters that were omitted or not fully address in substantive treaties must further be promoted to ensure timely responses to unique experiences of certain classes of rights-holders. This should be the case for the use of citizenship participation as a means of realising economic, social and cultural rights such as the right to health as guided by the UNCESCR. Health rights interventions must solicit citizens' participation in democratically established social institutions that respond to health and health determinants and be reflective on the aspirations and concerns of right- holders in order to be relevant.[391]

[391] Supra note 308, para 20

3.3 ZAMBIA'S LEGISLATIVE FRAMEWORK ON WOMEN INMATES' HEALTH RIGHTS AND PARTICIPATION IN HEALTH-RELATED DECISION-MAKING AND PROGRAMMES

In this section, I will examine Zambia's legal standards for promoting and protecting women inmates' health rights in two main ways. Firstly I examine the extent to which Zambian laws recognise women's right to health. Secondly, I examine Zambia's legal provisions on health determinants including those promoting participation in healthcare for women inmates.

3.3.1 Legal protections for women inmates' right to health in Zambia

Zambia is a signatory to key regional and international human rights treaties that guarantee the right to health, such as the African Charter on Human and Peoples' Rights[392] and the International Covenant on Economic, Social and Cultural Rights.[393] However, neither its Constitution nor the Zambia Correctional Service Act embody a right to health provision. The Constitution,[394] the Zambia Correctional Service Act,[395] Anti-Gender Based Violence Act,[396] the Gender Equity and Equality Act,[397] the Persons with Disabilities Act[398] and the Mental Health Act[399] have few provisions that can be relied on to promote some aspects of health rights for women inmates. These laws are also relevant for responding to social determinants of health for women inmates. Some of these social determinants of health include discrimination, violence, negative attitudes, disability, access to information, communication with family and friends, citizenship and participation in health-related decisions and programmes. These laws are discussed below in detail.

a) Legal protection for the right to health

Although the right to life is guaranteed in the Constitution,[400] an interpretation of its provision shows that it does not set any standard for the quality of life guaranteed to

[392] Supra note 62
[393] Supra note 61
[394] Supra note 42, Article 12
[395] Supra note 31
[396] Act no. 1 of 2011
[397] Act no. 22 of 2015
[398] Act no. 6 of 2012
[399] Act no. 6 of 2019
[400] Supra note, 394

persons in Zambia. The Constitution merely guarantees the right to be alive. The 'right to life' provision is weakened by the fact that there is no support from a 'right to health' provision. However, a decision of the Zambian Supreme Court found that the right to life entails the protection of inmates' right to health and right to food.[401] Although the progressive interpretation of the right to life led to the recognition and protection of inmates' right to health and the right to food as a health determinant, this is no guarantee that women inmates' right to health and health determinants will be protected to the same extent. This is because the case discussed the right to health and food in the narrow context of inmates with terminal illness. There is thus need for express and comprehensive legal guarantees of women inmates' health rights and health determinants.

The failure of the Zambian Constitution to comprehensively provide for health rights weakens the legal framework for the protection of women inmates' health. Although the Zambia Correctional Service Act[402] has a few progressive provisions for the protection of women inmates' health rights, it largely subscribes to the systems-centred approach which focuses on medical interventions promoted by health systems. The systems-centred approach to health of the Zambia Correctional Service focuses primarily on creating a correctional health system anchored on medical responses including medical systems and procedures to which women inmates must fit. Previously, I have referred to it as a State-centred approach since the State drives the use of medical systems as their primary intervention for correctional health promotion. This approach is not primarily concerned with the individual, their social determinants of health and their experiences in the correctional facilities as is the case with a people-centred and more specifically, the woman-centred approach to health. This is evident from part IV of the Zambia Correctional Service Act which establishes the Correctional Health Service as an enforcement body for the management and control of correctional health. It does not have the responsibility to promote inmates' health rights. Its focus is on the role of correctional officers in managing medical situations in prisons.

Similarly, other provisions of the Zambia Correctional Service Act focus on ascribing powers and responsibilities to correctional officials for maintaining prison

[401] George Peter Mwanza and Melvin Beene v. The Attorney General Appeal no. 153/2016 Select Judgment no. 33 of 2019
[402] Supra note 31

health. Section 15 of the Zambia Correctional Service Act imposes a duty on a health practitioner appointed under section 14 to ensure that every inmate is medically examined on admission and before discharge from a correctional centre. By section 18 of the Act, an Officer- in-Charge (OIC) of a correctional facility is empowered to order an inmate to be medically examined and treated as often as the OIC deems necessary. Further, section 46 empowers the OIC to make an order for the removal of an ill inmate from a correctional centre to a health facility. Sections 15, 18 and 46 of the Act do not guarantee health services to an inmate, but give correctional officers discretionary powers to order that an inmate be subjected to medical examination and treatment. These provisions do not entitle an inmate to illness-prevention interventions. Instead, they impose a duty on a health practitioner to examine and treat an inmate who is already ill. This is the limited extent to which inmates' health rights are provided and to which women inmates are subjected.

A women-centred approach to health would be concerned with holistically promoting and protecting women's health rights, including their as sexual and reproductive health rights. The Gender Equity and Equity Act is exemplary of this approach. It contains the most comprehensive health rights provisions for women in Zambia. It embodies sexual and reproductive health rights[403] and proscribes discrimination against women in healthcare services including access to health information and education as well as rights in family planning.[404] Through these provisions the government ministries responsible for health and gender have a duty to work together to "take appropriate measures to ensure that women access healthcare services on an equal basis with men".[405] A health officer is also mandated to, among other things, "respect the sexual and reproductive health rights of every persons without discrimination" and impart information necessary for a person to make a decision whether or not to undergo procedures, or to accept any service, affecting their sexual and reproductive health".[406] Although these provisions are generic and are applicable to women inmates by implication, they have not been used by women inmates to assert their health rights.

[403] Supra note 397, Sections 21 and 32(2)
[404] Ibid, Section 32(1)
[405] Ibid, Section 32(1)
[406] Ibid, Section 32(3)

To address health rights of women inmates with disabilities, the Persons with Disabilities Act and the Mental Health Act are useful. The Mental Health Act expressly embodies the health rights of incarcerated persons with mental disabilities.[407] The Persons with Disabilities Act and the Mental Health Act provide for access to healthcare and mental health services respectively.[408] These provisions cater for the unique health needs of persons with disabilities.

The above legal provisions on access to healthcare are affected by some legal provisions on social determinants of health of women inmates discussed in Chapter one. These are examined below.

b) Legal protection for social determinants of health

Chapter one identified social determinants of health for women inmates as including the welfare of inmates' children, privacy when accessing health services, inmates' mental health needs, communication with relatives and existing systems for addressing discrimination, violence and other forms negative social practices.[409]Although there are some progressive legal provisions that address these social determinants of health for women inmates, the Zambian regulatory framework does not adequately provide for these. This section examines the extent to which Zambian laws embody women inmates' social determinant of health.

i. Communication with family and friends

Many women inmates experience mental health breakdown when they do not have regular contact with their families nor have decision-making power over the welfare of their children.[410] A legal provision that enables women inmates to keep in contact with family and friends is thus important for maintaining good mental health. Section 22 of the Gender Equity and Equality Act protects women's right to decide and act on matters relating to marriage and family life. This provision could potentially address issues relating to

[407] Supra note 399, Part XI
[408] Supra note 398, section 27 and Supra note 399, Part IV
[409] Baker and DIGNITY op cit note 10
[410] Penal Reform International *Women in detention: Putting the UN Bangkok Rules on women prisoners into practice* (2017) at 99

maintenance of family ties through visitations and communication of women inmates with their family and friends.[411]

ii. Access to food, clothing and other basic necessities

Part X of the Zambia Correctional Service Act contains provisions affecting some health determinants of civil and unconvicted inmates.[412] Section 63 permits civil[413] and unconvicted inmates to maintain themselves from private sources. However, section 64 proscribes the transfer of food, clothing and other necessaries to another inmate. It is difficult to justify the existence of this provision given that globally, many women inmates have inadequate access to State-provided food and other basic needs.[414] Women inmates are disproportionately affected as they are fewer in number and therefore have fewer correctional facilities. The facilities are located far from inmates' usual places of residence thereby reducing the frequency of food and other supplies from family, friends and well-wishers.[415] Women inmates may thus have to leverage food parcels that they individually receive from their friends and relatives by sharing with one another. This could mitigate the inadequacy of food provided by the State.

Zambia also has much fewer correctional facilities for women than men and past studies have shown that the distance to and from correctional facilities inhibits most inmates' families from visiting.[416] Proscribing food sharing in law may therefore have negative consequences for women's inmates' health. Section 64 is not alive to women inmates' lived realities regarding access to basic necessities and effects on their health rights. It also has the potential to negatively impact spaces within which women inmates can exercise their individual agency to build networks and facilitate better health outcomes by sharing basic necessities. As argued by Baker[417] and Topp et al,[418] social networks within correctional facilities in Zambia play a key role in facilitating access to basic

[411] Ibid
[412] Part X covers sections 63 and 64 of the Act
[413] Section 2 of the Act defines a civil inmate as "an inmate other than a criminal inmate from non-criminal processes including failure to pay debts."
[414] Supra note 410
[415] Ibid
[416] Baker & DIGNITY op cit note 10 and Topp et al op cit note 19
[417] Baker & DIGNITY op cit note 10
[418] Topp et al op cit note 19

necessities.[419] The law must thus empower women inmates to build such social networks as required whilst establishing safety measure to address any negative consequences that are inherent in them.

iii. Access to information

As discussed earlier in this Chapter, access to health information is vital for the realisation of health rights. Lack of health information can be a barrier to women inmates' participation in health decisions and programmes. The Zambia Correctional Service Act require an Officer-In-Charge (OIC) of a prison to provide information to an inmate on their rights, the manner of obtaining information and procedure for making requests. [420] This provision has the potential to create a conducive regulatory environment for equipping women inmates with the relevant information to participate in decision-making in their facilities. It is a new provision, having only been enacted in 2021 and thus is yet to be tested.[421]The provision can however be enhanced by stipulating in prison rules, policies and procedures the requisite mechanisms for inmates to access and share information. Clearly documented standard operating procedures for access to information and information exchange would enhance transparency and protect such procedures from being subject to whims and caprices of those in authority. By so doing, the provision will help create objectivity, transparency and promote equal access to systems and services by different classes of women inmates. Further, creating systems for exchange of information and ideas based on inmates experiences in correctional facilities can improve prison governance by allowing for creative, relevant and practical ideas to be shared by the women inmates and correctional officers.[422]

iv. Sex, gender, disability and incarceration

As illustrated in Chapter one, sex, gender, disability and incarceration are social determinants of health. They usually influence attitudes and conduct of members of the

[419] Topp et al op cit note 19
[420] Supra note 31, Section 32
[421] Women inmates were not asked about this provision during the interviews as the Zambia Correctional Service Act came into force after the interviews had been concluded. Women inmates and stakeholders did however identify lack of information and restricted access information to as barriers to participating in health-related decision making as discussed in chapters five and six of this thesis.
[422] Sarkin op cit note 90

public, inmates, health service providers and correctional officers towards health-rights holders such as women inmates. Negative attitudes, discrimination and violence towards women inmates on account of their sex, gender, disability and civic or legal status negatively impacts women inmates' access to health goods and services and enjoyment of health rights.

The Constitution does not expressly embody the rights of women. It, however, contains an anti-discrimination clause.[423] The anti-discrimination clause proscribes discrimination on account of one's' social status and sex, among others. However, article 23(4)(d) provides that nothing done in accordance with customary personal laws is deemed to be discriminatory. Yet, many experiences of discrimination against women in Zambia are embedded in customary personal laws and practices. Article 23(4)(d) thus renders the Bill of Rights ineffective in protecting women's rights. The Bill of Rights does not effectively respond to the gender dynamics of the Zambian society.[424] It fails to recognise that social, cultural, and economic norms place women and men and a privileged class of women at different levels on the social gradient. Instead, the Constitution treats women as a homogeneous group. Similarly, the Constitution does not expressly recognise rights of prisoners and persons with disabilities. This limits the extent to which it responds to the unique experiences of women inmates and more specifically women inmates with disabilities and thus fails to adequately protect their health rights.

The Zambia Correctional Service Act also contains meagre provisions on women and does not take into account their heterogeneity and resultant health needs. For instance, women inmates are permitted to enter correctional facilities with their children below the age of 4 years. However, the health needs of the children are not provided for in the Act. Section 15 of the Zambia Correctional Service Act, aforementioned, is restricted to inmates. Therefore, a child who enters prison with their mother would not be entitled to medical examination and treatment. This may pose a concern to an inmate with a child in the correctional facility and result in their ill health. As earlier stated, since the focus of the provisions of the Zambia Correctional Service Act is the correctional officials and not the women inmates, the Act primarily ascribes duties to officials for the medical treatment of

[423] Supra note 42, Article 23

[424] Muna Ndulo 'African customary law, customs and women's rights' (2011) 18:1 *Indiana Journal of Global Legal Studies and* Muna B Ndulo and Robert B Kent 'The Constitutions of Zambia' (1998) 30 *Zambia Law Journal*

inmates as opposed to ascribing rights to the women inmates. This renders the law blind to the impact of gender roles on health and, more specifically, the health implications of women inmates with children. This approach of the Zambia Correctional Service towards women inmates' health is not indicative of a women-centred approach to health rights, but a system-centred approach.

A women-centred approach to health rights would also be concerned with social determinants such as negative attitudes and practices, violence and discrimination directed at women inmates. The Gender Equity and Equality Act proscribes adverse social practices imposed on or developed for or against women.[425] It also provides for the need to eliminate discrimination against women in social and economic life[426] and requires that gender is mainstreamed in all policies, laws, programmes and budgets as a way of guaranteeing equal inclusivity of women and men's needs on the national agenda.[427] Discrimination and adverse social practices directed at women inmates have negative consequences on their enjoyment of health rights and their ability to participate in health decisions and programmes. Vetten shows that although many women in African prisons are subjected to rape and other forms of sexual violence, sexual exploitation, electric shocks, beatings, intrusive bodily search, cigarette burns and food and sleep deprivation (all of which constitute forms of violence against women), African prisons do not have sufficient mental and physical health services for women inmates.[428]

Violence against women in all forms has negative implications for women's mental and physical health as exhibited by common diseases among women inmates such as "human papilloma virus, hypertension, chlamydeous infection, anxiety and depression."[429] Curbing violence against women therefore promotes women inmates' health rights. Albeit progressive, the provisions of the Gender Equity and Equality Act may not benefit women inmates without creating specific systems and procedures suitable for women in correctional settings. The Mental Health Act provides guidance on how specific regulations and systems can enhance enjoyment of health rights. It provides that a

[425] Supra note 397, Section 28
[426] Ibid, Section 27
[427] Ibid, Section 4(a)
[428] Lisa Vetten 'The imprisonment of women in Africa' in Jeremy Sarkin (ed) *Human Rights in African Prisons* (2008) at 140-143
[429] Ibid

mental health facility or correctional centre shall ensure that mental patients are accorded privacy and confidentiality relating to their treatment, protected from exploitation, abuse and degrading treatment and have access to holistic information relating to their healthcare.[430] This provision enables inmates to assert their mental health rights. It also enables the State to explore ways and create procedures for guaranteeing privacy to women inmates, curbing exploitation, abuse and degrading treatment and facilitating access to holistic health-related information. Like the Zambia Correctional Service Act, the Mental Health Act is a recent law, having been passed in April of 2019, a few months before the interviews with the study respondents. Consequently, the practical implications of its provisions on women in correctional facilities was not inquired into in this study.

With regards to curbing gender-based violence (GBV), the Anti-Gender Based Violence Act is the most comprehensive law in Zambia. Many studies have been published on the negative impact of violence on women's health.[431] The Zambian government has over the last decade intensified its prevention and response efforts to GBV and particularly violence against women and girls as a result of the Anti-Gender Based Violence Act, albeit the focus being on women and girls in the general population.[432] The Anti-Gender Based Violence Act,[433] describes GBV as including physical, sexual, emotional and verbal abuse.[434] It provides that "an act of gender-based violence shall be inquired into, tried, and otherwise dealt with in accordance with the Criminal Procedure Code, the Penal Code and any other written law"[435] signifying the seriousness of GBV. Through this provision, it also empowers various institutions and systems, including correctional facilities, to address GBV in line with the existing legislative framework.

[430] Supra note 399, Section 18
[431] Taiwo M Williams 'Violence and women's health in Africa' *The Palgrave Handbook of African Women's Studies* available at http://doi.org/10.1007/978-3-319-77030; Mary Kimani 'Taking on violence against women in Africa' *Africa Renewal* July 2007; Mulunken et al 'Gender-based violence against women in sub-Saharan Africa: A systematic Review and Meta-analysis of cross-sectional studies' *International J. Environ Res Public Health* (2020) 17:3
[432] Government of the Republic of Zambia-United Nations *Joint programme on Gender-Based Violence Phase II December 2019-December 2022* (2019) at 5 and 22
[433] Supra note 396
[434] Ibid, Section 3
[435] Ibid, Section 2

Under section 5 of the Anti-Gender Based Violence Act, an OIC of a correctional facility, having the same powers as a police officer,[436] is mandated to:

> *(a)* inform a victim of the victim's rights and any basic support which may be available to assist the victim;
> *(b)* obtain for the victim, or advise the victim how to obtain shelter, medical treatment, legal services, counselling or other service that may be required in the circumstances; and
> *(c)* advise the victim of the victim's right to lodge a complaint against the respondent including remedies available to the victim under this Act.[437]

However, due to the limited powers given to OICs of correctional facilities under the Zambia Correctional Service Act, the OIC of a correctional centre is not likely to follow this more protective provision of the Anti-Gender Based Violence Act. This is because the Zambia Correctional Service Act contains its own provisions on addressing violence and is more specific to addressing violence in correctional settings. As argued by Sarkin, "prison administrations in Africa tend to associate with the military or police, and so a sense of authoritarian control and discipline pervades prison culture."[438] The prison ethos and culture towards violence is largely viewed as a security and disciplinary issue which correctional officers are trained to curb. Violence in prisons is not seen as a human rights' issue whose violations must be prevented and remedied if it occurs. The requisite resources, systems and leadership for a rights-based approach to curbing GBV in correctional facilities are thus not likely to be present in such facilities.

Further, decentralisation of prison authority which allows prisons to act independently of the government's rights-based approach to GBV has weakened the legislative and resultant administrative response to GBV in correctional facilities. This is evident from the difference in legislative approach to violence between the Anti-Gender Based Violence Act and the Zambia Correctional Service Act. The Zambia Correctional Service Act was passed after the enactment of the Anti-Gender Based Violence Act indicating that it is the legislature's most recent strategy for addressing violence in correctional settings.[439] Violence is considered as a minor offence in the Zambia

[436] Supra note 31, Section 22
[437] Supra note 396, Section 5
[438] Sarkin op cit note 90
[439] Rules of statutory interpretation in Zambia require that specific provisions take precedence over general provisions as do latest legislative enactments. The presumption is that the drafter of the law was aware of existing

Correctional Service Act[440] for which an OIC is empowered to determine and mete out punishment to a perpetrator. Section 66(f) of the Zambia Correctional Service Act states "[a]n inmate commits a minor offence if that inmate commits an assault or act of violence."[441]The Zambia Correctional Service Act does not define "violence" and it may be argued that the reference to "violence" in Section 66(f) does not extend to gender-based violence. However, it is hard to imagine any circumstance, especially in a correctional facility, in which violence may be deemed as a minor offence. In any event, Section 3 of the Anti-Gender Based Violence Act describes violence that occurs in a domestic relationship as a form of GBV. It gives a broad interpretation of domestic violence to include situations where "the victim and respondent share or shared the same residence" or where "the victim lives in or attends a public or private care institution and is under the care and control of the respondent." By this definition, violence that occurs in a correctional setting could amount to GBV. This includes violence between correctional officers and women inmates, violence among women inmates, violence among women inmates and male inmates and violence suffered by women inmates at the hands of health practitioners providing health services to them. Section 66(f) of the Zambia Correctional Service Act creates an inferior parallel approach to GBV for the correctional facilities thus limiting the protection offered to survivors of GBV in correctional settings by treating such GBV as a minor offence and by taking acts of violence out of the ambit of the Anti-Gender Based Violence Act.

The Zambia Correctional Service approach to addressing GBV against women inmates falls short of the more protective measures of the Anti-Gender Based Violence Act applicable to the women in general population. If women in the general population are able to access information on GBV complaints procedures, lodge complaints and seek redress for the violence they suffer, women inmates must equally exercise these rights. Section 5 of the Anti-Gender Based Violence Act not only provides for access to justice for survivors of GBV, but also entitles them to access healthcare for both physical and

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provisions and if they legislate on a similar subject, then they intended to alter an earlier provision. The Zambia Correctional Service Act was passed in 2021 while the Anti-Gender Based Violence Act was passed in 2011. The provisions of the former statute thus take precedent over the latter.

[440] Supra note 31, Section 66(f)

[441] Ibid

mental health.[442] This allows both the individual survivor of GBV and the State to take steps for ensuring health promotion for the GBV survivor. Many women's experiences of GBV have informed and shaped the overall public health response to GBV in Zambia, It is no wonder that the public health system for responding to GBV in the general population has expanded and contributed to a more effective health system, whereas that of prisons lags behind. The provisions of the Zambia Correctional Service Act on violence do not guarantee similar protection to women inmates who experience GBV in prisons. Instead, the Zambia Correctional Service Act lists the possible penalties that an OIC may met out for perpetrators of GBV.[443]It does not entitled a women inmate to commence court process for addressing GBV, nor does it compel an OIC of a prison to facilitate court process for prosecuting GBV cases in a similar fashion to prosecutions that occur in the general population. This approach to GBV by the Zambia Correctional Service Act thus creates a discriminatory system that weakens women inmates' ability to assert their rights to equality as citizens and make demands on the government on issues that affect their health and related interests. It also entails that health issues that emanate from violence experienced by women inmates are likely to go unattended in public health facilities that women inmates may access due to the invisibility of their issues.

v. Active citizenship and participation in health decisions and programmes

Active citizenship promotes participation that enables citizens such as women inmates to assert their health rights, among others. The Zambian Constitution provides for citizenship and representation of the people.[444] The Constitution however focuses on describing types of citizenship, political participation and the creation of systems and processes that enhance citizenship for persons in the general population. Constitutional provisions on associative rights[445] such as the right to vote, freedom of expression, association and assembly are cardinal in realising women inmates' health rights and interests. They promote active citizenship and have the potential to empower vulnerable and marginalised groups to assert their rights and present their interests to the government. These provisions

[442]Supra note 396, section 5
[443] Ibid, section 67
[444] Supra note 42, Part IV and V
[445] Ibid, Articles 20 and 21

therefore set the tone for the extent to which ordinary members of the public and interest groups, such as women inmates, can participate in governance.

The Mental Health Act is very specific in imposing a duty on mental patients "to participate effectively in decision-making and request additional information or explanation about their health status or treatment."[446] Women inmates with mental illness may therefore rely on this provision to assert their health rights. The Gender Equity and Equality Act also has provisions for promoting women's participation in health decision and programmes. The Act entitles women to equal representation and participation in formulating and implementing policies, strategies and programmes in public and private spheres.[447] It also provides that the recognition of women's rights and the empowerment of women are integral for achieving gender equality and equity.[448] The Act imposes an obligation on public and private bodies to work together as partners in a coordinated manner to achieve gender equality and equity.[449] This provision allows for State and non-State actors to work together to promote gender equality. On the other hand, the Zambia Correctional Service Act empowers the members of the judiciary, religious leaders and civil society organisations to visit prisons, interact with inmates and document their findings from the interactions.[450] This provision accords women inmates the opportunity to meet key decision-makers and potential allies who can influence their positive health outcomes. Read together with the Zambia Correctional Service Act, the Gender Equity and Equality Act creates a conducive regulatory environment for women inmates to actively engage in dialogue and other programmes for their involvement in health governance.

vi. Institutional mechanisms for health

Institutional mechanisms for health are a social determinant of health. According to Marmot et al, the correctional system is itself a health determinant.[451] For example, the Zambia Correctional Service (which is primarily responsible for correctional facilities and

[446] Supra note 399, Section 17
[447] Supra note 397, Sections 24 and 29
[448] Ibid, Section 4(b) and (e)
[449] Ibid, Section 4(g)
[450] Supra note 31, Part XVI (Sections 93-100)
[451] Michael Marmot et al op cit note 9

maximum prisons) heavily relies on the inadequate Zambia Correctional Service Act to address the health-related needs of women inmates. Of greater concern is the fact that other government departments responsible for health, sanitation, child care and general welfare in the Country do not operate in correctional settings as a matter of their routine work.[452] Further, the Constitution considers the Zambian correctional facilities as an exclusive subject for the national government and not subject to any municipal control.[453] This takes the correctional facilities and prisons out of the realm of local authorities where health goods, services and governance can be closer to the community. This is a serious problem considering that correctional facilities are very often at the bottom of Government's budgetary priorities and thus are often underfunded.[454]

Another institution relevant to promoting women inmates' health rights and interests is the Judiciary. The Zambia Constitution empowers the Zambian judiciary to protect the rights guaranteed in the Bill of Rights. Rights-holders such as prisoners can thus hold the State accountable for human rights violations and assert their rights. Courts therefore serve as a cardinal institution in guaranteeing rights and promoting citizenship as is illustrated below.

The courts can use provisions of the Constitution and the Zambia Correctional Service Act or any other relevant law to recognise inmates' rights to participation in governance as well as their health rights. This can, in turn, ensure that relevant public institutions fulfil their obligations for women inmates' participation in health. The courts can recognise fundamental rights in their own right or develop existing laws to better protect women inmates' human rights in accordance with the courts' obligations under the Constitution and any other law.[455] For example, the Zambia Correctional Service (ZCS) is guided by principles that recognise the dignity and value of inmates as human beings, respect and uphold their rights as citizens while ensuring that the needs of those most vulnerable including women inmates are considered.[456] The courts as well as the Zambia Correctional Service can use these guiding principles for realising women inmates' health

[452] Baker & DIGNITY op cite note 10
[453] Supra note 42, Article 147(2) as read together with Part A of the Annex on Functions of National, Provincial and Local Levels of Devolved Government
[454] Topp et al op cit note 19
[455]Supra note 42, Article 9 and Article 267
[456] Supra note 31, Section 4

rights in at least two interdependent ways. Firstly, they can provide a conducive regulatory framework for promoting and protecting women inmates' fundamental rights, including their health rights. Secondly, they can promote recognition of women inmates as citizens entitled to many legal and constitutional rights.

In the case of the former, it should be noted that the use of guiding principles and values in legislative drafting in Zambia is a fairly new feature. The significance of legally endorsing these values can be seen from how guiding principles stipulated in Part II of the Zambian Constitution have been applied. The constitutional principles include democracy, human dignity, equity, social justice, equality, non-discrimination and good governance.[457] Article 9, in particular, stipulates how the national values and principles will be applied in Zambia. It provides to this effect that:

> 1. The national values and principles shall apply to the-
> a) Interpretation of this Constitution;
> b) Enactment and interpretation of the law; and
> c) Development and implementation of State policy.
> 2. The President shall, once in every year, report to the National Assembly the progress made in the application of the values and principles specified under this Part.[458]

Given that the Zambian Constitution does not expressly guarantee the full spectrum of human rights, including the right to health and other social and economic rights, the national values and principles help to hold the government to their human rights obligations and to good governance in a manner that best promotes the principles and values of the Constitution.[459] This helps rights-holders to enjoy fundamental rights beyond the restrictive interpretations, limited enactments and through the development of laws and State policies. In the case of *Godfrey Malembeka v. the Attorney General and the Electoral Commission of Zambia,*[460] the Court considered the State values and principles to recognise the right to vote of inmates. The Court did not only focus on the specific constitutional provision on the right to vote, but considered how the Constitution expected the judiciary to interpret the provision. The Court stated to this effect:

> Article 267 of the Constitution as amended enjoins us to interpret the constitutional provision in accordance with the Bill of Rights in a manner that promotes the

[457] Supra note 42, Article 8(c), 8(d) and 8(e)
[458] Supra note 42
[459] Ibid, Article 267(1)
[460] 2016/CC/0013

> constitution's purposes, values and principles; permits the development of the law and contributes to good governance.[461]

As a result of this finding, the Court was able to better protect the rights of prisoners. The values and principles stipulated in the Zambia Correctional Service Act can enhance the health-rights protections accorded to women inmates by applying expansive interpretations of the law to promote the Act's values and principles. In the case of *George Peter Mwanza and Melvin Beene v. The Attorney Genera*l,[462] the Court extended the interpretation of the right to life guaranteed in the Constitution to include the right to food and the right to health, both of which are not expressly provided for in the Zambian Constitution. The Court upheld the right to food and health as an extension of the right to life in the context of inmates living with HIV whose poor diet negatively impacted or could potentially negatively impact their enjoyment of good health and ultimately their right to life. In conformity with their constitutional mandate to adhere to State values and principles for interpreting and developing the law, the Court did not allow itself to be restricted to the right to life provision. It was instead persuaded by the guidance provided in General Comment No. 9 of the Committee on Economic, Social and Cultural Rights that favoured the justiciability of economic, social and cultural rights to the same extent as civil and political rights.[463] It found that "economic, social and cultural rights are now increasingly being widely recognised as enforceable in the courts either directly or indirectly through civil and political rights."[464] The Court then proceeded to endorse the Indian case of *Francis Mullin v. Administrator Union Territory of Delhi* where a wide interpretation of the right to life was constructed:

> We think that the right to life includes right to live with human dignity and all that goes along with it, viz the bare necessities of such life such as adequate nutrition, clothing, shelter and facilities for reading and expression of oneself in diverse forms, freely moving about and mixing and co-mingling with fellow human beings.[465]

By construing the right to life as including basic necessities such as adequate nutrition, clothing, shelter and recreational activities, the Court in the *Mullin case*

[461] Ibid
[462] Supra note 401
[463]Para 13.10 of Mwanza case
[464]Para 13. 11 of Mwanza case
[465]Francis Mullin v. Administrator Union Territory of Delhi (1981) AIR SC 746

subscribed to the UDHR standard for the right to health which encompasses a right to an adequate standard of living. This conceptualisation of the right to health not only shows the close link between the civil right to life and the socio-economic right to health, but also shows how a limited conceptualisation of the right to life can negatively impact one's quality of life and enjoyment of physical and mental health. By approving this finding in the *Mullin case*, the Zambian Court endorsed the position that the interrelationship between the right to life and right to health renders the categorisation of rights as civil and political and economic, social and cultural as irrelevant when it comes down to the State offering protections for human rights. In the *Mwanza case*, the Court was convinced that failure to construe the right to life in a broad manner, including taking into account a rights-holder's special requirements renders the right to life merely rhetorical or metaphorical.[466]

The judgment in the *Mwanza case* not only demonstrates the powerful position courts have in holding the State accountable for realising fundamental rights, but also how conducive regulatory frameworks can empower institutions such as the judiciary to promote and protect inmates' health rights. Although there are lacunas in Zambia's Bill of Rights which, for many years, have negatively impacted on the enjoyment of social rights such as the right to health, the Court in the *Mwanza case* filled the gap by recognising the interdependence and indivisibility of rights, especially the directly connected rights. This was partly achievable due to the fairly recent constitutional provisions that require the State to take into account values such as "recognition of rights and dignity of all" when interpreting the Constitution. This enabled the Court to recognise inmates' health rights in the absence of an express constitutional provision. The Court in the *Mwanza case* demonstrated that there are positive and negative State obligations to rights such as the right to life, which if violated, render the legal protection of the right otiose.[467] In both the *Mwanza* and the *Malembeka cases*, the Courts were legally bound by the State values and principles to interpret constitutionally protected human rights in a manner that ensured that the actions of the judiciary and the executive promoted the enjoyment of the said rights to

[466] Supra note 401, para 13.17
[467] Ibid

the broadest extent possible. This resulted in protecting inmates' health rights and their rights to vote respectively.

By analogy, the guiding principles stipulated in the Zambia Correctional Service Act create a legal standard for assessing the systems and operations of the ZCS. These values include "respect for inherent dignity of human beings,"[468] "use of least intrusive measures consistent with the protection of society,"[469] "ensuring the efficient service delivery of programmes to inmates,"[470] "retention of rights of citizens,"[471] "correctional decisions are…fair…with access by an inmate to an effective grievance procedure"[472] and "correctional policies, programmes and practices that respect gender…differences, and are responsive to special needs of women, inmates with disabilities, the aged, children and persons requiring mental health care."[473]These can be used in conjunction with other progressive provisions of the law to protect women inmates' health rights and citizenship as was done in the *Malembeka* and *Mwanza* cases.

The latter case in which guiding principles of the Zambia Correctional Service are useful is when they are used to promote the citizenship rights of women inmates. As earlier stated, neither the Constitution nor the Zambia Correctional Service Act expressly protect the health rights of women inmates. This limits the extent to which women inmates may assert public health goods and services and participate in health-related decisions and programmes. For women inmates' in Zambia, their low social standing and citizenship status is thus an important determinant of health. The guiding principle which requires the ZCS to respect the citizenship of inmates is thus an important contribution to legally enhancing women inmates' citizenship status and protecting their health rights and interests. In the *Malembeka case*, the Court used the national values and principles to demonstrate that constitutional rights guaranteed to citizens are applicable to inmates so far as they are compatible with imprisonment. The Court's approach to constitutional interpretation in this case illustrates that inmates' enjoyment of fundamental rights as citizens must be protected. These rights may include freedom of expression, association,

[468] Supra note 31, Section 4(1)(a)
[469] Ibid, Section 4(1)(b)
[470] Ibid, Section 4(1)(d)
[471] Section 4(1)(e)
[472] Section 4(1)(f)
[473] Ibid, Section 4(1)(g)

assembly and freedom from discrimination when contributing to public affairs as well as asserting their individual rights and interests.

The Zambian Correctional Service Act must thus be strengthened to ensure that it protects fundamental rights and creates opportunities for women inmates to participate in health governance and enjoy their health rights in correctional settings. Guiding principles and values for the Zambia Correctional Service, just like the Constitution, have the greatest impact when applied in the context of other progressive legal provisions and rights. From the discussion on the *Mwanza case* above, it is evident that the progressive provision on the right to life in the Constitution paved way for the legal recognition of health rights of Zambian inmates. If there was no right to life provision, the values and principles would not have been used to promote inmates' right to health and food.

If there are no progressive legal provisions for State institutions to protect women inmates' health rights and interests, the Zambian government is duty-bound under international law to create such provisions. If progressive legal provisions exist for the protection of women inmates' health rights, it is incumbent on the government to ensure actual opportunities of women inmates to participate in correctional health governance. As citizens, women inmates must be involved in public affairs such as prison health governance. Considering the provisions of laws such as the Gender Equity and Equality Act, this may entail participating in formulating laws and policies and in the implementation of such laws in correctional facilities. In line with its constitutional mandate, the government must create actual opportunities for women inmates to enjoy their health rights and interests. For instance, existing institutions such as the Human Rights Commission, the Correctional Health Service, the Gender Equity and Equality Commission, the Anti-Gender Based Violence Committee and the Zambia Agency for Persons with Disabilities must use the powers ascribed to them in their enabling legislation to extend their protections to women inmates for better realisation of their health rights and interests.

3.4 CONCLUSION

This Chapter demonstrates that international and regional human rights systems on health and citizenship view rights-holders' participation in health-related decision-making and

programming as an effective means of promoting their health rights and interests. International and regional human rights systems on health and citizenship envisage the State, as principal duty-bearer, putting in place legal, administrative and other measures for the realisation of rights-holders' participation in health governance.

While citizenship participation in health-related decision-making and programming is considered essential to the realisation of health rights under international and regional rights systems applicable to Zambia, the treaties created thereunder do not expressly connect the realisation of health rights to citizenship participation. In fact, international and regional human rights treaties do not explicitly recognise the fact that, for marginalised groups like women inmates, citizenship participation is at the core of realising health rights and determinants. Citizenship participation must therefore be adequately represented in the treaty-based standards for health.

The recognition of citizenship participation allows for consideration and planning on health needs of vulnerable and marginalised women like women inmates and allow for their specific provision at national level. The standards relating to healthcare contained in the Bangkok Rules of 2010 and the Nelson Mandela Rules of 2015, although specific to women inmates, may not be holistic to respond to unique experiences of Zambian women inmates and their participation in health governance. This requires localised interventions that study, implement and evaluate State interventions for realisation of women inmates' right to health as envisaged in the minimum standards set under international and regional human rights framework.

This Chapter has further demonstrated that Zambia's regulatory framework for health is inadequate for responding to women inmates' health rights, including their right to participation in health governance. The Constitution and the Zambia Correctional Service Act do not recognise the right to health of women inmates. Further, they provide limited spaces by which women inmates may participate in health decisions and programmes. These focus on generic provisions relating to participation in elections, political party activities and recognition of associative rights such as freedom of expression, association and assembly. In addition to these laws, other legislation such as the Gender Equity and Equality Act, the Anti-Gender Based Violence Act, the Persons with Disabilities Act and the Mental Health Act have comprehensive provisions that could

potentially enhance women inmates' health rights, including their participation in health governance of the Zambia Correctional Service. However, without specific provision of how this can be achieved for women inmates, the use of these laws could prove problematic.

The creation of a conducive legal environment for women inmates' participation in health is necessary for the creation and effective functioning of participatory spaces such as asserting health rights through the ccourts and dialogue with key duty-bearers and allies. Even though the laws and policies are not a panacea for addressing barriers to citizenship participation that may be experienced by women inmates, they are capable of creating a conducive framework for placing women inmates' health concerns on the national agenda.[474] Women inmates' health rights, experiences and views on their role in health governance are a key consideration for establishing the requisite spaces for placing their interests on the national agenda. The next Chapter discusses the methodology for realising the objectives of this thesis, highlighting how women inmates, State and non-State institutions perceive the participation of women inmates in health governance.

[474] Factsheet on the Right to Health available at www.who.int/hhr accessed on 28 March 2022

CHAPTER FOUR
RESEARCH METHODOLOGY

4.0 INTRODUCTION

In this Chapter, the methodology used to collect and analyse data in this study is presented. The Chapter also explains my methodological choices and the epistemological underpinnings of my study.

The scope and depth of existing feminist scholarship on human rights law has not fully engaged with the identity and status of women inmates and the effects this has on their enjoyment of fundamental rights and freedoms including enjoyment of the right to health within correctional settings. This is particularly true in the Zambian context where feminist human rights literature on participation and citizenship has significantly improved the enjoyment of human rights of vulnerable and marginalized groups such as women, young persons, children and persons with disabilities. This Chapter commences with an explanation of the ethical issues involved in the study, followed by a discussion about the methodology that was used to collect and analyse data. The limitations of the study are also included.

4.1 ETHICAL ISSUES OF RESEARCH

This section describes the ethical issues surrounding the data collection and analysis process. It discusses the participant recruitment process, ethical clearance and benefits to study respondents.

4.1.1 Ethical issues around data collection and analysis

The ethical issues of the research study were concerned with the feasibility of the study in terms of access to correctional facilities, informed consent of participants, possibility of using data collected for publications beyond research study and potential harm to women inmates based on their participation in the study.

The primary approach to data collection was to use standardized open-ended interviews and, depending on the outcome of the interviews, focus group discussions could be conducted. The focus group discussions were meant to reconcile any information obtained from the open-ended interviews that was contradictory and irreconcilable. Since

no such contradictory and irreconcilable information was obtained, there was no need to conduct focus group discussions.

The targeted participants for the interviews were women inmates, civil society organisations (CSOs), government and quasi-government institutions.[475] For the interviews with women prisoners, permission was obtained to access correctional facilities. This required seeking permission either from the Provincial Ministers where the correctional facilities are located or the Ministry of Home Affairs, which is responsible for all correctional facilities in Zambia. The former method was convenient to use if one had easy access to individual ministers, but it takes up more time due to the multiplicity of applications. The latter method was convenient to use as it involves a single application, but if access to correctional facilities is denied, it applies to all correctional facilities. The latter method was used to apply for access to correctional facilities through the School of Law at the University of Zambia. This is because the University of Zambia (UNZA) is readily granted access to correctional facilities and government departments by virtue of being a public university with a function of community development and evidence-based solutions.

Access to governmental and quasi-governmental departments and CSOs was also applied for through the School of Law at UNZA. The purpose of the interviews was explained verbally and in a language participants understand. Participants were informed that they were free to withdraw from it at any time before the publication of the research findings. Research participants were also given my contact details for this purpose. Participants' permission was further sought to use the data collected in the research for other future publications. All consent obtained from participants was informed consent collected either through thumb print or signature in writing and audio recording if the participant was unable to write or print their thumb on the consent form.

In terms of potential harm that could befall the participants, the most likely participants to be at risk of harm were the women inmates. There was a potential danger of some correctional officials and fellow inmates wanting to influence the participation of women inmates or intimidate and subject women inmates to violence on account of their participation in the research study. To mitigate this, all the interviews were conducted with

[475] The list of participants is given in the methodology section.

the women inmates first, in other words, before the interviews with State institutions thereby curtailing the State institutions from being privy to the content of the questionnaires of the women inmates. The questionnaires were also not shared with the Zambia Correctional Service or the Ministry of Home Affairs from whom permission was sought to conduct the research study in correctional centres. This largely prevented the prison authorities and other State institutions from influencing the inmates' responses or subjecting them to harm. I further advised women inmates not to share their responses or questions asked with the correctional community, highlighting the fact that they were free to answer any question and could thus inform any person who asked them about their responses to specific questions that they opted not to answer. The women inmates were additionally reassured of confidentiality in the study. This way, those who participated in the study were not overly exposed to intimidation and undue influence.

In the write-up of research findings, many of the findings were presented as collective views of women or institutions. Where a participant was specifically referenced, it was done by referring to a pseudo or code name which was assigned to all participants, correctional facilities, and other institutional participants. Thus, anonymity was guaranteed to participants of the study. Ethical clearance was obtained from the Faculty of Law Research Ethics Committee at the University of Cape Town (UCT) and from Eres Convergence, a private research ethics committee in Zambia to conduct the empirical research in correctional centres.

4.1.2 Benefits to research participants

The research gave the participants an opportunity and platform to critically reflect on access to healthcare challenges, interventions, and possible solutions for women in Zambian correctional facilities. It also gave an opportunity for participants to share information on citizenship and health rights generally and to reflect on what this means for women prisoners. Women prisoners and their representative organisations had an opportunity to share their views on access to healthcare challenges that they experienced and if their participation in health-related decision-making and programming was a viable way of enhancing their access to healthcare. For participating institutions, I undertook to conduct a dissemination workshop on the findings of the research within one year of the

publication the thesis and to share copies of the research findings with participating institutions including libraries in the correctional centres.

On advice of Eres Convergence, women inmates who participated in the research were provided with refreshments to compensate for their time on the study. The participants were advised that the provision of refreshments had no bearing on their consent to participate in the study and that they could withdraw their consent at any time. All participants were given the refreshments after their participation in the interviews, including those who had chosen to withdraw from the study.

4.2 RESEARCH METHODOLOGY

I conducted socio-legal research considering the multifaceted nature of my study and the limitations of purely doctrinal legal research. My choice of research methods was influenced by existing literature on enforcement of health rights, my research questions, assumptions and experience working on human rights, inclusion and social justice issues. As shown in Chapters 1 and 3, laws alone are inadequate in addressing women inmates' enjoyment of health rights. Similarly, a purely doctrinal methodology inherent in legal methodology would be inappropriate for the study due to the dearth of academic writing on the subject. It would be difficult to satisfactorily answer the research question of this study if a purely doctrinal approach is taken.[476] Further, modern legal research warrants that "the researcher should not only have knowledge about the traditional elements of the law, but also about the quickly changing societal, political, economic and technological contexts and, possibly other aspects of relevance."[477] As argued by Paul Chynoweth, "the law cannot be determined with certainty from an analysis of the rules alone."[478] A socio-legal approach is thus appropriate for this study as it combines doctrinal research with interdisciplinary research.

[476] Reza Banakar 'On Socio-Legal Design' (2019) at 12 available at https://lucris.lub.se>files.pdf accessed on 17th July 2024
[477] Philip Langbroek, Kees van den Bos, Marc Simon Thomas, Michael Milo, Wilo van Rossum 'Methodology of Legal Research: Challenges and Opportunities' (2017) 13:3 *Utrecht Law Review* at 1-2
[478] Paul Chynoweth 'Legal Research' in Andrew Knight and Les Ruddock (eds) Advanced Research Methods in the Built Environment (2008) at 34

Desk-based and empirical methodologies were employed to conduct research for this study. The empirical research involved standardized open-ended individual interviews with women inmates, correctional officials, law and policy makers and implementers and NGOs working on prison issues, women's issues, or health. It also involved use of the observation method by the research team. Regarding standardised open-ended individual interviews, carefully worded questions were developed to interview participants.[479] These questions were coupled with follow-up probes that provided in-depth and broad-based information on my subject of interest. This is what made standardised open-ended interviews the appropriate method for the research. This method was also suitable for this research study as it guarantees that similarly placed participants, that is, inmates, CSOs and government and quasi-government institutions were asked the same questions and in the same order to enable their responses to be compared.

The nature of health rights required me to understand individuals' interests as well as the dynamics of women inmates as a group. These dynamics should, however, exist within the context of similarly placed women to facilitate accurate comparisons, hence the approach taken. Observation methods were also used to put in context the responses that were received from participants and to inform the analysis of data. This entailed that the notes taken by the research team were detailed. I also kept a journal of aspects of interviews and the presence of the research team in research spaces that were of interest to me. On many occasions, the research team would discuss these issues as reflection points.

Interviews were also conducted with relevant CSOs, governmental institutions and quasi-governmental institutions. These took the form of standardised open-ended interviews for the same reasons given above. This method enabled an improved quality and scope of responses, which included information on issues that could not have been anticipated prior to the research.

4.2.1 Preparation of research team for field work

The empirical research was conducted with the help of three research assistants. The use of research assistants was to assist in:

[479]See Annex 1-3 for the interview guides administered to study respondents

i. managing the scope of the study. I anticipated spending long hours in the correctional facilities and the daunting task of handwriting all the responses from the women inmates and later own transcribing them.
ii. the timeous completion of the data collection process. As we were able to conduct the interviews and almost simultaneously transcribe them, this enable me to complete the data collection just before the prisons were closed to the public due to the Corona Virus (2019-2020). It also enabled me to conduct a substantial part of my interviews with institutional participants. This would not have been possible if I did not have assistance in the data collection process.
iii. translating for women inmates who were unable to communicate in English.

Two of the three research assistants provided support for interviewing, note-taking, transcribing and logistics for the meetings. The two research assistants who participated in the data collection were trained for two weeks prior to conducting the data collection to ensure that they understood the tasks involved, the kind of information the study was seeking to collect and the responsibilities of the researcher in the data collection and storage process. They were female to ensure that women inmates are comfortable discussing their health concerns and experiences. The third research assistant was male. He was brought in after the interviews and the peer review session of the transcribed notes were conducted. The peer review session revealed that one set of transcribed notes were over summarised and thus needed to be re-done. The research assistant who had worked on this set of transcripts was not available to re-do the work necessitating a replacement. As the work was desk-based and did not require any interaction with the women inmates, the gender of the research assistant did not matter at this stage. The third research assistant was thus deployed and trained to transcribe the interviews to the acceptable standard.

4.2.2 Recruitment of women inmates

The number of women inmates at the time of conducting the research had grown exponentially from the 2010 data shown in my research proposal. The statistics showed that Lusaka Central Correctional Facility has 149 women prisoners; Kabwe Maximum has 111 women prisoners and Kamfinsa Female and Livingstone General have 55 and 51

respectively. This brought the total of women prisoners in these facilities to 366. A review of literature conducted at the time of designing the study showed that there were four documented correctional facilities for women prisoners in Zambia and 250 women inmates.[480] Based on these recorded numbers, the initial plan was to interview one quarter of the estimated number of female inmates at the time, which brought the number to 15 women inmates per facility. A balance had to be struck between identifying a representative sample of participants and ensuring feasibility of the study. To manage the study within the time and resources permissible, the study sample was limited to two correctional facilities. - one in an urban area and another in a peri-urban area. One of the major considerations taken in making this decision relates to the study design which sought to obtain qualitative data, namely, the experiences of women inmates regarding their participation in health-related decisions.

The choice of representative sample was therefore less concerned with the quantity of the responses. For purposes of quantitative research, what amounts to a sufficient sample size depends on several factors including the aims of the study, the quality of the data, the research design, and sampling methods, which in turn influence saturation.[481] Researchers therefore tend not to prescribe what constitutes an ideal sample size for qualitative interviews.[482] What is important is to demonstrate that "the dataset is sufficient to address research problems."[483] In this research, the sample size is justified by three key considerations. Firstly, the interviews were conducted in two of the facilities with the highest number of female inmates. Secondly, the two facilities are representative of existing correctional facilities that house female inmates in Zambia. Apart from their geographical representation, the two facilities also provided optimal representation because of their purpose and character. One is an ordinary correctional centre whereas the other was a maximum prison and correctional centre. Thirdly, participants who had served a sentence in a different facility were asked to narrate their experiences in those other facilities for comparative purposes.

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[480] Todrys & Amon op cite note 6

[481] Mark Mason, 'Sample Size and Saturation in PhD Studies Using Qualitative Interviews' (2010) 11:3 *Qualitative Social Research 2* (ISSN 1438-5627) <http://www.qualitative-research.net/> Accessed 13 April 2020.

[482] Ibid 3.

[483] Bryan Marshall and Others, 'Does Sample Size Matter in Qualitative Research? A Review of Qualitative Interviews in is Research' (2013) 54:1 *Journal of Computer Information Systems* at 20 available at DOI:10.1080/08874417.2013.11645667

Approval of my supervisors was obtained to facilitate the changes in the research design. The fieldwork proceeded with these changes which did not require further ethical approval by the research ethics committees. The study used random sampling of the shortlisted participants who met the selection criteria.

Within the two facilities included in the study, I identified a representative sample of participants to ensure inclusion of views from a diverse group of women inmates. I selected inmates who:

a) Served a long time in the correctional centre and could ably speak about women inmates' experiences. In this regard, the study prioritised those who had been in the correctional centre for at least 3 years; or
b) Were imprisoned with their young children or other dependents in the correctional centre; or
c) Were prohibited immigrants; or
d) Were indigent; or
e) Were elderly; or
f) Had left young children or dependents at home or under the care of family or friends; or
g) Had a terminal illness; or
h) Had a disability.

After applying the above criteria, a total of 50 women inmates were interviewed from two correctional facilities. The selection criteria for the interview participants was informed by the findings of the literature review and the recognition that women inmates are not a homogeneous group and their individual situations would impact on their willingness and ability to effectively participate in health-related decision-making and programming in correctional settings.

4.2.3 Recruitment of and interviews with institutional participants

Interviews were conducted with 22 institutions that comprised the following: Eight (8) CSOs, two correctional facilities and twelve (12) governmental and quasi-governmental institutions. Purposive sampling was used to identify institutions that were selected to

participate in the study owing to their mandates or longstanding work they carried out in their respective fields. The following institutions participated in the study:

Civil Society Organisation:

a) Women for Change
b) Women in law in Southern Africa
c) Prisons Care and Counselling Association
d) Prison Reintegration and Education Organisation
e) Disability Rights Watch
f) Mental Health Users of Zambia
g) Paralegal Alliance Network
h) Panos Institute in Southern Africa

Governmental and Quasi-governmental institutions, namely:

a) Ministry of Gender
b) Ministry of Health
c) Ministry of Community Development, Mother and Child Development
d) Ministry of Local Government
e) Zambia Correctional Services
f) Chimbokaila (Lusaka Central) Correctional Facility
g) Mukobeko Female Medium and Maximum Correctional Centre
h) Judiciary
i) National Assembly of Zambia
j) Legal Aid Board
k) Zambia Law Development Commission
l) Human Rights Commission
m) Kabwe Municipal Council
n) Lusaka City Council

In one participating correctional facility, the Officer-In-Charge could not be interviewed as they were not available and not willing to delegate the interview to another person. Due to COVID-19 and non-responsiveness of some institutions, the field work was restricted to only those institutions that had confirmed their willingness and availability to participate in the study. Institutions that did not consent to participate in the

study are thus not listed here in line with research ethics. Institutions that qualified to participate in the study but indicated their non-availability to do so were replaced by similarly placed institutions. The criteria for selection of replacement institutions remained the same and an institution's mandate or longstanding work were the primary consideration.

Through the interviews, there was an endeavour to determine how identified governmental and quasi-governmental institutions coordinate their work to meet the health needs of women inmates. The interviews further sought to determine how the health governance framework of the Zambia Correctional Services could directly address the plight of women inmates to enhance their access to health goods and services and what government institutions envisaged as the role of law in achieving this. There was always the possibility that government institutions would not view the law as a necessary tool for facilitating women's participation in correctional health systems. However, the enquiry on the role of law in facilitating women inmates' participation in health decisions and programmes was a core component of this research study.

4.3 DATA MANAGEMENT: TRANSCRIBING INTERVIEW AUDIO-RECORDINGS

I transcribed the interview audio-recordings. Some recordings were of poor quality due to various forms of interference and malfunctioning of the recording device. In one instance, a respondent did not grant consent to be audio-recorded as this was against their institutional policy. All the responses were thus handwritten and read back to the respondent to verify the accuracy of the response. In another instance, permission to audio-record the interview was granted mid-way through the interview and thus it was recorded partly in writing and partly through audio. As a result, I obtained information not captured through audio-recording devices from the interview notes I took. Where these were unclear or incomprehensive, I reverted to the respondent to obtain their response. This was done via phone or email, considering the COVID-19 restrictions. All the interviews were transcribed, assigned double pseudo names, and coded. Initially, a temporary pseudo name was assigned to all transcripts at the time of data collection. This was known to all the research team members. The transcribed interviews were then peer reviewed and edited after which I assigned a second set of pseudo names to the participants. The research assistants were not privy to the second set of pseudo names that

were assigned to the study respondents. Thereafter, all of the transcripts were coded. The coding was done by colour-coding the transcribed interview notes according to the five broad areas of inquiry, that is, personal data, access to healthcare and health determinants, citizenship and human rights, participation and lastly the role of laws, policies and institutions.

4.4 DATA STORAGE AND MANAGEMENT

All the recordings were saved on a hard drive and flash disc with their second code names. Each research team member's work was saved on a separate flash disc and all the transcribed work was saved on one disc as a master copy. The recordings and transcribed interviews were stored in separate devices and saved under a password-locked file identifiable to only the lead researcher. All the information was backed up in the cloud and was accessible by a password locked file. Individual transcripts did not contain personal identifiable details and the list of participants with personal details is password protected. All permissions including participants' consent forms are kept in a hard copy file. They were scanned and stored in a lockable file.

Most of the data is in electronic form and stored on my Google drive, a web-based cloud platform, her personal laptop and external hard drive all of which are locked by password. I am solely responsible for data management of this PhD research project. I have intellectual property rights to the data and knowledge produced herein.

4.5 DATA ANALYSIS

To meet the aims of this study, it was necessary to document women inmates' health rights experiences in correctional facilities in Zambia, as well as the views of stakeholders. I also sought to develop a practical model for realizing greater enjoyment of health and citizenship rights by women inmates in Zambia to debunk a popularly held belief in the Zambian society that the participatory rights framework is not suitable for correctional settings or cannot be extended to women inmates in Zambia. This approach justifies the heavy reliance on feminist-influenced legal and human rights literature from which participatory methods are largely analysed, unlike feminist criminology literature. Feminist criminologists and scholars with feminist criminology interests have published relatively extensively on feminist critiques of traditional criminology contributing to the

development of the feminist theoretical framework,[484] the impact of penal interventions for health promotion on women inmates,[485] victimisation and criminal offending by women including in intersectional contexts,[486] the impact of imprisonment on women inmates[487] and strategies for reforming women's incarceration.[488] These works do not strictly fall within the focus of my research as I rely on socio-legal research which amalgamates feminist theories of rights and citizenship. Amy S Tsanga and Julie E. Stewart use the perspective of Stang Dahl to argue that in applying feminist perspectives to law, including public law such as human rights law, criminal law and administrative law, three critical steps must be taken:

i. Examine strong legal support: in this case, examine the progressive aspects of human rights law that women inmates and their allies may utilize to ensure their social inclusion.

ii. Examine weak legal support: for example, by assessing how human rights law or correctional laws reinforce women inmates' exclusion in health governance.

iii. Scrutinize judicial voids: to what extent have issues affecting women inmates' rights been addressed by the judiciary or more broadly by justice actors? How have they addressed them? Have such interventions taken into account women inmates' lived realities and voices?[489]

Ultimately, the process of applying feminist perspectives to law involves the critical elements of reviewing laws, critiquing and reforming them at every stage of the Dahl model.[490] My woman-centred citizenship participation model for health of women inmates in Zambia presents the requisite normative theory of change that seeks to

[484] Carol Smart. 'Women, Crime and Criminology: A Feminist Critique' (1976) London: Routledge
[485] Douglas, Plugge and Fitzpatrick op cit note 14
[486] Claire M. Renzetti. 'Feminist theories of violent behaviour' (2004) Routledge available at https://www.taylorfrancis.com/chapters/edit/10.4324/9781315721231-15/feminist-theories-violent-behavior-claire-renzetti accessed
[487] Caroline Agboola. 'Memories of the 'inside' Conditions in South African Women's Prisons' (2016) 56 South African Crime Quarterly available at https://www.ajol.info/index.php/sacq/article/view/138588
[488] Uju Agomoh "A Critical Analysis of the Current Situation and Treatment of Female Offenders in African Countries' (2015) available at https://www.unafei.or.jp/publications/pdf/13th_Congress/14_PRAWA.pdf see also Dawn Beichner and Otmar Hagemann 'A Global View of Women, Prison and Aftercare: A Call for Reform" (2022) 28:8 Violence Against Women 1788-1808. https://doi.org/10.1177/10778012221085997
[489] Amy S Tsanga and Julie E. Stewart eds. 'Women & Law: Innovative Approaches to Teaching, Research and Analysis' (2011) at 7-14
[490] Ibid

"rediscover and safeguard the transformative roots of participation" [491] One of the cornerstones of this model is to amalgamate rights-based approaches and feminist approaches to citizenship participation as a way of curbing the weaknesses inherent in these theories that "leave power imbalances and structural inequalities unchallenged."[492]

A contextual analysis was used to analyse international and national human rights instruments to ascertain the standard for right to health protections for women inmates applicable to Zambia and to ascertain the extent to which participation in health decision-making and programming is guaranteed under international and national human rights and developmental instruments. I also reviewed notes from observations and debrief discussions held with the research team on what was observed in the correctional centres and from interviews with State and non-State actors. This was done to give context to the data collected in the various interviews.

A thematic analysis approach was used to analyse the findings of the field research. No data analysis software was used. Instead, all the transcripts of the interviews were colour-coded as explained above. Further, data based on the type of respondent was also analysed, namely, women inmates, CSOs, correctional officers, and other governmental and quasi-governmental organisations.

4.6 DESCRIPTIVE TERMS FOR STUDY PARTICIPANTS

The following terms are used to describe the different study respondents in this research study:

'Women inmates' refers to the women prisoners who participated in this study.

'Institutional participants' refers to State, quasi-governmental and non-governmental organisations that participated in this study.

'State respondents' refers to participants from State institutions.

'Quasi-governmental' refers to participants from quasi -governmental institutions.

'Civil society participants' refers to participants from civil society organisations..

'Study respondents' refers to the women inmates and institutional participants.

[491] A A Frediani, J Peris and ABoni 'Notions of empowerment and participation: Contributions from and to the capability approach' (2019) available at https://link.springer.com/chapter/10.1057/978-1-137-35230-9_5
[492] Ibid

4.7 CONCLUSION

In this Chapter, the methodology for the research was explained, focusing on the research methods used as well as the ethical considerations of the research. The next Chapter documents how women inmates in Zambia understand health rights, experience human rights and citizenship, and view their participation in health governance as a means of enhancing their health rights. It also documents how women inmates use the law to advocate for their rights.

CHAPTER FIVE
WOMEN INMATES' AND INSTITUTIONAL PARTICIPANTS' HEALTH RIGHTS EXPERIENCES IN THE ZAMBIAN CORRECTIONAL SYSTEM

5.0 INTRODUCTION

Having examined the normative standards for participation as a vehicle for enhancing enjoyment of health rights in Chapter three, this Chapter focuses on the study respondents' perceptions of women inmates' participation in health-related decisions and programmes.

The Chapter addresses three of the four key areas of inquiry identified in the previous Chapter. The first area of inquiry aims at understanding women inmates' health situation in their correctional facilities. Study respondents were asked questions about health determinants and access to healthcare for women inmates. These questions informed the findings on women inmates' health situation and their vulnerabilities to health rights' violations, study respondents' understanding of health rights and the extent to which women inmates enjoy their right to health. In the second area of inquiry, study respondents were asked about their understanding of the impact of women inmates' participation in health-related decision-making. In the last area of inquiry, an understanding of women inmates' citizenship and social standing was sought with the aim of ascertaining the extent to which women inmates enjoy citizenship as well as bench-marking what citizenship entails for a woman inmate.

The Chapter begins with a discussion on women inmates' views of their health situation in the Zambian correctional facilities. It then presents findings on study respondents' understanding of women inmates' health rights and their experiences of participating in health-related decisions. Further, women inmates' perceptions of the impact of their participation in the correctional health system are examined. To this effect, the following issues are addressed: the benefits and costs of women inmates' participation in health-related decisions and programmes; women inmates' experiences of the impact of participation in advancing health equity; institutional participants' views on the impact of women inmates' participation in health decisions and programmes and women inmates' experiences of citizenship vis-a-vis their enjoyment of health rights. The Chapter ends by summarising of the study findings.

5.1 WOMEN INMATES' VIEWS ON THEIR HEALTH SITUATION IN ZAMBIAN CORRECTIONAL FACILITIES

This section provides a brief description of women inmates' health situation in the Zambian correctional facilities. It seeks to contextualise women inmates' perspectives on the impact of the correctional healthcare system on their health situation and the role of participation in promoting health rights.

Women inmates were asked about their health situation and health determinants in the correctional facilities.[493] When asked who were the most vulnerable women inmates in their facility, many women inmates were reluctant to identify the group of women inmates most vulnerable to ill-health stating that all the women were unique and had their own health challenges and situations that impacted on their health.[494] One woman inmate stated "I wouldn't choose [who is most vulnerable]…we all need healthcare. We are all suffering because some inmates have visitors while others don't [therefore they have no access to basic necessities]." [495]Another put it more succinctly:

> People struggle in different ways. Someone may be elderly, but have the strength to make doormats and raise money. Prohibited immigrants come from far and have no one to supply them with basic necessities, but some among them may have a lot of money. You may think mothers are more vulnerable, but maybe they have people supplying their needs.[496]

Understanding the health situation of women inmates can inform whether the health system of the correctional service responds to the identified health concerns. It also helps to contextualise study respondents' views on the impact of women inmates' participation on their health. While women inmates shared a common view that they are all vulnerable to ill-health, it was also evident from their responses that their individual circumstances expose them to different vulnerabilities. For example, a woman inmate who is elderly was more likely to be susceptible to poor health compared to a young inmate arising from poor sanitary conditions in the correctional facility due to their relatively weaker immunity. However a young person may be more vulnerable to poor health due to poor menstrual hygiene in the correctional facility. When probed further about women inmates' vulnerability to poor health and the common health challenges in correctional

[493] See Annex 1 on the Interview Guide for women inmates
[494] Participants TCT008, C023, CCT019, TCT020, TCT024
[495] Participant CC001
[496] Participant CCT010

settings, women inmates were able to identify those deemed as most vulnerable among them. Vulnerable women inmates identified by participants were "the elderly",[497] "women with disabilities",[498] "pregnant women",[499] "mothers including those with children in the correctional facilities",[500] "women who did not receive visitors",[501] including "prohibited immigrants", [502] and "women with terminal illnesses". [503] Further, women inmates identified common health challenges in their correctional facilities to include "mental stress", [504] "hypertension", [505] "vaginal fungus", [506] "vaginal cysts", [507] "diarrhoea", [508] "HIV",[509]Tuberculosis,[510] Syphilis,[511] "diabetes",[512] "body pains",[513] and "bodily rash."[514]

Women inmates also identified health determinants as including lack of access to basic necessities like "food",[515] "sanitary pads and underwear",[516] and "running water".[517] Women inmates also identified other health determinants as women inmates' "lack of post-surgery care",[518] "reluctance to seek health services and programmes due to stigma and discrimination"[519] that flows from "appearing in public in prison uniform",[520] "being chained to a hospital bed when seeking treatment or medical procedures",[521] "violation of their right to confidentiality by fellow prisoners",[522] and "poor relationships with State and

[497] Participants CC001, CCT002, CC016, CCT019, CCT003, TCT024 , CC020, TC003, TC014
[498] Participants CCT010, TC006, TT007, TC012
[499] Participant TCT020
[500] Participant CC001, CCT003, CCT010, TD009, T019, C023, CCT019, TCT020, TCT024
[501] Participants T019, CC022, TCT015, TCT018, CCT003, CCT010
[502] Participant CCT003, TCT018, CCT010
[503] Participant TCT008, CC016
[504] Participants CC011, TC014, TC006, TT007
[505]Participants CC011, CCT019, TCT005, TC006, TCD011, CC001, CCT003, CC008, CCT004, CCT005, CCT006
[506] Participants TCT001, TC003, TCT008, TCT010, TC012, TCDT013
[507] Participants TC006, TCD011
[508] Participants CC011, TCT008, CC001
[509] Participants TC004, TCT018, CCT003, CCT004, CC009
[510] Participants TCT 001, TC017, CC008
[511] Participants TCT 001, TCDT013
[512] Participants CCT019, TCT015, CCT004, CC008
[513] Participants TC004, TCT005, TT007, TCT010, TC012, CC001
[514] Participants TCT001, TT007, TCT008, TD009, TC017
[515] Participants TC017, CC008, CC009, CC001
[516] Participants CCT010, CC008
[517] Participant TC004
[518] Participant TCT002
[519] Participants KU002, KU004, TCT001
[520] Participants TCT001, KU002
[521] Participant KA005
[522] Participants TT007, TC006

correctional officials"[523] that prevent their communication of health needs. These health determinants for women inmates require prison administrators and health experts to work closely with women inmates to address their unique situations.

Women inmates' lived realities and experiences equip them with knowledge on their health situation which, if shared with prison administrators and health experts, would enable them to jointly design and implement effective programmes for improving their health outcomes. The next section analyses study respondents' understanding of the right to health and participation in health for women inmates in Zambian correctional facilities.

5.2 STUDY RESPONDENTS' UNDERSTANDING OF WOMEN INMATES' HEALTH RIGHTS AND PARTICIPATION IN HEALTH-RELATED DECISIONS AND PROGRAMMES

Below are findings on study respondents' views on the right to health and experiences of women inmates' participation in health governance.

5.2.1 The right to health

Study respondents were asked about their understanding of the right to health. This was done to ascertain their views on the standard for enjoyment of women inmates' health rights. Over 90% (47 out of 50) of women inmates understood the right to health to mean "access to treatment whenever an inmate fell ill".[524] One inmate referred to the right to health as the ability "to look for medicines so that I can get better".[525] Another said "one has to go to the clinic when they are not feeling well."[526] Another indicated that the right to health means "despite being incarcerated, you have the right to medicine when you are sick; you have the right to be taken to the clinic."[527] Most State institutions mandated to work with women inmates held a similar view as the women inmates, that is, that the right to health is one that guarantees treatment to a person who is unwell.[528] Most quasi-governmental and non-governmental participants provided a broader understanding of the right to health. They understood the right to health to extend beyond access to treatment

[523] Participants TCT010, CC017
[524] ParticipantsT019, TCT022,TC012, TCD011, TD009, TCCT003, CCT006, CCT010, CC001, CC011, CC017
[525] Participant TCT014
[526] Participant TCT015
[527] Participant TCT020
[528] Participants KA002, KA003, KA004.

for diseases, and included "access to health-related information",[529] "access to health services including preventative services",[530] "access to health facilities",[531] "access to health personnel",[532] and "access to affordable health goods and medicines".[533] One quasi-governmental participant stated that the right to health included "access to primary healthcare as well as specialised healthcare".[534] Relatively fewer study respondents recognised that access to healthcare extends beyond physical health to include access to social and mental well-being.[535] A few quasi-governmental and non-governmental participants stated that the right to health is enjoyed when a person is able to access health goods and services without any difficulties or barriers.[536]

The aforementioned views illustrate that the right to health can be violated if barriers to accessing health goods and services are not addressed. Some State respondents viewed proximity of health services to the population, equity, and the quality of health services as enablers to the enjoyment of health goods and services.[537] Thus State respondents identified access to healthcare as essential to the right to health. The views on access to healthcare as a core component of the right to health were augmented by a non-governmental participant who stated that "[The right to health] is the process or the ability of an individual to get the health requirements or health needs at a particular time. The ability to find [assistance for health needs] …"[538] Participant KU006 and others who expressed similar views focused on the right to health standard that addresses 'the three As' and Q' (Accessibility, Availability, Affordability and Quality) under international and regional human rights laws.[539] Participant KU005, another civil society participant, extends this standard to include access to "health requirements or health needs".[540] In response to the question on the scope of the right to health, none of the study respondents

[529] Participants KU003, KA001
[530] Participants KU003, KU002, KU008, KA011
[531] Participants KU003, KU008, KA002, KA007, KA011
[532] Participants KA002, KU001, KU008
[533] Participants KU007, KU008, KA002, KA004, KA008, KA001, KA006
[534] Participant KA005
[535] Participants TC006, KU002, KU004
[536] Participants KA008, KU004
[537] Participants KA009, KA007, KA011
[538] Participant KU006
[539] Office of the United nations High Commissioner for Human Rights and World Health Organisation "The Right to Health" Fact Sheet No. 31 at 4 available at https://www.ohchr.org/Documents/Publications/Factsheet31.pdf
[540] Participant KU005

expressly identified access to health determinants such as food, sanitary pads, sanitation, clean and portable water, and visitations from family and friends of women inmates as forming part of this right. Many of the study respondents nonetheless identified the aforementioned health determinants as negatively impacting on women inmates' realization of health rights. One woman inmate stated with regard to the impact of a poor diet that: "hunger negatively impacts on our health… the diet we have consists of beans everyday…If you don't have a variety of food when you are sick you lose your appetite."[541] Another woman inmate stated that some concerns that negatively impact on women inmates' health include "limited access to soaps, sanitary pads… lotion, others have no underwear, and others need 'chitenge' material[542]… slippers…" [543] Participant "TCT022", another woman inmate, also added that "if only they can bring us enough disinfectants and toiletries, sanitation would improve… and put up modern toilets." These views reflect the fact that although many women inmates do not largely understand the right to health language as contained in international human rights treaties, women inmates are able to use their personal experiences to identify health needs and how to address them. This is required to enhance women inmates' enjoyment of health rights through avenues for social learning, women inmates may learn about rights standards for health.

A rights-based understanding of health is cardinal for realizing 'the three As' and Q' in line with international and regional human rights standards. A limited understanding of the right to health by women inmates and State institutions mandated to care for them is indicative of women inmates' limited exposure to human rights education and limited enjoyment of the full range of health rights. Considering that many women inmates and State respondents' views on the right to health cited above deem the right to health as constituting one's access to health services when a person is unwell, one could argue that this understanding emanates from what they are taught and are exposed to in correctional facilities. Such understanding would typically exist in contexts that take a 'medical-centred approach' to inmates' health described in Chapter three of this thesis.

[541] Participant CC008
[542] A 'chitenge' is a traditional Zambian fabric used mostly as clothing to wrap around one's waist or make an outfit or to use as a sling for a baby.
[543] Participant CC020

Although most institutional participants did not provide holistic rights-based responses to the understanding of the right to health, they gave a broader understanding of the right to health than women inmates and State institutions that work directly with them. As earlier stated, the majority of women inmates and State institutions understood the right to health as being synonymous with the right to treatment. Conversely, most quasi-governmental and non-governmental participants' views on the scope of the right to health aligned with the standards set by international and regional human rights treaties, that is, within the purview of the "highest or best attainable standard of health" discussed in Chapter three above. It is important for all women inmates, NGOs representing their interests and State institutions with a direct mandate over women inmates' rights and interests to have a comprehensive rights-based understanding of health. This would ensure that State and non-State actors work towards providing the full spectrum of health rights to women inmates. Some respondents suggested that consistent, formal, and structured interactions among women inmates, the State and non-State actors could provide a pathway for guaranteeing a comprehensive rights-based understanding of health. They stated that such interactions could provide an opportunity for health and rights-related information-sharing and capacity-building for better realization of health rights. This in turn can advance the realization of a women-inclusive citizenship participation model for women in Zambian correctional health system.

Consistent, formal and structured interactions between the State, women inmates and organisations that represent them are feasible considering that women inmates and correctional officers are within close geographical proximity and correctional officers have easy access to requisite State and non-State institutions. The ease of access to State and non-State institutions also allows for implementation of programmes in correctional facilities thereby facilitating direct access of women inmates to such actors.[544] Over 90% of participants from non-governmental organisations (NGOs) indicated their involvement in advocacy and awareness-raising work in gender programmes such as access to justice, disability and women's rights. However, they all indicated their limited engagement in health-related advocacy and awareness-raising, citing lack of prioritization of such work as opposed to their inability to carry out health-related work. Thus, if such NGOs

[544] Participant KA010

prioritized health-related work, they would be in a better position to learn about and advocate for the full spectrum of health rights for women inmates. Similarly, most State and quasi-governmental institutions indicated that they do not work on women's health issues. Those institutions that indicated working on women's health issues stated that they do not work in correctional facilities. One State institution stated that they were reluctant to work with women inmates as they had violated the law. Women inmates must therefore suffer the consequences of imprisonment.[545] Another State institution indicated the inadequacy of funding to work in correctional settings.[546]

State and quasi-State institutions in Zambia do not carry out comprehensive (i.e. consistent, formal and structured) health-rights work targeted at women inmates.[547] They felt that, in hindsight, both these areas constituted areas of work they should be involved in by virtue of their broad mandates which constituted health issues or welfare of inmates or human rights including gender equality or a combination of these issues. Study respondents' views, in this regard, presents an opportunity for the institutions mandated with advancing women's health rights or the welfare of women inmates to scale-up their health-rights sensitization and advocacy. This can empower women inmates to better understand their right to health and include them in health-related decision-making and programming. To fully assess the extent, impact, and means of enhancing citizenship participation in health for women inmates in Zambia, it is necessary to examine their experiences and views in this regard.

5.2.2 Respondents' understanding the role of participation in health

Over three-quarters of women inmates confirmed having participated in one way or another in the health system of the correctional facility as discussed below. The different ways in which women inmates participated in health-related decisions and programmes reveal the forms, spaces, and underlying values for such participation. They reflect actual and perceived enablers and barriers to participation that women inmates encountered. These are discussed in turn below.

a) Forms of health-related participation by women inmates in Zambia

[545] Participant KA006
[546] Participant KA011
[547] Participants KA001, KA004, KA011, KA012

Women inmates were asked about how they participate in health-related decision-making and programming in their correctional facilities. From the three broad forms of participation that is, individual, social and public participation, respondents identified two forms of participation that they were involved in. They identified participation at an individual level as the most common form of participation. They stated that inmates participated in health decision-making and programming by "notifying cell captains and correctional officers when they were unwell and needed medical treatment."[548] Justifying the importance of participation at individual level, one woman inmate stated that "the enjoyment of health rights was a personal responsibility where one should make sound decisions that prevent them from negative health outcomes."[549] There are also weaknesses in placing the whole responsibility for realising health rights on the individual. One woman inmate reported that "certain health decisions should not be left to the individual alone as some individuals make bad health choices like neglecting to participate in prison activities that are meant to keep inmates busy or not taking prescribed medicines for their recovery and better community health."[550]

Another form of participation cited by a few women inmates was social participation. One woman inmates stated:

> We help one another like when one is sick. The inmates take very good care of each other because sometimes one may be very sick and have no strength, but the inmates would bath her, wash her clothes and give her porridge. [551]

Social participation has the advantage of pooling and leveraging meagre resources for greater impact of programmes. However, with social participation, there is a risk of overburdening and discriminating against some actors of the social organization or community particularly where inequality exists.[552] For instance, when asked whether inmates were comfortable with having care-giving responsibilities imposed on them for sick inmates, one inmate stated that "they do not mind such responsibility."[553] Another

[548] Participants TCD011, TCT014, CCT004, CCT006
[549] Participant TCT005
[550] Participant TC004
[551] Participant CCT025
[552] Mary Law '*Participation in the Occupations of Everyday Life*' available at http://ajot.aota.org/pdfaccess.ashx?url=data/journals/ajot/930146/460.pdf accessed 15 August 2017
[553] Participant TCT008

observed that "others just don't want to help [take care of sick inmates] while others really do have a lot of things to do."[554] Another inmate felt that "sometimes care-giving responsibilities are burdensome."[555] Inmates who provide care-giving responsibilities "are still expected to carry out other chores assigned to them by the cell captain or correctional officers."[556] Since these duties are mandatory, inmates often opt to carry out these chores rather than undertake their care-giving roles. Yet another shared the challenges of care-giving roles as follows:

> Those with babies are affected mostly because in here there is a lot of work we do, such that when it's time to work, you are not supposed to be with the baby, even if it's crying or it doesn't have food, you just have to work. And like those who are sick, there is nothing like you are sick, when it's time to go into the field, you just have to go, there is nothing like you are disabled. They'll find something for you to do, even sweeping the surroundings...[557]

Care-giving roles imposed on women inmates may negatively impact on their mental or physical health. Women inmates who are willing to carry out care-giving roles in correctional facilities must be excused from other assignments or chores within the correctional centre because they get overburdened and put their own health at risk. The health of ill inmates in need of community support is also put at risk as inmates who are overburdened opt to shun such care-giving roles.

Care-giving roles must be equivalent to community-based care-giving programmes implemented by the Ministry of Health. This will ensure access to quality health services for ill inmates and equality of prison-based community health programmes with those offered to the general public. This entails another level at which participation should occur, that is, at the public level. Public participation ensures interaction between individuals and/or their communities with public institutions for the realisation of their interests and rights. Thus, in the general community, participation occurs at three levels: individual, social and public and these forms of participation are not mutually exclusive.[558] Although women inmates gave examples of their individual and social participation in correctional centres in Zambia, none of them indicated participation at public level for

[554] Participants CCT021, TCT004
[555] Participant CCT021
[556] Participant TCT005
[557] Participant CC016
[558] Law op cit note 540

health decisions and programmes. The spaces for participation enjoyed by women inmates in Zambia are discussed in detail below.

b) Spaces for participation for women inmates in Zambia

Participating in health decision-making creates opportunities for participating in health programming and vice versa. Rights-holders who are given opportunities to participate in health-related decision-making are more likely to participate in identifying, planning and implementing health programmes. Similarly, rights-holders who participate in health programmes are likely to get opportunities to inform health-related decisions compared to those who do not participate in health programmes. Spaces for participation for women inmates range from health programmes and opportunities to participation in health decisions as illustrated below.

i. Self-advocacy interventions

Some study respondents gave examples of how inmates' self-advocacy efforts helped to address health rights violations and mitigate negative health determinants. A civil society participant, who was also an ex-prisoner, explained how he presented a complaint on behalf of other inmates to visiting public officials in the company of the Commissioner-General of the Zambia Correctional Service and a UN delegation.[559] The inmates were receiving poor service from the medical officer-in-charge of the clinic, who did not spend much time at the clinic. When the medical officer was there, he did not attend to inmates. This led to inordinately long delays in accessing healthcare. The inmates took the opportunity of the visiting delegation to complain about the conduct of the medical officer and soon thereafter the medical officer was replaced with a more committed one.[560] This incident, however, occurred at the male section of the correctional facility and there is no similar incident reported among female inmates. Women inmates cited more subtle forms of registering complaints. These include engaging in dialogue with correctional officers rather than reporting officers to external persons. An incident was cited where female inmates' individual and collective complaints to correctional officers helped to move an inmate with a mental illness to a mental health institution.[561] The complaints lodged by

[559] Participant KU005
[560] Ibid
[561] Participants TCT005, TDT011

fellow inmates ensured that the inmate with a mental illness had access to the mental health services that they required. The removal of the sick inmate also ensured that other inmates were safe from her violent behaviour when she had a mental crisis.[562] Some women inmates however identified how "discussing health needs and experiences in correctional facilities with external visitors such as churches helped inmates' issues to be broadcast through the public media."[563]

ii. Lodging anonymous complaints

Some women inmates cited 'table complaints' as a space for their individual participation in health.[564] These are desks set up by NGOs and quasi-governmental bodies for inmates to register their health and legal complaints. Women inmates explained that desks have helped them address some of the health-rights violations experienced by inmates. One inmate explained that "table complaints fora set up by the Human Rights Commission and the Legal Aid Board are very useful for addressing issues affecting women inmates."[565] Table complaints enable independent investigation of health rights violations.[566] The preference of table complaints to overt petitions by women inmates may be due to cultural issues where women are socialized to be subtle when lodging complaints, or due to fear of punishment.

Other inmates stated that "they do not use the table complaints much because they lack privacy".[567] Whether the lack of privacy is perceived or actual, it negatively impacts on the uptake of services offered by institutions working in correctional facilities. This concern must be addressed to ensure that the space created is useful for the purpose for which it is created. The use of table complaints can also be negatively affected by ignorance of the target beneficiaries. One inmate stated that "I thought they [Legal Aid Board] were just helping the prohibited immigrants. I stayed for nine months without knowing what they were doing on their table." [568]

iii. Requesting medical attention

[562] Ibid
[563] Participant CC016
[564] Participant T005
[565] Participant TT007
[566] Participants KU006, KA007
[567] Participant TC004
[568] Participant TT007

Most women inmates cited actively seeking medical attention for ill inmates as a space for their participation in health decision-making and programming. However, some inmates shunned seeking medical attention for lack of privacy as they would have to see a medic in the presence of the correctional officer or fellow inmate.[569] One woman inmate referred to how inmates are quizzed about their illness when they notify the officers of their illness:

> You raise your hand at the parade when you are not feeling well. They will ask if you are not feeling well, and fellow prisoners will pass negative comments. And the officers will say "but you were at the clinic yesterday." So even when I am not feeling well it makes me think I wouldn't want to go through that.[570]

Others would shun seeking medical attention if it required them to access a public hospital because they did not want to be identified by members of the public as criminals since they are required to access public hospitals dressed in their prison uniform.[571] Many of the women inmates also felt that the procedures for accessing medical attention applicable to inmates on death row inhibited them from timely access to treatment.[572] One woman inmate observed "like for us the condemned inmates, it takes some time for us to be taken to the clinic."[573] Another said "when someone is sick, they are supposed to rush them to the clinic as fast as possible … but it just takes time from the time you are sick until the time they take us to the clinic."[574] Women inmates on death row have more rigorous procedures for accessing medical treatment outside the correctional facility as they are considered to be more dangerous and more likely to escape prison than inmates who are not on death row. Another inmate demonstrated how this space is not always effective for women inmates:

> Many women inmates have conditions like BP, epilepsy, pregnancy… We can be calling and calling [when a medical emergency arises] but it takes long for the officers to come and take the patients to the hospital since the keys are not here. The keys are kept in the male section. When there is a problem on the women's section, they don't come quickly and we suffer. [575]

[569] Participants TT007, TC006
[570] Participant CCT017
[571] Participant TC004
[572] Participant CCT019
[573] Ibid
[574] Participant CCD013
[575] Participant TC019

The Zambia Correctional Service does not have an alternative procedure or system that allows for quicker access to health goods and services for inmates on death row. This means that actively seeking medical attention for inmates on death row is not a very effective space for their participation. Similarly, the practice of keeping keys to the cells on the male section disadvantages women inmates. The Zambia Correctional Service must keep keys for each section of the prison closer to that section to cut down on the time delays for unlocking prison cells when there is an emergency.

iv. Prison-based safe spaces for dialogue

Some State respondents submitted that they have been participating in decision-making concerning women inmates' health through the Correctional Health Committees established under the Health Directorate. They averred that the use of Correctional Health Committees recently introduced in correctional centres has worked well to reduce the disease burden in prisons.[576] These Committees comprise of inmates, correctional officers and NGOs. One quasi-governmental participant observed:

> We have introduced health committees in facilities to help women prisoners be involved in their health… They meet quarterly to discuss and address different health issues. The Health Directorate of the Zambia Correctional Service identifies issues for discussion based on what is happening in the correctional facilities. This is how we have managed to control outbreaks of diseases such as cholera.[577]

Seemingly, health committees discuss disease prevention and treatment. Not much emphasis is placed on health determinants for women inmates hence many of these have gone unattended as is evidenced by submissions of women inmates and the NGOs participants. Further the health committee is not multi-sectorial as it does not include personnel from other line ministries.

For mental health services, the Chaplin for the correctional centre offers counselling in a safe and trustworthy environment for women inmates to share their health concerns and mitigate negative determinants of health.[578] Further, some women inmates cited discussions with and visits from family members as useful spaces where women inmates could communicate their medical needs and receive the requisite support.[579] Visits

[576] Participants KA009, KA010
[577] Participant KA010
[578] Participant TC006
[579] Participants TCT005, TCT022

from family members and friends created opportunities for inmates to know how family members were doing and a means of enjoying better mental health. Family visits thus constitute an important space for improved mental and physical health for women inmates.[580] Peace clubs were also cited by some women inmates as creating spaces for women inmates to participate in health programmes.[581] Peace clubs are social clubs that were introduced in selected correctional centres by an NGO to help inmates peacefully resolve disputes among themselves. Although not every inmate subjects their dispute to peace clubs, it offers a space for those willing to reconcile their differences to do so and "many inmates find them useful."[582]

Peace clubs promote good mental and physical health among women inmates as they create opportunities for de-escalating conflict among inmates. The continued existence of strife among inmates not only affects the health of those involved but could extend to the larger inmate population. The Zambia Correctional Service further introduced the Offender Management Unit to resolve disputes arising from inmates' conduct.[583]The Offender Management Unit operates to punish offensive behaviour by inmates including all forms of violence that are harmful to inmates' health thereby ensuring a safe prison environment.[584] By addressing offensive behaviour it ensures that fights and quarrels among women inmates are mitigated thereby promoting inmates' physical and mental health. Inmates are engaged to ensure that they do not repeat the offensive behaviour thus involving them in creating a safe space in the correctional facility. The Unit also serves as a deterrent to would-be offenders whose actions could be harmful to inmates' health. Although the Unit was not established to respond to health rights, it has the unintended consequence of curbing health risks as previous explained.

Considering that there are several spaces for women inmates' participation in health decisions and programmes, it is necessary to examine women inmates' perceptions of the underlying institutional and inmates' values governing their access to healthcare. Values influence attitudes. Efforts to reconcile the institutional values of correctional facilities and personal values of women inmates can contribute to creating a conducive

[580] Participant TCT023
[581] Participant TC004
[582] Participants TC003, TC004
[583] Participant KU001
[584] Participant KU001, KA010

environment for women inmates' participation in health. Examining women inmates' perceptions of the requisite institutional and inmates' values would also assist us to better understand their perceptions and experiences on the role of participation in advancing their health rights and interests as well as informing an effective and women-centred paradigm for health governance in correctional facilities in Zambia.

c) Values influencing women inmates' perceptions of health entitlements, and their participation in claiming health rights

i. Values identified by stakeholders

Many women inmates who participated in the study felt that there was little they could do to change their health situation in correctional centres. When asked what individual and institutional values they considered necessary for improving their health situation, they listed the values indicated in Table 1 below. The values listed in Table 1 constitute all the values identified by women inmates. While some women inmates were not able to identify any values, others were able to identify similar values and others identified unique values. The list in Table 1 is presented in order of frequency with the most frequent values identified by participants presented first.

TABLE 1:

INSTITUTIONAL VALUES	PERSONAL VALUES
Promotion of good hygiene	Responsibility for good personal hygiene
Prompt responses to addressing illness especially in provision of prescribed medicines	Encouraging inmates to take prescribed medicines
Caring for those who do not have visitors	Punishing inmates who do not take their prescribed medicines
Effective orientation to prison life	Caring for those who do not have visitors
Provision of counselling services to inmates	Need to be strong-spirited
Respect for inmates	Forcing inmates to take their prescribed medicines

Allocation of ample visitation time for inmates and their family and friends	Respect for correctional officers
Provision of transport to health facilities	Responsibility for one's health
To have compassion especially to inmates on the death row	Responsibility for each other's health including taking care of the sick and encouraging each other
Formulation and implementation of inclusive policies and laws	Protection of privacy and confidentiality
Standardisation of treatment of inmates within and across facilities	Inclusion of family members for better health outcomes
Equitable access to health goods and services for women on death row	No arguing and fighting among women inmates
Empowerment of women to aspire to better health outcomes	Need for unity among inmates if they are to help each other achieve better health outcomes
Protection of dignity of inmates	Protection from stigma and discrimination
Protection from stigma and discrimination	

Understanding the values held by women inmates and the institutions mandated to protect their rights presents a good indication of interventions to be taken when promoting women inmates' health rights. The attitudes and behaviour of citizens and of State institutions can be shaped by the values they hold. As discussed in Chapter three, the Zambia Correctional Service (ZCS) Act stipulates its values and principles. In this study, I assess whether there are overlapping values that women inmates believe they and the ZCS must hold to foster enjoyment of health rights. Understanding women inmates' value system helps to know their expectations of the ZCS and the role it should play in facilitating women inmates' participation in health decisions and programmes.

Understanding women inmates' values also help to contextualise their views on their right to health in the Zambian correctional health system.

ii. Women inmates' enjoyment to health rights

Women inmates considered it a personal value for them to "take responsibility for their own health".[585] They also considered it an institutional value for the ZCS to "empower women inmates to aspire for better health".[586] Many of the values identified by women inmates as being necessary for promoting their health rights impose obligations on women inmates. Women inmates indicated that access to healthcare in the Zambian correctional facilities is highly dependent on inmates registering their needs for healthcare services. Describing how women inmates access healthcare, one said "every morning the captains will call a clinic card. A clinic card is to find out who needs to go to the clinic and for what and they are attended to." [587] All the women inmates interviewed in the two correctional facilities that participated in the study confirmed that they are required to present their health concerns to either their cell captain or correctional officers at least once every day. This procedure was also attested to by institutional participants. Inmates assemble every morning and sometimes in the afternoon at a forum where health concerns are presented:

> When I am unwell, I must inform the correctional officers that I am unwell and inform them what I need…they give us the opportunity to tell them. When we are not feeling well, we lift our hands at the forum and inform them.[588]

Another stated:

> When we are sick, we tell the correctional officers and they write our names down. The bwanas[589] have to know how many are going to the clinic, for example, if there are four or seven, they all go together when they are sick. The correctional officers escort us to the clinic. We tell them what we are suffering from.[590]

Since the correctional health system is largely dependent on the involvement of women inmates in communicating their medical needs, it follows that women inmates should be provided with opportunities to communicate their broader healthcare needs and barriers to enjoyment of health rights. This function is often left to health experts on

[585] Table 1
[586] Ibid
[587] Participant TC006
[588]Participant TC003
[589] 'Bwana' means correctional officer
[590] Participant CTC005

account of their expertise. In the study, women inmates identified as relevant institutional values, for their enjoyment of health rights, the need for the ZCS to provide health determinants such as medicine, transport, counselling services, among others. However, they did not identify their participation in health as a necessary value. This is indicative of the limited role women inmates see themselves playing in the enjoyment of their health rights or their understanding of the role of the State in facilitating their health rights.

As discussed in Chapter three however, women inmates should be active participants in the enjoyment of their health rights. Although women inmates did not identify their participation as a requisite value for enjoyment of health rights, they were able to provide a wide array of shortcomings of the medical approach that the correctional health system takes. They demonstrated how these shortcomings negatively impacted on their enjoyment of health rights. One woman inmate noted the shortcomings in preventing disease outbreak. She stated "the main problem here is vaginal fungal diseases. We don't have disinfectants for cleaning the toilets. We stay one month without any cleaning products and disinfectants."[591]A woman inmate with her child in the correctional facility stated how difficult it was to access medication for her child:

> This child has an obstructive cough, but the clinic here does not have the required drugs. So they mostly just write us prescriptions, then we go and buy the medicine…They have given me six prescriptions in total, but I do not see much of a difference. Unless I ask for some medicine from those who have to help ease the obstruction. I haven't been able to buy the medicine myself for my child.[592]

Identifying another barrier to the enjoyment of health rights, a women inmate stated that:

> They [sick inmates] are taken to the clinic from where they receive treatment, and if they cannot manage [to treat them], they are referred to the main hospital. When you are given a prescription to buy drugs and you don't have money, they you will just stay. Then the condition may worsen.[593]

Another woman inmate identified the neglect of mental health in the correctional facilities as problematic:

> What is not catered for is mental health in terms of the support groups to address depression, stress, anxiety…Mental health wasn't even acknowledged and to be honest I think it's a huge trigger of physical illnesses that come at a later stage in the sense that when you don't treat depression, stress and anxiety, and you allow it to lead to high

[591] Participant CTC005
[592] Participant CCT 001
[593] Participant CC020

> blood pressure …Like I have low blood pressure. When I came here, I never had low blood pressure, but I am now a low blood pressure patient.[594]

From the above experiences, it is evident that women inmates are able to identify their health needs and barriers to the enjoyment of health rights. The ZCS is largely responsible for the health risks to which women inmates are exposed. The collaborative effort of women inmates and the ZCS in addressing women inmates' health needs and barriers is thus core to a women-centred citizen participation model to health.

iii. The role of women inmates in asserting their health rights

Women inmates' perceptions of their role in claiming their health rights are shaped by what the correctional centres permit them to do. Some inmates felt that "the correctional health system functioned well because women inmates were accorded opportunities to seek medical attention."[595] For these inmates, their ability to access the health facilities, goods and services was viewed as a positive aspect of the correctional health system. Inmates' view that the correctional health system functions well based on the opportunity to seek medical attention not only reflects the limited understanding of their health entitlements, but also an acceptance of this standard of healthcare as the norm which they must not challenge. Other inmates felt that there was nothing they could do if the correctional health system cannot facilitate access to healthcare for them.[596]

Whereas many of the women inmates felt confident to communicate their health needs, they did not feel confident to make health-rights demands on the State as is the case with people in the general population.[597] Some women inmates felt that they could only receive what the State provides to them and that demanding for more could be a sign of disrespect as they "had no power to speak to the authorities."[598]Another inmate stated that "women inmates have no powers to use the laws [to assert their health rights]."[599] This attitude weakens women inmates' social standing and citizenship. Further, even when the

[594] Participant TC006
[595] Participant TC006
[596] Participant CCT005
[597] Field Observation notes of 11th February 2020
[598] Participant TCT013
[599] Participant CCT023

State was considered to have responsibilities toward women inmates to promote their health rights, these responsibilities were not fully understood by women inmates. The inadequacy or failure of the Zambia Correctional Service to provide health information, meet mental health needs and provide for health determinants such as a balanced diet, sanitary pads and running water were not considered as part of the responsibilities of the correctional health system.[600] Inmates identified the importance of these items for the promotion of good health, but they considered them as items beyond the State's reach. Inmates instead recognised the role that the church and other well-wishers played in providing health information and determinants such as medicines, soap and sanitary pads. This can limit the extent to which women inmates can assert their health rights from the State. They would value charitable donations that meet their health needs over actively asserting their health right as a result.

Women inmates' values have an impact on the way they perceive and claim health rights. Women inmates held a wide range of values. Some of these are useful for promoting a rights-based approach to health. Examples of these values include protection stigma and discrimination, protection of dignity of inmates, empowering women to aspire for good health, facilitating timeous access to health goods and services. Other values promote a charity-based approach to health. Examples of these values include feeling compassion for inmates especially those on death row and caring for inmates without visitors. While a women-centred citizenship participation approach to health may embrace both, its primary focus should be promoting a rights-based approach. As demonstrated in Chapter three, a rights-based approach reflects international and regional human rights standards for health that empowers both the duty-bear and the rights-holder to enjoy guaranteed rights. It is not sufficient for women inmates to identify their health needs, but to understand the demands they can make on the State for its effective response to their needs. The barriers to enjoyment of health rights identified by women inmates in this section cannot be holistically addressed without women inmates' input on the appropriate State responses. A medical approach to women inmates' health that the ZCS takes is therefore inadequate. The State would have to set up a correctional health system that allows women inmates to share their experiences and views on the effectiveness or

[600] Participant KA005

otherwise of the correctional health system and prison-based health programmes. The assumption here, however, is that women inmates will be willing participants in State-sanctioned spaces for participation. From the experiences shared by women inmates, it is evident that they will participate in spaces which have a positive impact on their well-being. In the next section, the impact of health-related participation on the enjoyment of women inmates' health rights is considered.

5.3 WOMEN INMATES' PERCEPTIONS OF THE IMPACT OF THEIR PARTICIPATION IN THE CORRECTIONAL HEALTH SYSTEM

This section seeks to firstly document women inmates' perceptions on the desirability and usefulness of their participation in health-related decision-making. Their views form a key consideration for determining the feasibility of establishing a women-centred citizenship participation paradigm for addressing women inmates' health rights. The establishment of such a paradigm for participation in health will in turn facilitate the inclusion of women inmates in health governance of the Zambia's correctional system. Secondly, this section examines the impact of women inmates' participation in health decisions and programmes in Zambia's correctional system. By so doing, it aims to ascertain the extent to which such participation advances women inmates' health rights and interests, and for informing interventions for improvement to the prison health governance system, if any.

5.3.1 Is participation in health-related decisions and programmes beneficial to women inmates?

a) What is the impact of women inmates' participation in health decisions and programmes?

When asked if it would benefit women inmates to participate in health-related decision-making and programmes, a women inmate stated that "Yes it would [be beneficial for women inmates to participate in health-related decision-making]. I would present my concerns. I am sick and in need of healthcare services."[601] Another woman inmate stated that "since we are the ones who are facing those challenges, we should be allowed to make decisions on what we are facing."[602] A yet another accentuated how important their participation in health is:

[601] Participant CC001
[602] Participant CCT002

> [Participation in health] can bring in more advancement because it is us who are inside here, we know the problems we are going through and if we sit with [decision-makers] and tell them what we are going through, and they would know how to help us. But if they don't know what we are going through they can't help. They will do what they think is right which is very wrong for us.[603]

Women inmates' active participation has the potential to influence strategic decisions and thus inform the health system of the Zambia Correctional Service. The above participants' views supports the assertion that when citizens have meaningful opportunities for active participation, they shape government policies and actions to claim their rights and advance their interests.[604] By recognising the importance of women inmates participation in health-related decisions and programmes, women inmates see themselves as a relevant partner in the governance and development agenda. Further, by relegating women inmates to donee status where they are simply receiving donations of health goods and services from well-wishers and the State, they fail to contribute to a system that responds to their health needs and interests. The Zambia Correctional Service and the Ministry of Health solely design and administer a correctional health system with little to no consideration of women inmates' health rights and interests. Women inmates thus miss out on the chance to communicate their health needs and challenges and shape the health system in their correctional centres.

Women's lived experiences are best communicated by women themselves rather than solely depending on health experts or correctional authorities who may not correctly represent inmates' views. As expressed by one respondent, women inmates' participation would help improve health standards as correctional officials do not always adequately represent women's needs and challenges. She stated:

> It's a good idea [for women inmates to participate in health decisions and programmes]. I think we would say it as it is, unlike somebody speaking for us. I sat in for one opening session of the High Court. The Commissioner General Prisons was asked about the challenges he was facing. The whole lot of the Commissioner General said, "nothing that we can't handle." Seriously? How could he say that! "At the time he was answering that issue, how many incarcerated prohibited immigrants had died that day…The Committee wanted to hear the challenges, to see how we can address the challenges in the correctional facility and yet the Commissioner-General just said "that's nothing we can't handle!" So even these same ones [referring to the correctional officers at the facility][they say] "we are all set", "we are ok", "we are all what…etc" [605]

[603] Participant TC004
[604] Irwin & Stansbury op cit note 196
[605] Participant TCT 022

The participant underscored the importance of being able to represent themselves in decision-making spaces. This does not only entail one's ability to communicate health needs and concerns, but to identify individual and communal challenges.

Some women inmates did not think their participation in health-related decision-making could yield positive health outcomes for them. They stated that the health system of the correctional facility does not facilitate enjoyment of health rights because sometimes the views of women inmates are dismissed. One woman inmate said their participation would not be effective in promoting health rights "because at times when you call them [correctional officers] to report about a sick person, they think it is not serious when it is very serious."[606] Another stated:

> [The practice in correctional facilities of notifying officers of one's health needs] does not work so much. They do take us [to a health facility], but for them to just find the time, it takes long…Some officers even say to me "old woman, you are not even sick, you are just wasting our time" or they tell you "you are just lying; you do not suffer from anything."[607]

Several women inmates opined that their participation would be a waste of time as duty bearers do not take any action after collecting views of the women prisoners:

> We complain most of the time but nothing happens. The same people who come, when we complain they go and don't bring us any solutions. That's why people feel discouraged when people come to receive complaints from inmates. A while ago there would be many [prisoners lodging health complaints], but now they feel discouraged because they don't see any change. [608]

Participation which does not facilitate inmates' active and effective involvement tends to leave participants uninterested. The above view evidences this fact. To be more effective, citizenship participation must be invoked as it facilitates a more active involvement of citizens. Clapper argues that citizenship participation may not produce immediate results for participants but has long-term benefits.[609] Participants would thus have to be educated about how citizenship participation works to help them participate for the long-term benefits.

b) How do health decisions and programmes that exclude women inmates' participation impact on their enjoyment of health rights?

[606] Participant CCT026
[607] Participant CC001
[608] Participant TCT015
[609] Bekker op cit note 181 at 72

Many study respondents drew on their experiences in the Zambian correctional centres to support their assertions that women inmates' participation in health would be beneficial for the realisation of their health rights. Some women inmates cited the correctional centres' health programmes for pregnant inmates and HIV positive inmates as examples of health programmes that are seemingly progressive, but do not holistically meet the needs of the intended beneficiaries. The study revealed that there is a perception in the prison community that pregnant women are often availed good quality health services whenever it is needed.[610] Women inmates also noted that HIV positive inmates received relatively good health services.[611] Both these programmes were solely designed and implemented by the Zambia Correctional Service and Ministry of Health. However, women inmates showed that they suffer health-rights violations due to the failure to design and implement inclusive and participatory health programmes. Thus, even though the correctional facilities promote access to health facilities for women inmates who are pregnant, they do not routinely subject women inmates to pregnancy tests upon admission to the correctional facility thereby negatively impacting their health. One woman inmate stated:

> [I'm not pregnant]. But I did come in here pregnant and I lost the pregnancy…I had no idea [that I was pregnant at the time I came in the correctional facility]…When I started bleeding heavy and obviously with excruciating pain I was taken to the clinic. We thought it was heavy periods due to stress. They decided to do a pregnancy test and then the pregnancy test came out positive. We could also see from the scan that I was pregnant, but the sack was already empty.[612]

This experience demonstrates that it is not sufficient to provide pregnant inmates with antenatal and child-birth services, but also necessary to provide comprehensive sexual reproductive health services to all women inmates of child-bearing age. Had a routine pregnancy test been offered to the inmate on admission to the correctional facility, she could have had an opportunity to know of her pregnancy status and would have been offered the same quality of care other pregnant inmates were given.

Regarding the health response of the Zambia Correctional Service toward HIV positive women inmates, women inmates who are HIV negative thought it was comprehensive. A large part of the prison community holds the view that the HIV positive inmates have more comprehensive healthcare because there are prison programmes that

[610] Participant TC006
[611] Participant CC016
[612] Participant TC006

ensure that they have a special diet and access to anti-retro viral treatment. A woman inmate said that "for the HIV people … [the prison health response] is perfect. Those ones are catered for."[613] Many women inmates with HIV, however, complained that even though they had ready access to anti-retro viral drugs (ARVs), health facilities and a "special diet", their access to a balanced meal was nonetheless compromised. The food that comprised "a special diet" was different from the ordinary diet that other inmates took, but was not balanced: "The government is not doing much to improve the standards of living in prisons regarding our diet. They just give us beans and mealie meal, and even though they provide rice it's only given to those who are terminally ill."[614] For the most part, HIV positive inmates were "given rice in substitute of nshima (maize meal)".[615] Occasionally, they also received food parcels from churches and other well-wishers. The situation for HIV positive inmates who had no visitors was worse.[616]

Similarly, HIV positive inmates who had their small children with them in the facility were disproportionately affected by the poor diet as they "had to share their food portion with their children."[617] One HIV positive inmate stated that " [i]t's difficult in here. It's hard in here because when you come in here and are abandoned by your relatives then you don't have visits, then you only have the church bringing you things. It's very hard to get well.[618] Some HIV positive inmates also attested to the difficulty they experience in accessing treatment for opportunistic infections.[619] They felt that they too "face challenges accessing medicines for infections contracted in correctional facilities."[620] These findings from HIV positive inmates illustrate the misconceptions that may exist among implementers and non-beneficiaries of programmes about the effectiveness of health interventions. This is particularly true when there are no opportunities for beneficiaries to participate in the design, implementation and evaluations of such programmes.

[613] Participant TCT022
[614] Participant TCT001
[615] Participant TCT002
[616] Participant TCT024
[617] Participants CCT019, CC018, CCT016
[618] Participant TCT024
[619] Participants TCT010
[620] Participant TCT010

Sometimes women inmates choose not to participate in health decisions and programmes due to, among others, "fear of repercussions"[621] or "lack of trust that their participation will be beneficial to them."[622] The barriers to women inmates' participation are discussed in detail below. The consequences of self-exclusion are the same as the consequences of social exclusion. It is important to consider factors that negatively impact on women inmates' participation in health to inform appropriate responses that enhance their participation.

c) What are the barriers to participation in health that women inmates face?

Women inmates identified several barriers for their participation in health. They mentioned the fear for reprisal as one of the reasons they cannot communicate their health needs and challenges to correctional officers. One woman inmate stated that:

> …You find women would rather seat and keep quiet so that they can maintain peace… Everybody in this place has [the attitude of…] "I am already incarcerated I don't want to be incarcerated twice. I am already incarcerated and I already have a relationship with this bwana or that bwana or this captain. If I say this and this bwana is going to come against me. So let me suffer it out. Let me wait for my EDD [estimated date of discharge]. I am going one day, let me shut up."[623]

Another woman inmate stated that they fear participating in dialogue activities on health within their correctional facility because "the correctional officers mete out so many punishments. This is why we are scared. They make you sleep in the sun, underneath a thick blanket till 16hrs."[624] Women inmates cited other forms of punishment meted out against them by correctional officers such as "the imposition of manual work"[625] and "removal of remission of one's sentence"[626], popularly known as "ku fwatikila" among women inmates.[627] This entails spending a longer period in the facility than would otherwise have been the case without the punishment."

Another woman inmate stated that lack of spaces for their dialogic participation prevents them from expressing their views on health matters. She said to this effect that "you cannot just start talking about what you are not asked about. But if we have people

[621] Participant TCT008
[622] Participant TC006
[623] Participant TC006
[624] Participant TCT010, TCT008
[625] Participant TC006, CC018
[626] Participant CC011
[627] Participants TT007, TC012, CCT017

with high authority come over and give us that opportunity to talk, then a lot of us would be free to talk."[628]

Considering the individual and communal health needs of women inmates, their participation in health within correctional facilities would facilitate greater enjoyment of health rights provided the identified barriers to participation are attended to. Failure to address women inmates' unique and collective health needs subjects them to health discrimination among women inmates as well as in comparison to women in the general community as elaborated in the next section. Such discrimination also presents barriers to individual and communal participation in health decisions and programmes.

5.3.2 Women inmates' experiences and perceptions on the impact of participation in advancing equality in health

Many women inmates interviewed did not address the role of participation in advancing equality in health. Some, however, recognized that individual participation in health-related decision-making would facilitate effective responses to women inmates' unique health needs. In essence, women inmates felt that attending to women's unique needs would promote equal treatment of inmates in health decisions and programmes. Women inmates whose health needs and rights are subsumed in collective health needs and rights would be given equal recognition in individual spaces for their participation in health.

It should, however, be noted that some women inmates reported discriminatory practices suffered by women inmates at the hands of fellow inmates, correctional officers and the correctional system as barriers to their enjoyment of health rights. Further, women inmates reported the types of discrimination experienced as including violence against women, discrimination based on sex, disability, one's social and legal status within the correctional system and discrimination on account of one's health status as illustrated below.

a) Discriminatory practices perpetuated by inmates and correctional officers

Several women participants referred to the practice called "ku chipupa" which was used as a means of orienting new inmates to prison life and as a disciplinary measure for

[628] Participant CC011

punishing errant inmates. Sometimes ordered by correctional officers and sometimes by cell captains, the practice entails surrounding an inmate in a prison cell wall corner and performing various forms of prison initiation or punitive practices. These practices include "coercing inmates to perform sexual dances",[629] "mocking them about the crimes they committed", [630] "informing them about acceptable and unacceptable conduct in the correctional centre and threatening them with consequences of not adhering to the rules".[631] . The "ku chipupa" practice is always performed by fellow inmates. Although peer orientation could be used in a positive way to ease anxieties a new inmate may have by sharing coping strategies with those who have been in a correctional centre longer, this is not the case in the Zambian correctional centres that participated in the study. The existing model of "peer orientation to prison life" and "peer discipline" which subjects women inmates to bullying and violence is not sanctioned by law or any policy. It has been a long-standing practice in many correctional centres in Zambia attested by some study respondents.[632] A woman inmate reported that the practice "subjected women inmates to physical violence and threats of physical violence."[633] Thus, physical, verbal and emotional violence against women has the effect of negatively impacting the physical and mental health of inmates and could potentially negatively affect their confidence to participate in health-related decisions and programmes.

Other forms of inequality among inmates were recorded. One narrated how difficult it was for her to participate in decisions affecting her life, stating that her cell captain and other inmates believed she was mentally ill and forced her to take medication prescribed for another inmate who was mentally ill.[634] She told of how her feeding group (that is, small groups of women inmates created in correctional facilities to share food, cooking and cleaning responsibilities) treated her like a slave and made her carry out all the chores because she did not receive visitors and therefore could not contribute any food to the group.[635] Another inmate narrated how correctional officers were not willing to

[629] Participant KU002
[630] Participants TCT008, CC017
[631] Participant TCT008
[632] Participants KU001, KU002
[633] Participant TCT008
[634] Participant TT007
[635] Participant TT007

facilitate her access to a health facility because they thought she was pretending to be ill.[636]

b) Failure of the Zambia Correctional System to recognise women inmates' care-giving roles and need for family support.

It is trite that most women in Zambia, as in most parts of Africa, are care-givers to their children and dependents. At the same time, women are largely dependent on male family members for provision of their basic necessities.[637] This assertion presupposes that incarcerated inmates are able to communicate with family and friends either in person, through prison visits or virtually, for example, by mail correspondence or by phone. Imprisonment negatively impacts on women inmates' abilities to care for their families. Most inmates who participated in the study expressed anxiety over the welfare of their children and other family members. They also complained about the severely constrained communication with family members. Experiences of women inmates discussed below indicate how limited visitation and other communication rights negatively impact on women inmates' mental and physical health and even discriminated among different women inmates.

The current correctional system does not standardise visitation rights. In one correctional centre, the officers permitted limited visitation rights. This comprised of "five minute visits once a week on a designated day."[638] In another correctional centre, inmates "could receive visitors for however long and on any day, provided it did not interfere with lock in schedules."[639] Thus, women inmates had different visitation rights with no justification as to why this is so. Women inmates are also not entitled to phone calls.[640] This negatively impacted on their health in that some women were not able to check up on their families when needed. For example when there is a family emergency or if they need to communicate with their families about anything that affected them they were unable to do so.[641] One inmate stated that she had been in the correctional centre for close to a year

[636] Participant CCT004 at 7
[637] Chipo Mushota Nkhata 'Taking a gender-nuanced approach to the access to justice needs of women in Zambia's prisons' (March 2020) *ESR Review: Economic and Social Rights in South Africa* 21:1
[638] Participant TC006
[639] Participant CC016
[640] Participants TCT005, TCT022, TT007
[641] Participant TCT005

without any of her family members knowing where she was.[642] She failed to communicate with them as she "depended on well-wishes who visited the correctional centre to call and was not sure if they made the calls but no one ever visited. This affected both my physical and mental health."[643] Those who need to communicate with their families are required to make a request with the officer in charge.[644] They are not allowed to use cell phones of correctional officers or visitors to the correctional centre to communicate with their family members.[645]Another inmate explained the challenges they experience in accessing the communication facilities at their facility:

> Because phones are not allowed in here, but we have provisions where when we want to use a phone, you can ask from reception. There is a procedure where you ask from there and wait for the OIC to approve. You can't even discuss private things they will just put a phone before you and ask you to dial the number and talk... Ok we understand there are security reasons for this facility, but for the period of waiting for the OIC like now, she's out for a workshop. Until she comes back, no one is making a call…[646]

She further explained that even if women inmates experienced challenges in accessing the communication facilities at their correctional centre, some inmates found it relatively easy to do so due to good relationships they had with some correctional officers. She stated to this effect that:

> …we have a group of people in here, like myself I would go and say bwana I need to use the phone. Before I even write in the book that am requesting to make the call, the deputy will just tell me "KKK you go to the reception and tell them that I have permitted you to make the call." But what about the other person. [If some other inmate makes a similar request, the officer would say] "No, you know the procedure. You have to follow the procedure. I don't have a problem [accessing phones in the correctional facility]…[647]

Unequal treatment of inmates perpetrates health discrimination. Inmates with better relationships with correctional officers are more confident to express their health needs to them whereas others remain silent and thus get deprived of their health needs. In the case of discriminatory procedures that negatively impact women inmates' abilities to communicate with their families, the correctional health system perpetuates discrimination by turning a blind eye to women inmates' care-giving roles and need for family support.

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[642] Participant TT007
[643] Participant TT007
[644] Participant TCT022
[645] Participant TT007
[646] Participant TCT022
[647] Participant TCT022

c) Discriminatory practices experienced by inmates on the death row

Many women inmates alluded to the discrimination to which inmates on death row are subjected in comparison to other inmates concerning access to treatment and participation in health programmes. Inmates on death row are subjected to "a procedure where there are several levels of approval to be completed before they can access a health facility".[648] Women inmates stated that "this procedure delayed timely access to services."[649] Whereas there may be a justification for a more rigorous procedure for releasing inmates on death row to access health services, such a procedure must be expedient to ensure timeous access to healthcare. The problem of delays in accessing health services due to rigorous procedures can also be "curtailed by establishing an in-facility clinic or hospital akin to the one in the male section"[650] of one of the participating correctional facilities. This would minimise movement out of the correctional facility.

Another discriminatory practice in the correctional system that negatively impacted on the health of women inmates was the "exclusion of inmates on the death row from participating in health, skills and sporting activities."[651] Inmates felt that this exclusion meant that women inmates on death row cannot engage in activities that kept them occupied and improved their physical and mental health. One inmate stated that "it is cruel to just keep inmates on death row locked up and not allow them to participate in activities in correctional facilities."[652]

d) Discrimination between female and male inmates in the Zambia Correctional Service

Discriminatory practices in the correctional health system were also noted between female and male inmates. Some inmates alluded to how their male inmates have a health clinic[653] and a school[654] within their correctional centre and women inmates do not. Further, only male inmates are employed as teachers in the school.[655] Thus, the male

[648] Participant CC012
[649] Participant CCT019
[650] Participant TCT011
[651] Participant CC020
[652] Participant CC020
[653] Participant TCT011
[654] Participant TC012
[655] Participant TC012

inmates are earning an income and experience from teaching which the women inmates are not. The male inmates also "have running water and control the source of water that runs into the female section. When the female inmates run out of water, they shout for the men to turn on the pump."[656]

e) Discriminatory experienced by women inmates with specialised health needs and unique health circumstances

While most women inmates viewed the correctional health system as responding to their common health needs, some were of the view that the health system was ill-equipped to address specialized health needs for diseases such as cancer and those that required special medical procedures. They opined that correctional health system worked well to facilitate access to healthcare for inmates with common health problems like HIV, hypertension, stomach pains, and rashes, but not for diseases such as diabetes,[657] asthma, cancer, heart diseases,[658] Hepatitis B,[659] or opportunistic infections that result from HIV.[660] Further, many women inmates complained of "being allocated heavy workloads which they were expected to fulfil even when they were menstruating and experiencing menstrual pains. Further, the way the correctional facilities are built is that the showers are outside the cell, therefore when we get back from the fields in time to be locked in, we cannot take a shower even when we are menstruating."[661]

From the discussions with women inmates, it was evident that they experience inequality on account of:

i. Power or lack of it, for example, if they hold a leadership position as a cell captain or are carrying out instructions on behalf of a cell captain or correctional officer;
ii. Economic status which impacts their ability to access food, medicines and other basic necessities and services;
iii. Gender roles and maternal status which extends to grandmothers and other relatives in correctional centres who have care-giving responsibilities for children in or out of the correctional centre;

[656] Participant TCT011
[657] Participant CCT025
[658] Participant CCT004
[659] Participant T006
[660] Participant TCT010
[661] Participant CC024

iv. Inmates' sex which impacts on their access to public facilities, goods and services;
v. Relationships with correctional officers and other inmates;
vi. Health status which affects and is affected by health goods and services that the correctional centre provides;
vii. The correctional system which takes a 'one-size-fits-all' approach to health, has many negative practices that are not backed by law or policies; lacks a transparent system for punishing erring inmates and officers who violate the rules and lacks independent arbiters to resolve disputes among inmates or between inmates and correctional officers.

5.3.3 Amplifying the voices calling for increased participation in health for promotion of health equity for women inmates

Several institutional participants supported the need for women inmates to be involved in health decisions and programmes that affect them.[662] One State institution stated that "…it is very vital that [women inmates] participate [in health decisions and programmes] because they have their own needs which cannot be generalised and if they are allowed to participate their needs would be let known and maybe the prison set up would actually be [tailored towards their needs]."[663]Another indicated that the public health system may not be best suited to respond to women inmates' unique health circumstances as public health systems are neither designed with women inmates in mind nor informed by their experiences and needs:

> I think that most of the times the health services that are given in the correctional facilities I think are of a generic nature. It's not specific to women's needs or a particular grouping's needs…So, I think that if [women inmates] spoke, if they engaged, if they reported, um maybe some of their needs will be addressed specifically. For example, it's the whole cervical cancer screening. As opposed to us waiting for sporadic cases, we could actually have preventive [services].[664]

A civil society participant agreed that participation by women inmates can foster direct response to their health needs:

If they have a say on what affects them, not just government, but also civil society provide services to correctional facilities, so if we *actually* know what they need, we can build better

[662] Participants KA005, KA007,KA008,KU004, KU006
[663] Participant KA007
[664] Participant KA002

facilities and [provide] medication that they *actually* need for them to be healthy in prison. [**Emphasis by study participant**][665]

Institutional participants held similar views with women inmates who felt that increasing women inmates' participation in health had several benefits for advancing positive health outcomes. One such outcome is mitigating health-related discrimination experienced by women inmates. Some institutional participants indicated that women inmates are often subjected to discriminatory treatment in accessing healthcare when they are subjected to the public health system.[666]

The potential of women inmates' participation in health has not been fully realised as a means for curbing health-related discrimination. A civil society participant felt that this was 'because many women inmates are scared of so participating".[667] The participant proposed that women inmates who fear to participate in health-related programmes can be empowered to participate by providing them with information on their legal entitlements.[668] This would enable them to access health needs on the same basis as those who are able to freely express themselves:

> [Women prisoners' participation in health-related decision-making] impacts [on their health] in that if they have the right information, they will be able to claim their health rights from the facility. Information empowers them to claim their health rights because the majority of the women are scared to speak. But if they know that they still have the right to freedom of speech within the facility, yes, it will impact on their ability to speak and when they speak, they'll be able to access the health services they need.[669]

Another civil society participant augmented the argument that participation of women inmates can enable them access to health services that they need and bridge inequity in accessing health goods and services.[670] Participant KA001, a State institution, stated that they "would budget better for women inmates' health if we were consistent with facilitating their participation."[671] The view that participation can facilitate women's unique health needs is critical given that a substantive number of women inmates complained of challenges to accessing specialised treatment and medicines through the correctional health system and depending on well-wishes to meet these needs. By failing

[665] Participant KU003
[666] Participants KU003, KU004, KA002
[667] Participant KU002
[668] Participant KU002
[669] Participant KU002
[670] Participant KU004
[671] Participant KA001

to recognise women inmates' unique circumstances and health needs, the Zambian correctional system indirectly discriminates against them. Women inmates' social exclusion from the public and correctional health systems means they are not fully enjoying public health services on the same basis as other members of society. Similarly, implementing a correctional health system that does not take into account individual women's health needs promotes discrimination among women inmates. This approach cannot be women-centred and does not reflect the paradigm shift which promotes correctional services. As submitted by one civil society participant, "… if we have changed from prison services to correctional services, there has to be also some underlying things that come with that…because [women inmates] are not entities that you just throw things to." [672]

By recognising women inmates' circumstances, their full identities and entitlements as citizens, women inmates stand a better chance at enjoying public health goods and services that advance their health rights and interests. The next section analyses women inmates' views in this regard, drawing from their experiences of citizenship in the correctional facilities.

5.3.4 How women inmates' experiences of citizenship impact on their enjoyment of health rights

Study respondents were asked about the relationship between women inmates and government officials and departments and whether their interaction improved their enjoyment of health rights. Women inmates stated that the weak relationship between government and women inmates was based on three main reasons: the lack of interaction between them, the failure of government to respond to women inmates' health needs and challenges, and the existence of a relationship of fear and violence. In describing the relationship with government, one woman inmate stated "no, there is nothing [no relationship]."[673] Another felt that there was no relationship with the government because government officials prioritize male inmates over women inmates:

> I think we are basically forgotten. I will give you an example. When the officials come they only go to the male section…Everywhere you go [inmates are sometimes moved from prison to prison depending on transfer requests or consideration of

[672] Participant KU003
[673] Participant TCT010

> appropriateness of prison facility to offence committed], they will be like oh the minister is here, but he will just go to the male section. In prison T "the minister is here" but he will just go to the male section. Yes even in prison C it was just the same. There was only one time when the President came, he gave us a short visit. But most of the times the officials that come they will not [address the female prisoners].[674]

Another woman inmate felt that the relationship between the State and women inmates was also negatively impacted by the latter's inability to effectively engage with State officials who visit the correctional facility. She stated:

> [The relationship between women inmates and the State] is non-existent in the sense that the Human rights [Commission] have come here so many times and you find women are so intimidated to talk because they are scared of what punishment they are going to receive afterwards or that they will be ostracized. Maybe you will say something to the Human Rights Commission because you are generally asking a situation and you find the bwanas withdraw from you. There is actually an after-effect.[675]

The above views on the relationship between the State and women inmates reveals that a good relationship between State institutions and women inmates is cardinal for guaranteeing effectiveness of spaces for participation in health. It is thus not sufficient to simply create spaces for participation akin to the one described by the participant above. Women inmates may relate differently with State institutions, but the nature of relationship with each of the State institutions determines how effective citizenship engagement is. A positive relationship with the State creates a conducive environment for women inmates to communicate their health needs and interests to the State. It signifies that that the State values such engagement and women inmates' views are therefore appreciated. The opposite is also true. As shown in the inmates' views above, a relationship dominated by fear will cause inmates to withdraw from engaging with State institutions on their health and other interests. The imposition of punishment for participation by women inmates reflects that the State is not interested in women inmates' views.

Many women inmates conceptualised "government" as public officials to the exclusion of correctional officers. When participants described a good relationship with the government, it was mostly in reference to correctional officers. One inmate said "so

[674] Participant CC017
[675] Participant TC006

far, the relationship has been good, especially with the Officer-In-Charge."[676] In one facility, the majority of women inmates held that they had a good relationship with the Officer-In-Charge who had introduced many changes in the correctional centre that improved women's health rights.[677]

Although a poor relationship between women inmates and the government negatively impacts health outcomes and enjoyment of health rights, citizenship participation may also work to strengthen this relationship. Many women inmates who participated in the study described their relationship with the government as non-existent, but also acknowledged the importance of a good relationship with government in advancing their health rights and interests. One inmate said "it would be good for women inmates to interact with government officials to address some of their health determinants."[678] She provided a list of social determinants of health that she felt she could present to the government for their intervention. She stated that "it would help [to have a good relationship with the State] because if you have a chance to complain, you would talk about your children, you will talk about your home, you will talk about your business and you will talk about your babies." [679]

Another woman inmate described how discussing social determinants of health would enable the State to address them. She said "when we complain to the bwanas, they know how they work with the government to help us. For instance, when food in the facility finishes, they bring, like mealie meal and beans for us."[680]

The State also has an obligation towards women inmates to deliver to them their needs and interests as citizens. State institutions assume the responsibility of meeting the basic needs of inmates. One State institution stated that "it is the government's responsibility to provide women inmates with health needs."[681] Another stated that they are responsible for facilitating access to basic needs of vulnerable citizens: "We look at the basic needs mostly. So we take into account their living conditions, their ability to access a

[676] Participant CCT003
[677] Participants TC003, TC004, TCT005, TC006, TD009
[678] Participant CCT010
[679] Participant CCT010
[680] Participant TD009
[681] Participants KA013, KA009

meal, their ability to send children to school and also access health services."[682] They confirmed that although women inmates are within the class of citizens who they must be serving, they hardly do so due to inadequate funding:

> We don't have a budget for women prisoners. If we meet with them it's in line with our usual just normal prison visits, there no budget line attached…For instance we have budgets…to represent juvenile delinquents, so when officers go there to interview a juvenile delinquent they may incorporate also checking the other prisoners in that same activity.[683]

Another State institution stated that:

> [It is mandatory for judges to conduct prison visits every session] because the prison officials give the judiciary the goal delivery which indicates a summary of the status of the prison as at that time …So on that core delivery there is a slot were the judge has to indicate how they conducted a prison visit, but then because of logistics and time, it's not yet practical for every judge to do a prison visit every time they have a session…[684]

Thus, a good relationship between the State and women inmates is not just necessary for the effective delivery of public goods and services, but also for ensuring that public goods and services are in fact provided to women inmates as citizens of a country. The paradigm within which public health goods and services are delivered to women inmates is equally cardinal for shaping the relationship between the State and women inmates. The nature of this relationship in a charity model (where facilitation of public goods and services is from the goodness of a government institution) will differ from the nature of the relationship in a rights-based model. In a rights-based model, the State has obligations to meet women inmates' health needs and interests whereas in a charity model no such obligation exists. A woman inmate stated in that "a good relationship is supposed to be there because that's the government who are like our parents. We have left children and other things, but we are in here. It is the government that has power over us, they are our parents." [685]

By creating this analogy in the relationship between the State and women inmates and that of a parent and child, the participant recognises the legal responsibilities that a

[682] Participant KA011
[683] Participant KA011
[684] Participant KA008
[685] Participant CC001

parent has over a child. The child is not treated as a charity case but as a rights-holder who must be provided with basic necessities of life. Just as there are laws that regulate the relationship between parents and children in the Zambian legal system and ensure that a healthy relationship exists, there are laws that ensures a healthy relationship between the State and citizens such as women inmates. However, many government and quasi-government institutions responsible for women inmates, health and governance attested to limited to no programmes and spaces for women inmates' health rights.[686]

The Constitution guarantees women inmates' citizenship rights including the right to vote and their freedom of expression. The right to vote is one of the oldest platforms of participation that allow the governed (for example, women inmates) to hold the governor (the government) accountable for their needs and interests. Inmates' right to vote was recently recognised in Zambia following the 2016 constitutional amendments.[687] Thus, women inmates were asked what impact this would have on their enjoyment of the right to health. One stated that:

> We can vote in here, but we cry for our children outside and families outside. We don't know the situation they are in. We do not know what is happening at schools, others complain that they are in Devil Street. We cannot lament about voting. We can only lament for our children out there.[688]

For the inmate, the right to vote did not mean much to her if it did not translate in addressing her needs and interests, things that negatively impacted on her health such as worry for her children and other family members. The separation of an inmate from their family, particularly their children and dependents is a determinant of women inmates' health which the Zambia Correctional Service does not address in its health system nor do other government institutions. .

A citizen-State relationship is mutually beneficial if it meets the interests of the parties involved. The State seeks to reform citizens who have violated its laws and so it puts programmes in place for reforming the erring citizens. It also seeks to deliver developmental programmes to its citizens, including healthcare. However, citizens may also have their own interests which may or may not be in tandem with the State's reform

[686] Participants KA001, KA003, KA004, KA006, KA011, KA012, KA013
[687] Malembeka case supra note 460
[688] Participant TCT008

and developmental programmes. Many women inmates felt that participating in national elections would be a waste of their time because the State does not do much for them and such participation would only serve the State's interests and not those of women inmates. To create a mutually beneficial relationship for attainment of both interests, each party must be able to communicate, plan and implement its interests and programmes. It is thus important to build and continuously strengthen good relations between the women inmates and the State to better address health determinants and improve health outcomes.

5.4 CONCLUSION

The foregoing discussions examine women inmates' health situation, their opportunities for participating in health decisions and programmes in their correctional facilities, and study respondents' views on the role of participation in health-related decision-making and programming for women inmates. One of the key findings of the study is that while the correctional health system focuses on meeting some women inmates' medical needs, the greatest needs for women inmates relate to health determinants. The determinants of health identified by women inmates include inmates' age (with elderly inmates being identified as one of the most vulnerable groups of women inmates), pregnancy, disability, access to food, running water, sanitary pads, cleaning supplies and other basic necessities. Other determinants arose from personal relationships and social networks and included factors such as an inmates' status as a parent or care-giver to children in and out of the correctional facility, an inmates' relationship (or lack thereof) with correctional officers and fellow inmates who may provide access to basic necessities. These determinants make certain women more vulnerable to poor health than others. Women inmates most vulnerable to poor health and health-rights violations include those with a disability, old age, pregnancy, motherhood and terminal illness including HIV, cancer and diabetes. Women inmates without visitors or social networks to facilitate their access to basic necessities and health information, goods and services were also considered as being among the most vulnerable inmates. These present justifications for women's participation in health as a way of addressing their unique health needs.

Another key finding of the study is that women inmates' participation in health decisions and programmes is cardinal to enhancing their access to health goods and services. While many women inmates felt that their participation in health decision and

programmes would be beneficial to them, other inmates held an opposing view. Those who felt that participation in health was beneficial emphasised that women's experiences would inform the correctional health system to make it more responsive to women inmates' health needs and interests. Those who held opposing views felt that the State does not have any regard for the views of women inmates and would therefore not put them into effect. Women inmates also identified barriers to their participation in health decisions and programmes as including failure to create legally recognised spaces for women inmates to participate, sanctions meted out by correctional officers for participating in health programmes initiated by State and non-State actors independent of the correctional facility and experiences of discrimination. Study respondents demonstrated how women inmates' failure to participate in health decisions and programmes had joint and several negative consequences on the health of women inmates. These include failure of the ZCS to implement preventative health programmes such as screening for pregnancy on admission to prison to mitigate miscarriages, planning social and medical interventions for women inmates' mental health needs and providing specialised treatment for inmates with ailments such as diabetes, hypertension and HIV. The findings in this Chapter not only make a case for women inmates' active participation in health, but also provide a basis for planning and implementing their inclusion in health governance in Zambian correctional centres. State institutions submitted to this effect that they would plan better and be in a better position to meet women inmates' actual health needs if there were established effective platforms for women inmates to participate in health-related decision-making and programming.

The next Chapter presents views of the study respondents on resources required for an effective citizenship participation model for women inmates' involvement in health decisions and programmes in their correctional facilities. It also discusses the study findings on the institutional arrangement that directly impact on women inmates' health rights and facilitate effective participation in health governance for women inmates in correctional facilities in Zambia.

CHAPTER SIX
STUDY FINDINGS ON RESOURCES AND INSTITUTIONAL ARRANGEMENTS NEEDED FOR WOMEN INMATES' PARTICIPATION IN HEALTH IN ZAMBIAN CORRECTIONAL FACILITIES

6.0 INTRODUCTION

Chapter Five of this thesis presented the study findings on the benefits and shortcomings of participating in health decisions and programmes within correctional facilities. Although many women inmates felt that they would enjoy better access to healthcare if they participated in health governance, others were not so optimistic considering the many barriers they experienced in the correctional facilities. A determination of whether women inmates should participate in health-related decisions and programmes would be incomplete without considering resources, systems and institutional support required to facilitate such participation. Questions about what factors influence or prevent participation not only reveal whether citizenship participation is feasible, but also help to identify practical interventions for realising such participation. Chapter Six is thus concerned with the resource question and the role of Zambia's institutional framework in facilitating greater enjoyment of health rights by women inmates.

The findings in this Chapter are presented in two broad sections: the first focuses on the resources and spaces required for women inmates' participation in health and the second focuses on the institutional arrangements and systems required for such participation. I examine views of women inmates, State, quasi-governmental and non-governmental institutions. In the first section, I discuss responses from study respondents about what would be required for women inmates to effectively participate in health decisions and programmes in their correctional facilities. In the second section, I document institutional arrangements inside and outside correctional facilities that are key determinants of women inmates' participation in health. In this regard, the study respondents were asked to answer questions on the existing standards and norms for health governance and how these impact on women inmates' participation in health.[689] They

[689] See Annex 1-3 for the interview guides administered to study participants

were also asked to make recommendations for enhancing the correctional health system and other institutional frameworks to facilitate greater participation in health by women inmates.

6.1 RESOURCES REQUIRED FOR WOMEN INMATES' EFFECTIVE PARTICIPATION IN HEALTH-RELATED DECISION-MAKING AND PROGRAMMING

Several studies show that inadequate resources, spaces and systems pose a barrier to participation for ordinary community members. The types of resources required may differ depending on the nature of participation and the target audience of participatory activities. The issue of resources is often either overlooked or generalised to all settings with the negative effect of affecting the efficacy of participatory programmes. Women's lack of access to resources frequently causes a barrier to their effective participation in all spheres of life.[690] This makes the resources question an even more pertinent one for women inmates as they are secluded from the general population, thereby experiencing an additional barrier to access to resources. Below are research findings on the required resources, spaces and systems.

6.1.1 The need to establish platforms and systems for women inmates' participation

a) Group and individual meetings

Many responses made by the study respondents emphasized the importance of establishing complaints mechanisms and platforms for allowing women inmates to express themselves.[691] KU003, a civil society participant, stated:

> …they deserve a platform because if we are going to make policies that are going to be of benefit to them, they have to be policies that are informed: informed by the people with experience, say as inmates not prisoners. So, let's give them a platform to which they are going to contribute-either to policies or to changing things…[692]

This view resonates with women inmates' views discussed in Chapter five on the need to create spaces for participation in health for women inmates. When asked about the kind of platforms needed for their participation, the civil society participant responded:

[690] Supra note 15
[691] Participants CC011, CC018, CCT019, CCT023, TCT008, KU002, KU003, KA004, KA005
[692] Participant KU003

> …this platform can be direct meetings with stakeholders, or the powers that be can report on how we can also involve [women inmates] in national budgets. At the end of the day, we know that there is a significant amount that should go to prisons.[693]

A woman inmate who participated in the study agreed that meetings similar to the interviews held during the study were the appropriate platforms needed for their participation. She suggested that "one-on-one interviews with inmates would create effective platforms".[694] Thus, from this response, one would conclude that group meetings and one-on-one meetings with women inmates would serve the purpose of collecting women inmates' views on their health situation and proposals for improving such situation. By necessary implication, all the logistical preparations that accompany the convening of meetings form part of the resources required for women inmates' participation. This includes identification of a suitable venue within the correctional facility, stationary, refreshments (if need be) and a host to facilitate the discussions.

Regarding the hosting of meetings, some women inmates felt that they needed external hosts or conveners of meetings, someone outside the correctional system to hear their complaints: "We can participate by talking to you the way you have come, we complain, you are the ones who can help us. We cannot participate directly on our own. The way we are imprisoned it is difficult to participate." [695] Another inmate stated "interactions with outsiders would help a lot…Not just seating and talking about the same things among ourselves as a result we become tired and start fighting."[696] The views women inmates expressed concerning the host of meetings addressed the issue of freedom of speech and the issue of agenda-setting. Freedom of speech in this case is concerned with recognising women inmates' voices and allowing them to freely express themselves without worry of repercussions.[697] One woman inmate observed "the government should give us powers to have a say…If we have that opportunity, we will be able to talk about what is happening."[698] The issue on agenda-setting is about including issues affecting women inmates on the agenda. The host must be able to relate with women inmates' concerns to an extent where the host facilitates their meaningful participation in

[693] Participant KU003
[694] Participant CC020
[695] Participant TCT005
[696] Participant TT007
[697] Participant TC006
[698] Participant CC018

formulating State responses to their issues. One woman inmate stated to this effect that "insiders such as fellow inmates or correctional officers cannot be an effective resource as there would be no privacy since correctional officers are always listening to inmates' conversations".[699] The inmate was concerned that correctional officers may take offence with some of the assessments that women inmates may have about the prison conditions and relationships that negatively impact their health hence the need for outsiders.

Some study respondents suggested that government officials from outside the correctional facility were suitable hosts.[700] Government officials thus "need to visit correctional centres so that women inmates can air their concerns with them".[701] One inmate stated that "… [Government officials] need to ask us one on one. It is just that when officers are present during such one-on-one discussions many of the inmates are scared to express themselves."[702] A civil society participant stated that "government officials needed to put themselves in the same space as women inmates so as to understand what inmates go through, to have empathy and "not to deal with them like they are robots".[703] Agreeing with this view, a State respondent stated:

> It is the duty of judges to [conduct prison visits] and that is the opportunity to be able to interact with the prisoners and get their feedback, their views, what they are going through so that [the judges] have a feel of what [women inmates] are going through in there so that's how supposed to be.[704]

Since government officials are usually responsible for agenda-setting of meetings that happen in correctional facilities, their regular visits and interactions with women inmates would help inform the agendas they set. The views and experiences of women inmates could therefore potentially influence planning. As stated by one State respondent, their report from a prison monitoring visit contained the findings of inmates' living conditions and needs. The report was shared with the relevant authorities with recommendations for required interventions. This way they were able to carry the views of women inmates to the relevant authorities for consideration and possible action.[705]

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[699] Participant CCT019
[700] Participants CC011, TCT008, KU008
[701] Participant CC011
[702] Participant TCT 008
[703] Participant KU008
[704] Participant KA008
[705] Participant KA008

Some State respondents averred that both internal and external actors must work together to facilitate dialogue for the promotion of women inmates' health rights. The establishment of the correctional Health Committees was cited as evidence of how such collaborative work has reduced the disease burden in prisons.[706]

b) Independent monitoring visits

Whereas some women inmates felt that the host of meetings for women inmates must be independent to facilitate effective participation, others felt that the entire mechanism for soliciting women inmates' views must be independent of the correctional facility.[707] They proposed that the independent mechanism should be constituted by non-State and State actors who are independent of the correctional centres.[708] Some participants identified the need for external actors without specifying the preferred institutions.[709] On the other hand, some State respondents identified State institutions such as the Judiciary, Parliament, Legal Aid Board and the Human Rights Commission as they have the legal mandate to conduct prison monitoring visits.[710]One State respondent felt that these institutions were well suited to act as a conduit for information from women inmates to the public.[711]Another described how information obtained from prison monitoring visits is used by different stakeholders:

> The way [Parliament] operates is that every year, every committee, picks up topical issues to study…related to studies of prisons in general and committees. Different committees have gone to prisons and they make recommendations to the executive to address these issues. And when a recommendation is made, government must respond within -in the National Assembly Standing Orders-60 days. Government must give a report on their response to the issues raised.[712]

The State respondents also felt that women inmates' health situation could improve if more members of the public were aware of the conditions in the correctional facilities that pose a threat to women inmates' health. For instance, public knowledge could attract help and more funding for meeting women inmates' health determinants. One State respondent averred that "the government will be listening, NGOs will be listening… when

[706] Participants KA009, KA010
[707] Participant CC024
[708] Participants KA008, KA010
[709] Participants CC011, CCD013, CC018, CCT019
[710] Participants KA005, KA008
[711] Participant KA008
[712] Participant KA005

an inmate speaks and they get it from him or her then it will be easier to say we really need to help these people."[713] Another stated "I know prisoners cannot be given an opportunity to come on TV and talk, but if you just imagined that prisoners were put on the program to speak for themselves, the following day there will be donations of sanitary pads being taken by companies."[714] These views reflect the ability of participation to facilitate access to health goods, services and determinants. However, prison monitoring visits create a platform for women inmates to advocate for their health rights and not just a platform for soliciting donations from well-wishers. They offer avenues for strengthening citizenship relationship between the State and women inmates and should not be viewed solely or mainly as a means of soliciting for charitable donations.

An independent mechanism can help ensure that correctional facilities are improved by investigating and recommending sustainable areas for improvement of women inmates' health and health determinants. Information in the public domain about challenges that women inmates experience can thus prompt independent monitoring visits to correctional facilities. Currently, Zambia Correctional Service Act (ZCSA) allows for visiting court justices, inspectors, ministers of religion and civil society organisations to visit correctional centres and interact with inmates.[715] This provision can be used to promote systemic, coordinated, routine visits to correctional centres to establish women inmates' health situations, determinants and programmes among others and strengthen women inmates' advocacy abilities.

c) Correctional officers as human resource

Although some women inmates were mistrusting of correctional officers as a relevant resource for women inmates' participation in health, others felt that correctional officers are a critical resource. They viewed correctional officers as an important resource in "communicating the health needs of women inmates to healthcare providers."[716] Some felt that they were also important "for communicating their health needs to policy makers and implementers."[717] One inmate stated to this effect that "women need to have officers

[713] Participant KA010
[714] Participant KA005
[715] Supra note 31, Part XVII
[716] Participants TCT001, CCT025
[717] Participant CCT025

speak for them since [women inmates] cannot have the right to speak to the President because we are offenders."[718] A few women inmates felt that correctional officers may not be effective in attending to women inmates' health needs as "they often do not have the capacity to address women's concerns."[719] However, correctional officers may not always be helpless. They wield some power that could be used to facilitate women inmates' health rights including fostering their participation in health. On this premise an inmate averred that "matters that are within the control of correctional officers should be directly communicated to them and correctional officers must be willing to listen to the plight of women inmates." [720] Thus, "women inmates should be free to communicate with officers."[721] Human resources from within the correctional facility are thus just as critical for facilitating women inmates' participation in health as human resources from outside the correctional facility.

d) Use of suggestion boxes

A civil society participant proposed the use of suggestion boxes as a useful resource for facilitating women inmates' participation in health averring that it enables women inmates to communicate their views with policy makers and administrators.[722] The participant, who has done extensive rights-based work in correctional facilities in and outside Zambia, shared a good practice on the use of suggestion boxes which they noted from a correctional facility outside Zambia:[723]

> When I visited a correctional facility not here [in Zambia], each prison cell had a suggestion box… [to help] inmates who cannot express themselves well orally . The suggestion box is not opened by the prison warders in that cell…it is opened by a designated officer from the Prison Commanding Office… [to prevent] reading and removing what the people are saying. So a suggestion box would be very good for the women.

They further stated that suggestion boxes were good for guaranteeing confidentiality and anonymity to women inmates.[724] A woman inmate also suggested the

[718] Participant CCT025
[719] Participant CCT026
[720] Participant CCT021, KA012
[721] Participant KA012
[722] Participant KU002
[723] Participant KU002
[724] Participant KU002

use of suggestion boxes as an effective means of facilitating their participation in health decisions.[725] The views of women inmates, including views on health-related policy changes may can be written down and submitted in suggestion boxes contained in their prison cells, knowing that they will reach policy makers. Adhering to the "Do no harm" principle which requires that actions taken to promote human rights do not cause any foreseeable harm to beneficiaries, the correctional system can set up safety protocols. Safety protocols may be established through policies of the Zambia Correctional Service to ensure that no foreseeable harm is brought upon the inmates through the use of platforms such as suggestion boxes. To facilitate women inmates' participation through the use of suggestion boxes, the resources required thus include suggestion boxes, stationery and human resources. A conducive regulatory framework for the use of suggestion boxes is also essential to mitigate possible harm that inmates may be exposed to when they use the suggestion boxes.

e) Women inmates as human resource for peer support groups

Women inmates were also viewed as a useful resource for facilitating their own participation in health. A civil society participant proposed a unique use of peer support groups different from the current model obtaining in Zambian facilities:

> Within the prison facility, just like outside, [women inmates] must have peer support groups where the peers can sit down and discuss their health matters and their health challenges. They can take this to the correctional leaders…So [women inmates] begin to identify their own health problems. They select their own priorities according to the health they require, according to the individual needs and then the captain takes those complaints and solutions to the leaders.[726]

This model is different from the current peer support groups present in correctional facilities as the later focus on health education and counselling among women inmates. The proposed model adds the requirement for support groups of women inmates to not only discuss their challenges and explore possible solutions, but present these to correctional officers for their attention. This allows for a more meaningful form of participation in health for women inmates. If such a model is supported by laws or policies, an even more effective pathway for women inmates' participation would be

[725] Participant TCDT013
[726] KU002

created.[727] A peer support group cannot function effectively without a supportive regulatory framework outlining its composition, functions, activities, funding and accountability channels, among others. For correctional centres, State regulatory systems for supporting peer education groups are important for creating visibility of the State to the female inmates as State institutions would be directly involved in facilitating women inmates' participation in decision-making.[728] Participants' values also become critical for such a model to work. Many study respondents identified the need for unity, equality, privacy, trustworthiness and respect for women inmates' rights and dignity as key values for fostering their participation in health governance. Many of these values are stipulated in the Zambia Correctional Service Act, thereby making it easier to formulate and implement common goals and programmes that underpin these common values.[729]

This section considered platforms for participation in health by women inmates. From study respondents' responses it was evident that such platforms must include individual and collective spaces. One-on-one meetings with inmates, group meetings including through Correctional Health Committees, suggestion boxes, independent monitoring visits to correctional facilities and peer support groups were identified by study respondents as suitable platforms. Each of these platforms require different types of resources including time to visit correctional facilities and relate with inmates, stationery, suitable venues within the correctional facilities and suggestion boxes. Another critical resource identified by study respondents was human resources from within (that is correctional officers and women inmates) and outside (that is public officials from institutions such as the Judiciary, the National Assembly, Parliament, Human Rights Commission, the Legal Aid Board, and private entities such as churches) the correctional system. Ways of creating such spaces and requisite resources should be explored on an on-going basis, assessing what works and what does not work.[730] As each institution has its own mandate, it should be sufficiently resourced with staff who are qualified to discharge its mandate. If institutional staff have capacity gaps, these must be addressed as discussed later in this Chapter. Similarly, if women inmates are considered as a necessary human

[727] KU005, KA007, KA008
[728] KA010
[729] Supra note 31, Section 4(1)
[730] Participant TCT008

resource, their capacities must be built to effectively implement their role. The use of representatives as a requisite resource is discussed in detail in the next section.

6.1.2 The use of representatives as facilitators of women inmates' participation in health

Both women inmates and institutional participants identified representatives as a useful resource for advocating for women's issues:[731] While the majority of women inmates agreed on the need for representatives who can speak on their behalf, they had mixed feelings about how the representatives must be selected. Several women inmates felt that they needed representatives to be selected from among women inmates.[732] Participant "TCD011" stated that they needed "a representative group of mature inmates who can stand firm in representing the voices of women inmates."[733] She felt that the representatives must be "inmates who can speak from an informed perspective... it is better for the representatives to be chosen by the correctional officers since they know the characters of the inmates and would be able to choose objectively."[734] Some women inmates felt that it was better for the officers to choose representatives as all the women inmates would want to be leaders and this would cause acrimony among them.[735] The recommendation for external advocates to represent health interests of women inmates was supported by several women inmates,[736] one of whom stated "I would suggest having some people or an organization that can advocate for the women inmates. When women talk about their challenges, then that organization publishes that information so that the government gets access to it."[737]

Considering that correctional centres are in dire need of human resource for many areas including health, women inmates could be considered a key human resource for promoting a women inmates' participation in health. The selection of representatives from among women inmates would be similar to the selection of representatives at community and national levels who lead in social and political spheres among others. By the mere fact that women inmates were not agreed on the selection criterion for representatives, it is

[731] Participants CC016, TCD011, TD009, KA005, KA008, KU002
[732] Participant TCD011
[733] Participant TCD011
[734] Participant TCD011
[735] participantTD009, TCD011
[736] Participants CCT003, TCT005, CC016
[737] Participant CC016

clear that the controversies that often surround selection of representatives in the general population would be present in correctional settings. Whereas some preferred that representatives are selected by inmates, others preferred that correctional officers select the representatives and yet others preferred that inmates are represented by persons external to the correctional centres. All the women inmates identified the need to select representatives who would effectively advocate for women inmates health rights and interests as a collective. Those who proposed that representatives be selected from among themselves were guided by the need for inmates to exercise self-advocacy. Women inmates who proposed that representatives be selected by the correctional officers were seeking to avoid individual bias and self-interest inherent in self-regulatory processes. Those who preferred external representatives felt they have liberties that internal representatives did not have which placed them at an advantage in advocating for women's health rights and interests.

From the findings, one clear advantage of selecting representatives is that it would help to put women inmates' health issues on the agenda of correctional facilities and other government departments that work closely with correctional facilities. For example, some women inmates fear to express themselves and thus having representatives helps them to make known their concerns and seek the requisite interventions. Representation is therefore an avenue through which to harness the health-rights benefits of citizenship participation while mitigating the problematic issues such as fear. Carol Smart's argument[738] that social problems such as fear of reprisal would continue to exist even if rights were guaranteed can thus be countered by the recognition and use of representatives to foster social action and secure women inmates' capacity to participate in health related decision-making and programming.[739]

6.1.3 Empowerment through Information, Education and Communication programmes and activities

Another resource identified by women inmates in the study is the use of information, education and communication (IEC) empowerment programmes. IEC empowerment

[738] Smart op cit note 107 at 144-146
[739] Raday op cit note 292

programmes were deemed a key resource for women inmates [740] and correctional officers.[741] Although freedom of expression is guaranteed to all persons in Zambia,[742] it is not freely enjoyed by many women inmates. As shown in Chapter five, women inmates felt restricted in what they could say or demand for in their facility mostly because of correctional officers' intolerance of women inmates' views. A plausible explanation for why women inmates felt this way could be attributed to the historical prison ethos and approach to punishment of offenders that treats inmates as non-holders of rights. For Zambian women inmates, it is not sufficient to rely on the freedom of expression clause but to take additional steps to ensure de facto enjoyment of this right.

The additional steps required for de facto enjoyment of women inmates' freedom of expression necessitate a multi-faceted approach since women inmates are not a homogeneous group. Different factors affect their enjoyment of freedom of expression and other avenues for their participation. For instance, women inmates' reference to fear, feelings of inadequacy and unworthiness as some of the factors that affected their ability to participate in health decisions and programmes can also be attributed to the low social status that women have in the Zambian society. Women's low social status prevents them from participating in public spaces.[743] Coupled with imprisonment, women's low social status could cause an intersectional basis for marginalisation and sense of disempowerment.[744] This was illustrated in the views of "participant KU008", a civil society participant who described how women inmates may not participate in decision-making even when they may have opportunities to do so:

> Having information that they should take part [in health decision-making and programming] is very important because sometimes, they have platforms where they are allowed to voice out [their concerns]. However, because no one told them "you should say something," they'll be quiet. And looking at a prison situation, what an officer says is [the law]. An inmate would rather just say, "yes bwana" and move on cause you have to respect the officers. So, I think they need information for them to know that, there's nothing wrong to ask a question. There's nothing wrong to say "look, I want to say something" even when you are talking to prison officers themselves.[745]

[740] Participant CCD015
[741] Participant KU005
[742] Supra note 42, Article 20
[743] Supra note 76
[744] Douglas, Plugge & Fitzpatrick op cit note 14
[745] Participant KU008

To ensure that women inmates make use of available opportunities for participation, there has to be programmes that help them to assert themselves. "Participant KU008" proposed in this regard that:

> When you give them the information, also guide them [on how to use existing systems]. Guidance is really important. They need guidance on what they should look out for, what is important for them but also how they can go about getting that which is needed. So, they need information, but they also need guidance.[746]

A State respondent, "Participant KA008" also identified IEC materials and stated that "access to information is important for keeping inmates attuned to society." This enables them to also contribute to national matters that impact on them. Many of study respondents did not expressly refer to the use of IEC empowerment programmes for addressing women inmates' low citizenship status and its negative impact on their health-related participation. However, the theories of citizenship discussed in Chapter two show that awareness raising programmes provide communities with the requisite knowledge to participate in governance.[747] Such programmes not only enable communities to participate in existing spaces for decision-making, but also empower communities to demand and create new spaces for participation.[748]

a) Access to IEC programmes as means of addressing knowledge gaps, stigma and discrimination

Another factor that can negatively impact women inmates' ability to express themselves on health matters in correctional settings is lack of knowledge on a subject-matter. A civil society participant identified the need for information to be coupled with skills-building as relevant for generating subject-matter knowledge among women inmates. The civil society participant stated that:

> …So the form of support that would be appropriate to prisoners would be the knowledge. If there's need to impart some form of skill on whatever health-related issue that would be good as well. If we could have deliberate programmes that target specific issues in health and just the basic training of the inmates I think that would be good.[749]

The Participant is cognizant of the fact that some women inmates may not have the requisite information or knowledge of a subject-matter for their participation in health.

[746] Participant KU008
[747] Czapansky, Syma and Manjoo op cit note 303
[748] Cornwall op cit note 97
[749] Participant KU001

This may limit how one understands issues, shares ideas and contributes in a meaningful way to health discussions and planning for health programmes.[750] Baker and DIGNITY find that lack of information promotes self-stigma in that women inmates may fear to display their ignorance on a particular topic of discussion or feel that they do not deserve to participate in correctional health programmes and decisions.[751] Empowerment programmes therefore become necessary to address their barriers to participation.[752]

For empowerment programmes to be effective, they must address the underlying cause of disempowerment. Given the many causes of disempowerment of women inmates discussed above, different empowerment programmes may be required to provide women inmates with the requisite tools to participate in health-related decisions and programmes. With regards to self-stigma as a source of disempowerment for women inmates' participation in health, empowerment interventions may focus on addressing the causes of self-stigma. Many views about causes of self-stigma can be deduced from this study and other studies preceding it.[753] Chapter five shows that many women inmates felt that imprisonment did not entitle them to participate in health programmes and decision-making.[754] Some felt that "… as prisons who have committed crimes, we cannot have the right to make demands on the President or government".[755] This misconception that women inmates cannot participate in health decisions and programmes due to their wrongdoing can be corrected by educating them on the rights. As stated by a civil society participant:

> [Women inmates need information] on 'what rights do I have as a woman who is incarcerated?' 'What rights do I lose by being incarcerated?' And that way, it will help

[750] Participant TC006
[751] Baker Jo and DIGNITY- DIGNITY Publication series on Torture and Organised Violence Study Number 12.*Conditions for women in detention in Zambia: Needs, vulnerabilities and good practices.* (2015) 21Bureau of Democracy, Human Rights and Labor *Country reports on human rights practices* (2016) 3-10 available at http://www.state.gove/j/drl/rlaccessed on 1st July 2017; Topp Stephanie M, Clement N. Moonga, Nkandu Luo, Michael Kaingu, Chisela Chileshe, George Magwende, S. Jody Heymann and German Henostroza 'Mapping the Zambian prison health system: An analysis of key structural determinants.'(2017) 12:7 *Global Public Health* 864;Topp Stephanie M, Clement N. Moonga, Nkandu Luo, Michael Kaingu, Chisela Chileshe, George Magwende, S. Jody Heymann and German Henostroza 'Health and healthcare access among Zambia's female prisoners: A health systems analysis' (2017) *International Journal for Equity in Health* 3
[752] Participant TC006
[753] Op cit note 739
[754] Participants CCT025, TCT006, TCT013, CCT023
[755] Participant CCT025

> them know what to ask for. They'll be able to know that 'I cannot ask for this because in terms of my rights I am not entitled to this. While I'm here, this is what I have.' [756]

Eighty percent (80%) of institutional participants felt that women inmates needed to be exposed to information sessions that increase their knowledge and empower them to participate in health-related decision-making and programming. All the civil society participants (100%) and approximately 70% of State and quasi-governmental institutions believed information and sensitization programmes for women inmates were key resources for ensuring women inmates' participation in health.

Some study respondents also felt that it was important for IEC materials to be accessible to women inmates. One civil society participant stated to this effect that:

> The information [provided to women inmates] has to be in a language or format that the women understand. So, if for example a woman who speaks a certain language let's say Bemba, is incarcerated and is imprisoned in Kazungula where there's [mostly Tonga-speaking people]…they need to create an environment where the officers can communicate to them in a language which they can understand. Also, the material should be provided in a language which they can understand in order for them to be able to fully express themselves on the challenges they are experiencing or maybe on their desires or other requests that they may have. [757]

Information-related empowerment programmes would not serve their purpose if the IEC materials are not accessible to women inmates. Making information accessible to women inmates entails consideration of their communication abilities and disabilities including sensory faculties, language use, literacy and simplification of data on a particular subject-matter. Accessibility may also refer to women inmates' ability to physically reach or possess the IEC materials. Barriers to accessing IEC materials must be ascertained for the different groups of women inmates and measures taken to address the barriers.

Avenues for empowering women inmates through IEC interventions abound and must be explored to determine the most effective means in each correctional facility. For instance, the use of libraries was identified as a useful avenue for empowering women inmates to know and claim their rights. The participant, a civil society organisation that worked in correctional facilities, averred that the ZCS has libraries in some correctional

[756] Participant KU003
[757] Participant KU003

facilities, but they are insufficiently stocked.[758] Participant "KU001" stated that "there's need to beef up the correctional facilities' libraries, provide health pamphlets and translate them. If we do that, coupled with training, coupled with sensitization, it will actually help a lot…." [759] Although not all inmates are illiterate or will use the libraries, the improvement of correctional-based libraries could be a cost-effective way of ensuring women inmates have access to IEC materials. For instance, libraries afford a central space for literature which can be shared among library-users as opposed to distributing IEC materials to individual inmates, some of whom may be illiterate. This way distributors of IEC materials need not plan to provide each inmate with their own copy of materials. This also allows individuals and institutions to donate to the library materials that could outlive the inmate within the correctional facility.

Another civil society participant suggested the need to expose women inmates to mass-media including access to newspapers so that they have access to current affairs in the country.[760] These avenues are feasible in some correctional centres but not in others. For instance, it may be easier to avail newspapers and access to other forms of media in centres that are in urban and peri-urban areas, but not those in remote rural places. The different circumstances obtaining in correctional facilities due to their infrastructure, location or other such feature, necessitate exploring what is feasible and desirable in each correctional centre cannot be overemphasized.

b) Use of IEC empowerment programmes to mitigate abuse and violence

Some women inmates felt that those who had been in the facility longer had better standing to express themselves on matters that affected them than the newer inmates. They reported that those who had been incarcerated longer were more familiar with rules of the correctional facilities and how to manoeuvre the system.[761] One woman inmate indicated that "some inmates who have been in the correctional facility longer than others assert dominance over newer inmates."[762] This serves as a deterrence for any new entrant in the correctional facility to hold a different view from an older inmate. Just like women

[758] Participant KU001
[759] Ibid
[760] Participant KU007
[761] Participant CC017, TCD007
[762] Participant CC017

inmates who are ignorant of their rights, women inmates who are admitted to a correctional facility must be provided with information on their rights, where and how they can lodge complaints on rights' violations and the remedies to which they are entitled. This, coupled with a regulatory framework that proscribes bullying and information sessions on effects of bullying on health rights could help empower women inmates to assert their health rights.

Research studies show that abuse and violence may also fuel self-stigma among survivors. In a study by Douglas et al, it was established that women inmates with a history of sexual and physical abuse were often discouraged from participating in health programming as they experience a sense of dis-empowerment over their health.[763] Although women inmates in my study did not allude to violence as a cause of stigma for women inmates, some women inmates stated that they were in abusive personal relationships prior to entering prison, some of which led to their incarceration. This study also revealed that women inmates are also subjected to violence within correctional facilities due to social practices such as "ku chipupa" discussed in Chapter five. It is therefore possible that self-stigma experienced by some of the women participants could be attributed to the violence and abuse they are exposed to in and out of the correctional facility. Empowerment programmes targeting violence must be akin to those in the general population, that is, they must facilitate access to justice for victims and survivors of violence and provide a holistic health package which allows for restoration of their physical and mental health. IEC sessions that only address one's rights in the context of the general population may be inadequate to address violence as the underlying cause of stigma that prevents women inmates from participating in health decisions and programmes. Women inmates can be empowered to access justice as well as physical and mental health services through instructive IEC programmes. The IEC programmes could include use of information brochures, workshops, radio discussion programmes, one-on-one counselling sessions and safe spaces for peer discussions.

c) Use of IEC programmes to empower correctional officers

Officers in correctional facilities and other State institutions should equally be empowered to address cases of violence against women inmates and other forms of reprisals to which

[763] Douglas, Plugge & Fitzpatrick op cit note 14 at 752

they may be exposed. Well-trained correctional officers and officers in other State institutions are indispensable for the implementation of effective citizenship participation programmes. As one civil society participant in the study explained:

> I don't know at what point the engagement with the officers comes in because, the prisoners might have the information but, the ones that are overseeing their welfare [I.e. the correctional officers], do not appreciate the fact that these inmates have rights. Do correctional officers also appreciate the fact that these inmates have rights so that they can then allow them to access [participation platforms]? There would be that gap if we also don't involve the officers themselves in the process of [raising] awareness.[764]

This view was augmented by another civil society participant who averred "the office of the Commissioner-General of the Zambia Correctional Service could be ignorant of the factors in the correctional facilities that inhibit women inmates' participation in health… Once they are engaged and their permission obtained to train correctional officers, this could help alleviate some of the obstacles to women inmates' participation."[765] The participant further stated that their organisation is well equipped to train correctional officers and the prison command office on women inmates' health rights and would be available to conduct the training should the prison command approve it.[766]

It should be noted that monetary resources are required for IEC programming to meet logistical costs of the training such as travel costs for trainers, refreshments for participants, preparation of training and other IEC materials.[767] While civil society organisations may be willing and able to conduct training programmes for correctional officers, it is important for the government to equally invest in such IEC programmes as a way of demonstrating leadership in championing women inmates' health rights. One female inmate explained that from her experience, "only non-governmental organisations fund such training workshops, but it is important for government to fund such empowerment programmes since they are responsible for the welfare of inmates."[768] Government's investment in IEC interventions for correctional facilities could signify the importance they attach to women inmates' participation in health. Positive obligations on the part of the State, such as allocation of funds and human resource to empowerment of

[764] Participant KU006
[765] Participant KU005
[766] Ibid
[767] Participant TC006
[768] Ibid

women inmates could also make the government more visible in the lives of women inmates. This could help allay fears held by women inmates that government is not interested in them or their right to participate in health governance.

Empowerment programmes that target both women inmates and correctional officers are vital for ensuring the former's effective participation in health. They have the potential to address the barriers to participation that women inmates experience, as well as attitudinal and capacity gaps that correctional officers may have. The majority of the study respondents supported the need for IEC empowerment programmes to mitigate knowledge gaps of inmates and correctional officers that negatively impact women inmates' effective participation in health.

d) Linking IEC empowerment programmes to broad programming for health in correctional settings

IEC empowerment programmes for women inmates and correctional officers have the potential to achieve more than building capacity for a women-centred model for citizenship participation in health. In the process of conducting IEC empowerment programmes, State and non-State actors could have opportunities to collect data on women inmates' health. Considering the scarcity of research on correctional facilities in Zambia, IEC programmes could provide the much-needed information to inform health and related interventions in correctional settings. For instance, IEC interventions can be a gateway for generating data that feeds into the community health information system and the national health management information system. These are databases managed by the Ministry of Health to capture health data at community and national levels respective, which information is used to guide planning and decision making at community, district, and hospital levels countrywide.[769] The spaces that IEC empowerment programmes create could be used for documenting and exchanging information on the health situation, determinants and programmes for women inmates that in turn informs the community and national health management information systems. Information that is captured in these systems can be used to inform law and policy decisions in ways similar to health data

[769] Supra note 78

captured for the general population as espoused in the National Health Policy and National Health Strategic Plan.[770]

6.1.4 Empowerment through financial investment for fundraising activities

There is a correlation between women inmates' participation in income-generating activities for health and health determinants and their participation in health-related decision-making. Women's ability to meet some of their own needs is important for them to maintain control over their health.[771] In a study conducted among women inmates in the United Kingdom (UK), Douglas et al found that one of the effects of imprisonment on women is a sense of disempowerment even for routine tasks such as health maintenance. They argue that self-empowerment and control are "central tenets of health promotion theory and practice."[772] The findings of Douglas et al prove true for some Zambian inmates who opined that there was little they can do to improve their health outcomes and access to health goods and services within the correctional centre as they were wholly dependent on the government.[773] However, many of the Zambian women inmates identified ways in which they can participate in improving their access to health goods and services. They expressed willingness to scale up income-generating activities for better health outcomes.[774]

Women inmates and civil society participants identified the need to invest seed money to support women inmates to engage in fundraising activities to meet women inmates' health and other personal needs.[775] It was argued that some fundraising activities can be done from the skills training in which women inmates are involved.[776] Some of the skills women inmates are taught in the correctional facilities include "tailoring, making door mats and smoking chickens"[777]. Some inmates use their already existing skills such as hair plaiting and gardening to raise funds for their personal needs.[778] Enhancing women inmates' ability to raise funds "would help them to purchase medical supplies such as

[770] Ibid
[771] Douglas, Plugge & Fitzpatrick op cit note 14
[772] Ibid 752
[773] Participants TT009, CC001, CCD015, CC022
[774] Participants TC012, TCT015, TC006
[775] Participant KU001
[776] Participant TCT010
[777] Participant TC012
[778] Participant KA007

prescribed medicines"[779] and women's basic necessities such as sanitary pads, underwear, soap and lotion. This is particularly important in situations faced by women inmates where preventative medical supplies and medicines are not made readily available by the government. Although provision of health goods and supplies is the responsibility of government, allowing women inmates to engage in economic activities to meet their health needs provides them with options and empowers them to exercise agency over their health and general well-being. Providing women inmates with the option to exercise agency over their health and general well-being should not substitute the government's responsibility to fulfil its human rights obligations. This option would serve to mitigate women inmates' health challenges when the State is failing in its obligations, while retaining women's options to engage with and hold the State accountable to their obligations.

In the two correctional facilities that participated in the study, there are currently some income generating activities aimed at raising funds for the facilities. A civil society participant with experience in working in Zambian correctional facilities shared how they have collaborated with the government to train women inmates and provide them with equipment and supplies to engage in income-generating activities such as tailoring.[780] Women inmates volunteer to be trained and to participate in fundraising. The funds raised are used to purchase disinfectants, food and other supplies needed by the correctional facility. This intervention is mutually beneficial for the women inmates and the government. However, the benefits for women inmates can be enhanced by ensuring that those directly involved in the income-generating activities are remunerated for their services. Government interventions to support women inmates can thus empower women to contribute to a more efficient delivery of health services and ensure access to women-centred health goods and services. Women who are sentenced to imprisonment with labour can also work on income-generating activities for the benefit of the correctional facility. For a correctional system that experiences many resource constraints, both women inmates and government would benefit from human resource of women inmates and the financial resource that flows from their engagement in income generating activities.

[779] Participant KA007
[780] Participant KU001

Mechanisms such as the Citizens Economic Empowerment Fund and Commission which were set up to provide economic empowerment to vulnerable people in Zambia must be extended to women inmates to harness the potential benefits of their participation. The Citizen Economic Empowerment Commission (CEEC) provides capital to the indigent who apply for funds to invest in an economic venture.[781] Funds are awarded on condition that the recipients pay back the capital investment over a period of time stipulated in the contract.[782] The government acknowledges the challenges that poorer populations in society experience when entering the labour market and participating in income generation. It set up the CEEC to mitigate some of these challenges through provision of funds, mentorship and oversight to successful applicants.

6.1.5 Recreation and Rehabilitation programmes

There are many programmes that successfully use sports and other recreational activities to raise awareness on health issues and build active citizenship. This approach could be replicated in correctional settings. In Zambia, an organisation called Grassroots Soccer uses sporting activities to raise awareness and build capacities on health issues.[783] It describes itself as "an adolescent health organisation that leverages the power of soccer to educate, inspire, and mobilise young people to overcome their greatest health challenges, live healthier, more productive lives and be agents for change in their communities."[784] Recreational programmes enable people to gather and socialise, making it an accessible space for health information-sharing. As was shown in Chapter three, access to health information is a key component of the right to health. It is also one of the immediately realisable obligations that states have for promoting the right to health. Through recreational and rehabilitation programmes, rights' holders can also be empowered with practical skills for overcoming access to health barriers and asserting their health rights. Approaches to realising healthcare such as the ones undertaken by Grassroot Soccer are legally endorsed in statutes such as the Zambia Correctional Service Act, the Gender Equity and Equality Act, the Persons with Disabilities Act and the Mental Health Act discussed in Chapter three. Models for awareness-raising and capacity-building used by

[781] Citizens Economic Empowerment Act, Act no. 9 of 2006, Part II
[782] Ibid
[783] https://www.grassrootsoccer.org
[784] Ibid

such organisations can be studied and piloted in correctional settings as a means of facilitating women inmates' participation in health-related decision-making and programming.

Recreational activities bring participants together and can be a good avenue for health promotion as illustrated in Chapter five. The fact that women inmates are accommodated in one space makes it easier for them to come together for sporting and other recreational programmes. Peer health promoters present in the correctional facilities may thus take the opportunity to conduct health promotion services during recreational programmes. Some women inmates and civil society participants identified recreation and rehabilitation activities as the necessary resource for women inmates' participation in health.[785] One inmate submitted that "women inmates should be free to use their talents such as singing, art, poetry to express themselves".[786] The ability to share information through debate programmes among inmates could also be explored. Another inmate stated that recreational activities can give women inmates an opportunity to participate in health programming: "[women inmates] can facilitate their own recreational programmes. They can even form a very strong netball team…Sports is therapeutic, it's a health thing. They can be doing that themselves."[787] One advantage of recreational activities is that they keep women inmates occupied and can help address both physical and mental health threats. Another advantage is that women inmates may be able to conduct recreational activities with minimal State involvement, serve for freeing up time for such activities. Recreational and rehabilitation activities that are capital intensive can nonetheless be budgeted for by the government.

6.2 STUDY RESPONDENTS' PREFERRED INSTITUTIONAL ARRANGEMENTS FOR ADVANCING THE PARTICIPATION OF WOMEN INMATES IN HEALTH DECISIONS AND PROGRAMMES

Supportive institutions create a favourable environment for women inmates to participate in health. It is thus relevant to consider how the institutional set-up of the Zambia Correctional Service and other governmental, non-governmental and quasi-governmental organisations impact on and respond to women inmates' participation in health. Women

[785] Participants KU001, KU002, CC022
[786] Participant CC022
[787] Participant KU002

inmates and institutional participants in this study were asked about the institutional arrangements they believed would enhance the participation of women inmates in health decisions and programmes. Participants' responses included: abolishing retrogressive customs and practices in and out of correctional facilities that negatively impact on women inmates' health;[788] creating effective and transparent correctional health systems for women inmates to provide feedback to access to healthcare;[789] "establishing of in-house satellite offices for human rights institutions to ensure greater monitoring and effective protection of human rights of inmates"[790]; "improving prison infrastructure"[791]; "ensuring coordination among government institutions";[792] and "ensuring a regulatory framework that is conducive for women inmates' participation in health".[793] There did not appear to be a significant difference in the responses given by study respondents' participants attributable to their status that is inmates, civil society or government institution. The participants' responses are thus presented based on the issues raised and not the status of the participant.

6.2.1 Abolishing retrogressive customs and practices in and out of the correctional facilities that negatively impact on women inmates' health

Participants cited various customs and practices prevalent in correctional settings that must be abolished if women inmates' participation in health were to be promoted. One woman inmate cited the presence of fellow inmates, that is, cell captains during doctor visits as an unnecessary invasion of privacy that curtails some women inmates from seeking medical attention.[794] She felt that "it does not make sense for cell captains, who are non-medical personnel, to always be present during inmates' medical examinations".[795] She stated that doctors and nurses at correctional clinics are correctional officers and can provide the necessary security measures while conducting medical examination of inmates.

"Participant TCT008", a woman inmate, also identified the need to abolish excessive powers given to cell captains to facilitate women inmates' access to correctional

[788] Participant TT007, TCT008, CC017
[789] Field Observation note 4 of 2nd June 2020
[790] Participant TCT002
[791] Participant KU001
[792] Participant KA008
[793] Participant CC018
[794] Participant TT007
[795] Participant TT007

officers. She felt that many women inmates do not have access to correctional officers because the cell captains block them from presenting their concerns to the officers. She stated to this effect that "the captains isolate inmates and prevent reports of abuse."[796] Although limited examples of retrogressive customs and practices were given in response to the question on the requisite institutional changes, many more such practices were cited with reference to questions on women inmates' health determinants and their experiences in participating in health decisions and programmes. These were discussed as barriers to participation in the previous Chapter and include arbitrary punishment by correctional officers when women inmates seek to assert their rights, hazardous and intrusive bodily searches. They also include the practice of "ku chipupa" and other forms of violence against women inmates who are viewed as deviants in the correctional facility and other forms of mockery to which women inmates are subjected to when they seek to participate in health decisions or programmes.

Civil society participants also identified some negative customary practices that impact on women inmates' health. "Participant KU001" attributed the government's low allocation of funds to correctional facilities to the low regard for inmates. The participant stated that the inmates are discriminated against in the allocation of funds due to their wrongdoing. "Participant KU001" submitted:

> …unlike similar security institutions such as the Zambia Police Service that have their own vault for public funding… the funding for the Zambia Correctional Service is provided through the Ministry of Home Affairs and Internal Security who decide how much to allocate for correctional services... Given the other priorities of the Ministry of Home Affairs, prisons are often left with a small allocation of resources.

Therefore Zambia Correctional Service does not have much control over resources and are not prioritized in the allocation of funds due to stigma and discrimination associated with providing care to criminals. Another State participant confirmed that they "do not receive any money from the government at facility level. They only receive food parcels."[797] The Zambia Police Service, on the other hand, prepares its own budget and receives funding directly from the Ministry of Finance. Both the Zambia Correctional Service and the Zambia Police Service fall under the Ministry of Home Affairs and Internal Security, but are subjected to different funding protocols. One could argue that

[796] Participant TCT008
[797] Participant KA013

low funding for correctional facilities negatively impacts the medical approach that the Zambia Correctional Service implores to addressing women inmates' health needs. This is because low funding negatively impacts availability of drugs and other medical supplies as well as the ability of the Zambia Correctional Service to engage qualified medical personnel, equipment and infrastructure. The provision of healthcare goods and services are thus negatively impacted by stigma and discrimination that is attached to inmates and correctional facilities. Addressing such stigma and discrimination in the Zambian society can contribute to better provision of health goods and services to women inmates and encourage women inmates to better utilise individual spaces for asserting their health rights.

Another practice cited by civil society participants that negatively impacts on women inmates' health is the stigma and discrimination that imprisonment has on their lives in and after prison. While in prison, women inmates often abruptly lose their property, finances, employment, marriages and children with no prospects of recovering them.[798]"Participant KU001" stated that the rules of the Public Service Commission do not allow for convicts to be reinstated in public office even where the crime they committed is not directly connected to their job. "Participant KU001" further stated that a convict cannot be employed in a new job in the public service only by virtue of their past criminal record and yet correctional facilities are providing skills and professional training to inmates.[799] They felt that this practice was not only discriminatory but contrary to government's own rehabilitation and correctional programmes. The participant also felt that women inmates were disproportionately affected as many women already find it difficult to obtain jobs in the Zambian Society. Effective rehabilitation and re-integration programmes for women inmates must ensure they tackle recidivism. Many women inmates expressed anxiety on the inadequacy of the correctional system to facilitate their integration into society due to the limited income-generating opportunities once they left prison.

Some civil society participants felt that women inmates were an under-served stakeholder as they are often excluded from important opportunities for participating in

[798] Participants KU001, KU002, KU005
[799] Participant KU001

public spaces.[800] This was exemplified by the key informant interview with one participant from a State institution that confirmed that "while the Zambia Correctional Service was consulted over the law review and reform process leading to the current Zambia Correctional Service Act,[801] women inmates were never consulted… The assumption was that they would be represented by the Zambia Correctional Service."[802] If women inmates' needs and experiences are not prioritized within the Zambian correctional system, then the likelihood is that their experiences will not be represented in law-reform processes. Civil society and State institutions must therefore make deliberate efforts to solicit women inmates' participation in health and health determinants in public spaces and address stigma, discrimination and resultant negative practices that lead to women inmates' exclusion. One participant stated that achieving the paradigm shift from punitive to a correctional model requires that "such a shift must not be understood or desired at high level, but must trickle down to the gatekeeper and all actors must understand what their role is in ensuring its effective realisation".[803] In this scheme of things, the negative social norms and practices in correctional facilities should not continue to conform to the traditional punitive paradigm even in the name of ensuring public security. Therefore there is need to balance the important concerns for public security with the important obligation of promoting and protecting health and other human rights of women inmates.

6.2.2 Creating effective and transparent correctional health systems for inmates to provide feedback on the health information, goods and services they receive

Women inmates' participation in health can be improved in the correctional health system by creating a system where women inmates can provide feedback on their access to healthcare experiences. "Participant TC006" felt that "prison rules and procedures on women inmates' participation in health must be clear and ensure that every inmate has access to them"[804]. She also felt that prison rules must be desegregated to address the needs of different groups of women in correctional facilities. In her opinion, addressing the needs of different women inmates in correctional rules not only protects women inmates, but correctional officers who often use their discretion to put in place make-shift

[800] Participants KU004, KU006, KU008
[801] Supra note 31
[802] Participant KA004
[803] Participant KA002
[804] Participant TC006

rules to address day-to-day challenges of groups such as pregnant women, women with disabilities and women with children in the correctional facility.[805] Inclusive prison rules thus help to address individual bias, excessive use of discretionary powers and double standards inherent in prison customs and practice. This view on the need for a conducive regulatory framework which encourages the participation of women inmates in health was supported by civil society participants [806] and participants from State institutions.[807] "Participant KU001", a civil society participant, cited the practice of removal of remission of sentence as needing to be more transparent. The participant stated that "the practice of removing an erring inmates' remission of sentence is good as it instils discipline in inmates, but there is required transparency in administering the practice."[808] The participant also cited the need for correctional regulations such as the Commissioner General's rules and the Zambia Correctional Health Guidelines to be publicly available.[809]

With regard to the need to establish effective health systems for the Zambia Correctional Service, one civil society participant stated that "there is a gap in the prison health governance system as its structure is different from that of the Ministry of Health."[810] The Ministry of Health governance system is complete as it contains structures from primary to tertiary healthcare whereas this is not the case for prison-based health institutions. This must be addressed to improve the correctional health system. It is not clear whether the Ministry of Health has simply neglected the prison-based correctional health institutions or whether the Zambia Correctional Service has decided to establish its own health institutions independent of the Ministry of Health. A participant from a State institution stated that "all public health institutions in Zambia fall under the Ministry of Health."[811] However, the health governance structures for the prison-based health facilities and health facilities accessible by the general population are not the same, with the Ministry of Health not having as much control over the prison-based health facilities. A civil society participant felt that the Zambia Correctional Service insisted on having its own health facilities to serve the prison population. The participant stated that "although

[805] Participant TC006
[806] Participants KU001, KU002, KU004,KU005, KU006, KU007,
[807] Participants KA001, KA002,KA003, KA004, KA009, KA010, KA0011, KA012
[808] Participant KU001
[809] Participant KU001
[810] Participant KU002
[811] Participant KA009

the Zambia Correctional Service wants its own health system, they do not have the full establishment like other security wings like Zambia Army and Zambia Police. This disadvantages inmates who are at the receiving end of lack of health services."[812]

"Participant KU002" also stated that another way of improving the correctional health system is by "conducting admission interviews or entry interviews to orient newly admitted inmates and find out from them what their immediate health needs are."[813] This way the Zambia Correctional Service will be more proactive in responding to women inmates' health needs. It would also help to desegregate health needs and put the correctional system on early notice of the heterogeneity of women inmates in its custody. This view augments the submissions of Participants "KU002" and "KU004" for more inclusive health promotion rules and practices. "Participant KA002" felt that "the ZCS took a generic approach to women inmates' health rights therefore ignoring needs of others." "Participant KU004" felt that the "correctional health governance system in Zambia is built on the foundation that prisoners with mental disabilities are second-class and therefore does not take into account their unique needs."[814]"Participant KA008" a State institution, acknowledged that they struggle in identifying offenders with mental disabilities as these are often not obvious. Sometimes an offender presents with a mental illness or crisis at a time when it is too late for them to take any effective mitigatory measures.[815] Entry assessments for newly admitted inmates could thus provide an avenue for including marginalised groups of women offenders such as women with mental disabilities.

6.2.3 Establishing human rights monitoring and enforcement units within the correctional facilities

A few participants reported that rights of women inmates would be better protected if the correctional system allowed for the establishment of an office or desk of the Human Rights Commission within correctional facilities. "Participant TCT002" said:

> …there has to be a human rights office right inside here…not those who just come in when something is happening. There needs to be a human rights office here, independent away from the officers, where they can just see everything for themselves.

[812] Participant KU005
[813] Participant KU002
[814] Participant KU004
[815] Participant KA008

The idea of establishing independent human rights offices or desks in correctional facilities suggests that human rights violations that women inmates experience go unattended by the correctional officers. This would justify the need for human rights officers who are not only independent, but are competent in enforcing human rights and more specifically health rights. For such human rights officers to carry the authority they need to discharge the proposed function, they must be employed by a quasi-State institution as is the current status with employees of the Human Rights Commission. In a resource-constrained country like Zambia, it may not be feasible to employ human rights officers for all correctional facilities. There is need to thus explore different pathways for establishing such independent and competent human rights officers who can enforce women inmates' health rights. This study did not explore these pathways. However, "Participant KU003" felt there was need to strengthen the judiciary's role in monitoring inmates' welfare. In the same vein, since different quasi-State justice institutions are present in each province, the government can consider strengthening their role to effectively monitor correctional facilities in their provinces. This can be realised through legislative changes to their mandates coupled with capacity-building interventions. The use of NGOs and other civil society organisations, though critical, is not sustainable. Further, their work may serve to empower women inmates to claim their health rights and practice active citizenship, but they will not be in a position to make recommendations or take actions that are mandatory for the State to implement.

6.2.4 Improving prison infrastructure

As discussed in chapter 1, most of the prison infrastructure in Zambia was built in the colonial era, with little to no provisions for the needs of women inmates. A few new modern prison facilities have been built in more recent years (e.g Livingstone Correctional Facility, Chipata Correctional Facility, open air facilities), some of which serve as model facilities for building correctional services (e.g. Mwembeshi Correctional Facility). Except for the Mukobeko Female Maximum facility, all of these are male prisons. Housing women inmates in facilities that do not meet their needs therefore is likely to perpetuate the inhumane treatment they are subjected to and violate their health rights as protected in internationally guaranteed human rights standards.

Overcrowding in correctional facilities not only negatively affects the health of women inmates, but also potentially affects the quality and impact of participation in health. Study respondents indicated that poor prison infrastructure need to be addressed to improve women inmates' health and participation in health. Most of women inmates felt that the Zambian criminal laws were excessively harsh on women, leading to more women being incarcerated and filling up correctional facilities. Many of the inmates recommended the need to review criminal laws through the gender lens to mitigate the problem of overcrowding correctional facilities.[816] A few women inmates as well as civil society and State participants felt that prison infrastructure must be expanded and inclusive to ensure better accommodation of inmates.[817] Some women inmates indicated that the accommodation for women inmates on death row:

> was appalling in that their space was extremely limited and were not allowed to be housed in other parts of the facility even if there was room to do so. The cell blocks of women inmates on death row were separated from other inmates thereby allocating a very small portion of the correctional facility.[818]

This was compounded by the designation of a small area for women inmates' social interaction outside their cell. Women inmates on death row were not allowed to socialize with other inmates and to cross beyond the small boundary allocated to them in the facility.[819] Some women inmates expressed delight at the ongoing construction of a new prison block for inmates on death row, but stated that it had taken too long to complete the project.[820] The level of confinement for women on death row, even for the shortest possible time constitutes inhumane and degrading treatment and does not create a

[816] Participant TCT002, TC006
[817] Participants KU006, KU001, KU004, KA001, KA002, KA003
[818] Participant CC020
[819] Field Observation note 10 of 28th May 2020
[820] Participant CC012

conducive environment for such inmates to participate in health decisions and programmes.[821]

In addition to improving sleeping space and recreational space, health-related infrastructure must be improved in correctional settings. One woman inmate[822] and one civil society participant[823] felt that improving the infrastructure of correctional clinics would improve access to health information, goods and services thereby improving participation in health at individual and social levels.

6.2.5 Ensuring coordination among key governmental and non-governmental institutions

While there are potentially many actors who could improve women inmates' health-rights outcomes in the Zambian correctional facilities, most of these actors attested to not working in correctional settings or on issues affecting women inmates' health. Some reasons that were advanced by State and civil society respondents include inadequate resources to extend the provision of goods and services to correctional settings,[824] inadequate expertise,[825] lack of supportive regulatory framework for correction of inmates in correctional settings,[826] inconsistent programming for correctional facilities,[827] lack of institutional and political will[828] and ignorance on the need to implement work on women inmates' health rights.[829] Given that all the institutions that participated in the study have the mandate by law or by their constitutive documents to work on health issues affecting women inmates, each institution must work towards addressing the barriers they experience. Some of the identified barriers can however be addressed through effective collaboration and coordination among institutions.[830]

Collaboration among State and non-State institutions in prison health occurs haphazardly and usually in response to a health threat.[831] This occurs mostly because institutions do not have pre-determined programmes for working in correctional facilities.

[821] Participants KU001, KA002
[822] Participant TCT002
[823] Participant KU002
[824] Participant KA011
[825] Participant KA012
[826] Participant KU004, KU007
[827] Participants KA001, KA003, KA005, KA007
[828] Participants KU 007, KA006
[829] Participants KU 001, KU005
[830] Participant KA001
[831] Participants KA001, K002, KA003

A State respondent stated in this regard that "the 2018 Annual State of Human Rights Report for Zambia indicates that the Ministry of Health does not have any specific programmes for working in prisons. They must be prompted by other stakeholders to respond to a health crisis or potential health crisis. This is also true of the Zambia Public Health Institute."[832] Other State respondents indicated that they are sometimes invited by the Zambia Correctional Service to attend to health hazards within the affected correctional facilities or sometimes to share information on how to prevent health hazards. However, these interventions are not consistently done and are often dependent on availability of human and financial resources.[833] A State respondent recommended the need for government line ministries to have consistent working relations on prison health and to ensure that health services are decentralised.[834] Decentralisation not only unburdens one institution of having to carry out all the work, but ensures that services are provided as close to the correctional facilities as possible. This requires better organisation of grassroots structures within and out of government. Strong collaborative interventions among governmental and non-governmental organisations can potentially increase the spaces and quality of participation in health decisions and programmes as more actors and resources are available for realising such participation. Collaboration increases chances for effective partnerships between the State and women inmates and their representative organisations.

Coordination is important for leveraging resources among key stakeholders. It ensures that stakeholders know their roles and that overlapping mandates are better organised to facilitate efficient goods and service delivery.[835] A coordinated health response for correctional facilities encourages transparency as it has the potential to show with relative ease the strengths, weaknesses, opportunities and threats of the correctional health response. If all stakeholders with the mandate to work on issues affecting women inmates' health coordinated their work, participatory health interventions would stand a greater chance of success as institutions would be more accountable to each other and to women inmates. Effective correctional health systems must therefore reflect all

[832] Participant KA002
[833] Participants KA001, KA003
[834] Participants KA009, KA012
[835] Participant KA008

interventions for collaboration and coordination on women inmates' health. Given the required resources and institutional arrangements for enhancing women inmates' health and participation in health governance, it is important to consider study participant's views on Zambia's regulatory response.

6.3 STUDY RESPONDENTS' VIEWS ON THE ROLE OF THE ZAMBIAN REGULTORY FRAMEWORK IN CREATING PATHWAYS FOR WOMEN INMATES' PARTICIPATION IN HEALTH

The creation of a conducive environment was also identified by study respondents as necessary for the effective functioning of participatory platforms. Study respondents proposed that this could be achieved through formulating suitable laws and policies and promoting common values between women inmates and the correctional system.[836] To create legally binding spaces for citizenship participation in health for women inmates and address power relations and other barriers to participation, conducive laws, policies and institutional frameworks must be enacted and enforced.

Study respondents reported that the correctional system and its officers must facilitate a favourable environment for women inmates to participate in health.[837] Women inmates averred that correctional officers must be legally compelled to encourage women inmates' participation or at the very least be legally prohibited from discouraging women inmates' participation in health.[838] Some women inmates cited examples of how officers often discourage them from participating in health and related programmes initiated by external actors.[839] They felt that if laws and policies proscribed this kind of behaviour, more women inmates would be better placed to participate in health.[840] This helps to place responsibilities on public officers to promote women inmates' participation.[841]

Laws, policies and institutions may provide varying and innovative pathways to solicit women inmates' participation in health. Some study respondents identified Zambia's regulatory framework as cardinal for enhancing citizenship participation of women inmates in health governance mostly because they set transparent standards for

[836] Participants CCT012, CC018, CC020, KU008,KA005, KU002
[837] Participant KA005, KA007, KA008, KU001, KU002, KU008.
[838] Participant TCT005
[839] Participant TCT005
[840] Participant CC022
[841] Participant KA007, KA008

participation.[842]Women inmates felt that this makes the regulatory framework well-suited for fostering formal and structured spaces for participation and facilitating a women-inclusive citizenship participation approach to health in the correctional centres.[843]"Participant CC022" stated that "women inmates do not have powers to help themselves to address health challenges because prison rules set standards for their healthcare and treatment".[844] In other words, because prison rules do not ascribe roles to women inmates, but instead prescribe the dos and don'ts in inmates' healthcare to their exclusion, women inmates are limited in their participation.

"Participant CC018" also submitted that "… the law is a powerful tool for limiting officers' powers and allowing women inmates to be treated as human beings deserving of dignity."[845] "Participant KU004" described the empowering effect of favourable legal provisions for participation of vulnerable groups of inmates as follows: "the new provision of the Zambia Correctional Service Act has given us a chance to plan engagements with the police, correctional facilities and inmates on the new legal protections for inmates with mental disabilities." They felt that because of the new provisions, all laws and policies that impact on inmates must be reviewed to remove legal barriers that negatively impact on women inmates. "Participant KA001", a State institution, stated that some of the progressive provisions in Zambia's regulatory framework have had limited benefits for women inmates as they are generic. Thus, although laws and policies are important for creating a conducive regulatory environment for women inmates to participate in health decisions and programmes, they must specifically address their issues. General national laws and policies must be adapted to correctional settings to be effective.[846]

Laws and policies may not always be responsive to women inmates' health needs or even facilitate their participation in health as is the case currently.[847] This requires administrators and women inmates to acknowledge the limitations of laws and policies and examine alternative pathways for participating in health. One woman inmate submitted that "there may not always be spaces created for women inmates' participation

[842] Participants CC018, CC022, TCT005, KU004, KU006, KA001, KA002
[843] Participant KU002
[844] Participant CCT022
[845] Participant CCT018
[846] Participant KA001
[847] Chapter three of this thesis discusses Zambia's legislative framework for women inmates' health rights

in health, but women inmates need to fight for themselves to improve their access to healthcare. Therefore, they must speak up no matter the consequences".[848] By this, she implied that women must create their own spaces where they can voice their health concerns or issues that impact on their health if such spaces do not exist. This resonates with Cornwall who argues that unofficial spaces of participation must be identified and promoted as they have a bearing on official spaces.[849] This requires laws, policies and institutions to recognise and promote non-prescribed spaces and provide the necessary safeguards for their utilisation.

6.3 CONCLUSION

Chapter six has examined study respondents' views on the resources and institutional arrangements required for ensuring women inmates' effective participation in health-related decision-making and programming. Study respondents' views on the role of Zambia's regulatory framework in promoting and protecting women inmates' participation in health were also analysed. The Chapter has illustrated that women inmates require resources, legal and institutional arrangements that directly respond to their day-to-day barriers to participating in health decisions and programmes. Study respondents identified various resources for women inmates' participation in health. One of the resources identified is the need for platforms and systems for women inmates' participation in health. Study respondents felt that women inmates needed to have access to complaint mechanisms and other platforms that allowed them to express themselves on matters that impacted on their physical and mental health. Some of the platforms identified by respondents include use of outsiders such as researchers, civil society organisations working in prisons, visiting justices and religious leaders to convey their health concerns to prison administrators, policy and law makers. One civil society participant proposed the use of suggestion boxes placed in prison cells as a means of encouraging inmates to share their correctional health experiences. The suggestion boxes would be opened by a designated officer who is mandated to share findings with administrators, policy and law makers.

[848] Participant CC017
[849] Cornwall op cit note 97

Study respondents also felt that recreation and rehabilitation programmes would create platforms for women inmates to promote their health and express themselves on health matters. The study found that other health-focused programmes run by youth-led organisations have successfully used sports and other forms of recreation to dissemination health information and share experiences. Another resource identified by study respondents is the use of representatives. Respondents felt that human resource is an important resource for women inmates as those who are unable to express themselves would have their health concerns represented by others. While some women inmates proposed that such representatives should comprise of women inmates, others felt that external persons should be appointed as representatives of women inmates. Respondents further identified information, education and communication programmes and activities as a key resource which would empower women inmates to know their health rights and assert them. Some respondents felt that for women inmates' participation in health to be effective, both women inmates and correctional officers needed to be empowered with health rights information through training programmes and other information-sharing interventions. Lastly, study respondents felt that women inmates needed economic empowerment to enhance their ability to make health decisions at a personal or individual level. Economic empowerment would enable women inmates to participate in fundraising ventures. Such an intervention would build a sense of empowerment and control over routine health tasks.

In addition to requisite resources, spaces and systems, study respondents also submitted that the Zambia Correctional Service and other governmental and non-governmental organisations mandated to work in correctional facilities, or on issues affecting women's health in Zambia needed to undergo some institutional changes. They proposed institutional changes that would help women inmates better participate in health decisions and programmes. Some study respondents proposed abolishing retrogressive customs and practices in and out of correctional facilities that negatively impact on women inmates' health. Others proposed the need to create effective and transparent correctional health systems that allow women inmates to provide feedback on their access to healthcare experiences. Another institutional arrangement proposed is the need to establish human rights monitoring and enforcement units within the correctional facilities. Study

respondents also felt that improving prison infrastructure and ensuring coordination among key governmental and non-governmental institutions would improve the environment for women inmates' participation in health.

With regards to the role of Zambia's regulatory framework in promoting women inmates' participation in health, study respondents submitted that the Zambian regulatory framework is cardinal for creating pathways through conducive laws and policies. This can be realised by expressly creating spaces and systems for women inmates' participation in health as well as compelling administrators, policy and law makers to recognise women inmates' right to participate in health decisions and programmes through law and policy. While acknowledging that laws and policies are not the panacea for women inmates' participation in health, study findings in this Chapter show that the Zambian regulatory framework could potentially promote the creation of formal and informal spaces for women inmates' participation in health. The next Chapter explores how best a woman-centred model to citizenship participation can be realised for better realisation of health rights for women inmates in Zambia.

CHAPTER SEVEN
A WOMAN-CENTRED CITIZENSHIP PARTICIPATION MODEL TO HEALTH FOR THE ZAMBIAN CORRECTIONAL SERVICE

7.0 INTRODUCTION

Chapter five of this thesis presents study respondents' views on the benefits and shortcomings of women inmates' participation in health. Chapter six, on the other hand, discusses study respondents' views on the required resources and institutional arrangements for realising effective participation by women inmates. This Chapter synthesizes the findings from Chapters five and six by applying a feminist conceptual framework for citizenship participation as discussed in Chapter two to formulate a woman-centred citizenship participation model to health for women inmates in Zambia. Chapters five and six show that women inmates are in many ways uniquely positioned in the Zambian society thereby requiring the conceptualisation of a citizenship participation model that suits their circumstances. Women inmates' unique position in the Zambian society arises from their gender, health and civil status among others, with their legal and social status placing them as one of the most vulnerable and marginalised populations in Zambia.[850] Being mindful that there are some common experiences and needs that women inmates and women in the general population may have, this Chapter also draws some lessons from the experiences of women in the general population to explore how best to incorporate them into a participatory model for the health of women inmates in Zambia.

This study finds that women inmates' low social standing negatively impacts their enjoyment of health-related and citizenship rights.[851] Their health situation is part of their citizenship struggle. Citizenship for women inmates in Zambia determines the extent to which regulations and systems are established for the realisation of their human rights and interests. The recognition of women inmates' human rights, including their right to health, although better secured by law, is not dependent on the existence of legally prescribed provisions. By the very nature of human rights, human beings are entitled to health and other human rights merely on account of being human.[852] However, for human rights to be

[850] Republic of Zambia op cit note 11
[851] Marmot et al op cit note 9
[852] Anyangwe op cit note 305

enjoyed, the State must fulfil its obligations under international, regional, and national human rights frameworks.[853] These obligations may be legal and/or administrative.[854] In the context of the right to health, this study has shown that implementing legal and administrative interventions aimed at enhancing access to healthcare and participation in health decisions and programmes are cardinal for women inmates' enjoyment of health rights. From the study findings presented in Chapters five and six, the social determinants of health for many women inmates in Zambia may be addressed by women inmates as equal citizens and rights-holders, entitled to public goods and services that are relevant to them. Through their participation in health governance, women inmates can access public resources and assert their rights and interests as citizens.[855]

This Chapter makes a case for a woman-centred citizenship participation model for health for Zambian women inmates. It begins by justifying Zambia's need to adopt a woman-centred citizenship participation model for health realisable in the wake of the recently adopted corrective model. A discussion on the woman-centre citizenship participation model for health is then presented. Lastly, the Chapter considers how the woman-centred citizenship model for health could be implemented in Zambia.

7.1 REALISING A WOMAN-CENTRED MODEL TO CITIZENSHIP PARTICIPATION IN ZAMBIA'S CORRECTIONAL SYSTEM

Chapter five of this study showed that women inmates are largely excluded from the Zambia Correctional System with the consequence of, among others, limiting their enjoyment of their health rights and interests. They were not considered by the designers of the correctional system.[856] Considering the time in which the paradigm shift from a punitive model of the prison system to a hybrid model is occurring, one would assume that the Zambian correctional system would take into account women inmates' experiences to enhance the enjoyment of their health rights and citizenship status. This paradigm shift is happening at a time when there are so many women inmates in the Zambian prisons and thus, they should not continue being treated as a forgotten population.

[853] Resolution on Prisons and Conditions of Detention in Africa-ACHPR/Res. 466 (LXVII) 2020
[854] Article 1, ACHPR; Article 12, ICESCR
[855] Supra note 308, Para 54
[856] Baker and DIGNITY op cit note 10

As argued by Mcleod and Martin, it is important to know how prison health services are structured and funded and the processes by which they are held accountable as a means of addressing health inequities.[857] Women inmates' active participation in health has been hampered by the inadequate conceptualisation of the paradigm shift to the correctional model. One of the effects of a correctional model is that it improves attitudes of State officials, inmates, civil society organisations and the public at large on how they treat inmates.[858] The correctional model has the potential to make women inmates be viewed and treated as citizens entitled to fundamental rights and freedoms consistent with imprisonment.[859]

In a punitive model, however, women inmates are more likely to be viewed and treated as deviants to whom punishment for crimes must be meted out.[860] Various studies in Latin America, Nordic countries, California and England show the different models for prison governance in correctional and punitive criminal justice systems.[861] Although most of these studies are based on the experiences of men, they show how prisons can be organised using different governance models. In the Latin American countries where the presence of correctional officers is minimal, prisoners manage their own affairs to ensure access to necessary goods and services. In the Nordic countries where the State has prioritised the provision of essential public goods and services, correctional officers have a less militarised attitude towards inmates.[862] Not all the governance models shown in these studies depict best practices, but they show what works and what does not in contexts where prisoners govern as well as contexts where State officials govern. In essence, "high levels of variation in the governance practices are found to exist, not only between

[857] Katherine E Mcleod and Ruth E Martin 'Global prison health care governance and health equity: A critical lack of evidence' (2020) *AJPH*
[858] Augustine Mwangi Gatotoh, Briston E.E. Omulema and Dankitt Nassiuma 'Çorrectional Attitudes: An impetus for a Paradigm Shift in Inmate Rehabilitation' *International Journal of Humanities and Social Sciences* (2011)1:4 at 264 and 266
[859] David Skarbek 'The puzzle of prison order: Why life behind bars varies around the World'(2020) at 44-61
[860] Gatotoh et al opcit note 858 at 263
[861] Maximo Sozzo (ed) 'Prisons, inmates and governance in Latin America' (2022), David Skarbek 'The puzzle of prison order: Why life behind bars varies around the World' (2020) at 44-132 and Gillian Buck and Philippa Tomczak 'Prisoners regulating prisons: Voice, action, participation and riot' (2024) 24:1 *Criminology & Criminal Justice* at 144-163
[862] Ibid

countries but also within the same country, between prisons and within the same prison."[863]

Although the Zambian government shifted its prison paradigm to including a correctional model, the laws, policies and practices that regulate the Zambia Correctional Service have not been fully transformed to realise this paradigm shift. A punitive model that was developed and implemented with men in mind has been applied to women inmates for many decades with the disproportionate effect of negatively impacting on women's enjoyment of health rights as espoused in regional and international human rights standards. For example, many spatial designs of the prisons and prison procedures are not suitable for women inmates. Women inmates in the present study attested to the delays they experience in accessing health facilities when they fall ill at night due to the fact that they do not have in-built clinics within their premises like the male section does. Further, the keys for the prison cells are kept on the male section of the correctional facility, thereby complicating the unlocking procedures and delaying the response time for opening up the female cells where the patient is. Another example is where prison cells and procedures are ill-designed for women with children, pregnant women and women of child-bearing ages among others.

Make-shift attempts to incorporate women offenders into a correctional system designed for men curtails the promotion of women inmates' human rights and the holistic overhaul of the correctional system to provide for women inmates' unique needs. This, coupled with society's negative attitudes towards inmates resulted in women inmates experiencing discrimination at inter-sectional levels first as women, then as inmates and many other personal and social traits and dispositions. Women inmates experience discrimination on account of age, health, disability, immigration status, economic status and motherhood among others. At the time the legislative reforms to support the paradigm shift to correctional services were being conducted, women inmates' full and effective engagement in the process, which culminated in the enactment of the Zambia Correctional Service Act, was not facilitated.[864] While State and civil society respondents confirmed the participation of the ZCS in the law reform processes, neither could attest to whether

[863] Ibid
[864] Participants KU001, KA004

women inmates were consulted nor whether their views were presented by the ZCS representatives. Several institutional participants who took part in the law reform process indicated that they did not work on women inmates' health rights enough to represent their views in the process and only realised through this research study the different interventions their organisations could have done to include women inmates' views in the process and in other aspects of their work.[865] Although some State and civil society participants alluded to the paradigm shift of the ZCS from a punitive to a hybrid correctional model, there is insufficient evidence of this shift other than the name change. The Preamble to the Zambia Correctional Service Act states that it seeks to refine the functions of the ZCS, but does not provide reasons for this, making it difficult to understand the policy reasons for "seeking to refine the functions of the ZCS".[866] Anecdotally among women inmates and institutions working in correctional facilities, it is assumed that the change of name from the Zambia Prison Service to the Zambia Correctional Service is meant to facilitate the paradigm shift. An explicit explanation in the Preamble to the Zambia Correctional Service Act for the name change and the need to refine the objectives of the ZCS, as modern Zambian legislation tends to do with such types of legislation,[867] may have addressed the study respondents' conflicting views about the form and nature of the Zambian correctional model. The lack of common understanding of the alleged paradigm shift among inmates, correctional officers and State and non-State institutions working in correctional facilities could explain why the majority of study respondents felt that there has been very little change in correctional settings since the paradigm shift, with one woman inmate stating that "the change [from penal to correctional model for rehabilitating inmates] is only at headquarter level and has not trickled down to the correctional centres".[868] Another inmate averred that "the shift [from a penal to a correctional model] is only on paper and does not serve the needs and interests of women inmates."[869]

[865] Participants KU001, KU005, KU008, KA002, KA003, KA012
[866] Supra note 31, Preamble reads "an Act to continue the existence of the Zambia Prisons Service and rename it as the Zambia Correctional Service and redefine its functions…"
[867] See the Preamble to the Persons with Disabilities Act 2012, Gender Equity and Equality Act 2015, Mental Health Act 2019, Children's Code Act 2022
[868] Participant CC017
[869] Participant TC013

In its current form, the paradigm shift that incorporates a correctional model leaves a lot to be desired for women inmates as it still largely excludes their health interests and rights. This is particularly critical in the context where national laws and policies on women, health and citizenship contain generic provisions that are not tailor-made for women inmates. Although women inmates' needs have repeatedly been excluded from the Zambian correctional system, women inmates have not mobilised to assert their rights or advocate for access to public goods and services such as health. Instead, they have mobilised themselves to meet their basic needs. These findings align with those in a Californian women's prison which show that women inmates tend to stick to a code of conduct on prison behaviour and will generally not engage in any conduct that appears as deviant, but will set up "self-governing prison regimes with decentralised extralegal governance institutions".[870] Zambian women inmates have felt that this approach, although helpful for meeting their immediate needs, distances the government from the inmates and lowers their citizenship status and rights that flow from it. In view of the above, a woman-centred citizenship participation model is proposed that seeks to ensure women inmates needs and experiences are reflected in the correctional health governance system in Zambia. Details of the model are provided in the next section.

7.2 WHAT IS A WOMAN-CENTRED CITIZENSHIP PARTICIPATION MODEL TO HEALTH FOR WOMEN INMATES?

At the core of any approach to promoting and protecting health rights in Zambia is the realisation of the best or highest attainable standard of physical and mental health. This is the standard set by international and regional human rights norms applicable to Zambia.[871] To achieve this standard, health goods and services must be available, affordable, acceptable and of good quality (the 3As and Q). International and regional human rights treaties and their enforcement mechanisms do not explain what the 3As and Q would look like in the context of women inmates, other than providing generic provisions in the Bangkok Rules.[872] For women inmates in Zambia, the 3As and Q can promote the best attainable standard of health through a woman-centred citizenship participation model to health. The woman-centred citizenship participation model for women inmates' health is

[870] Skarbek, D op cit note 859 at 90-105 at 95
[871] Supra note 841
[872] See discussion in Chapter three of this thesis

formulated by synthesising the findings from study respondents and drawing on the theories of citizenship participation. It consists of three elements and six sub-elements. The first element uses the feminist lens to amalgamate the rights-based approach and the citizenship participation. The second element fosters effective partnership between women inmates and the State in promoting the goals of a political or social governance agenda such as health. The third element promotes a systematic, active and woman-centred participation in health governance. The above three elements are underpinned by the following cross-cutting sub-elements: a) women inmates' agency b) visibility c) accountability and transparency of the State to women inmates as citizens d) inclusion and e) recognition of the diversity of women inmates. The three elements of a woman-centred citizenship participation model for women inmates' health are discussed below, along with a discussion of the sub-elements.

7.2.1 Amalgamating the human rights-based approach and Citizenship participation approach through the feminist lens to promote women inmates' participation in health governance

This aspect of the woman-centred citizenship participation model to health acknowledges the need to take into account women inmates' current and historic experiences to facilitate their access to healthcare and participation in health-related governance.[873] The 3 A's and Q cannot be fully realised without due consideration of women inmates' preferred spaces for participation and their barriers to the enjoyment of health-rights.[874]This study shows that the correctional system is predominantly State-centred, with the State dictating forms of women inmates' participation in health governance. Further, study respondents' views show that the State's approach to health promotion in women's correctional facilities is predominantly medical. A 'medical-centred approach' to the right to health not only limits the full enjoyment of the right, but also negatively impacts spaces for their participation and inclusion in health-related decision-making and programming. The main form of participation in a medical-centred approach constitutes seeking medical attention for illness, providing consent to treatment or medical procedures and one's willingness to take their medication. A rights-based approach to health offers broader opportunities for citizenship participation in health as it allows for involvement of rights-holders in health-

[873] Preece op cite note 100 at 31
[874] Akiyode-Afolabi op cit note 274

related decision-making and programming even when one is not ill. The amalgamation of rights-based approaches and feminist approaches create a paradigm for promoting women inmates' health rights which enables them to know and assert their rights. It also empowers women inmates to respond to health-related discrimination and demand public goods and services as deserving citizens of Zambia. This view is in line with the findings of Brosens who observes "[m]any of these people are not able to make contact with social services or to engage in participation opportunities available outside. When participation opportunities are offered in prison, imprisonment can act as a circuit-breaker."[875]

Human rights theories recognize the inherent and inalienable rights of human beings regardless of their status or personal traits.[876] However, many human beings do not fully enjoy their rights and are subjected to social exclusion, limiting their enjoyment of rights as well as public goods and services provided to citizens. Being one of the most vulnerable groups in Zambia, women inmates disproportionately suffer the effects of social exclusion that comes with imprisonment. One effect of this is the limited access to healthcare and health determinants. This is exacerbated by the fact that most health goods and services provided in Zambian correctional facilities are designed for men.[877]

While human rights theorists believe in rights for all, social exclusion is one of the major concerns for feminist citizenship scholars.[878] Women inmates may be socially excluded in at least three ways. Firstly, they may be discriminated against by non-provision of public goods and services such as health care, sanitary pads or child-care services forcing inmates to devise normative standards of behaviour that help them access their basic needs.[879] Secondly, they may be discriminated against through the provision of a relatively lower standard of public goods and services in comparison to the general population. For example, the ZCS approach to addressing GBV against women inmates falls short of the more protective measures of the Anti-Gender Based Violence Act[880] applicable to the women in the general population. If women in the general population are

[875] Dorien Brosens 'Prisoners' participation and involvement in prison life: Examining the possibilities and boundaries' (2019) 16:4 *European Journal of Criminology* at 480
[876] Baker and DIGNITY op cite note 10
[877] Ibid
[878] Akiyode-Afolabi op cit note 274
[879] This was shown in this study as well as studies conducted among female inmates in Californian prisons as per Skarbek supra note 859
[880] Supra note 396

able to access information on GBV complaints procedures, lodge complaints and seek redress for the violence they suffer, women inmates must be able to equally exercise these rights within their context of imprisonment. The relevant systems must be devised in law to facilitate this kind of participation by women inmates. The Anti-Gender Based Violence Act not only provides for access to justice for survivors of GBV, but also entitles them to access healthcare for both physical and mental health.[881] This allows both the individual survivor of GBV and the State to take steps for ensuring health promotion for the GBV survivor. The Zambia Correctional Service Act must be amended to align its provisions on GBV to the Anti-Gender Based Violence Act. This is because the Anti-Gender Based Violence Act is progressive and contains women-centred systems for addressing gender-based violence.

Thirdly, women inmates may be discriminated against by failure to acknowledge their unique needs and treating them the same as other members of society in the provision of public goods and services. Feminists argue that the universal approach to citizenship undermines the recognition of diverse groups of citizens who do not fit in the mainstream category.[882] This assertion proves true for women inmates in Zambia as evidenced by this study's findings. In this study, it is shown that the situation of women inmates in Zambia varies depending on the correctional facility in which they reside, whether they are serving a death sentence or not, the type of illness they have, access to health goods and services and other determinants including proximity to health facilities, access to family and other visitors, the status of the inmate as a mother and caregiver, existence of a disability, terminal illness or legal status as an illegal immigrant. Other determinants of health for women inmates established by this study and previous studies[883] include the relationships between inmates and correctional officers, social networks with other inmates and the correctional system itself. These considerations position women inmates in Zambia differently from women in the general population to manage their health outcomes. Hence the need for an approach to health governance that recognises their unique positions and characteristics.

[881] Ibid, Section 5
[882] Ibid. See also Kabeer op cit note 170, Preece op cit note 100
[883] Topp et al op cite note 19

Whereas the human rights approach sets a standard for the enjoyment of rights, promotes inclusion and empowerment of human beings to assert their rights,[884]a feminist approach to citizenship promotes the use of lived experiences to shape how rights are claimed and enjoyed.[885] Feminist and human rights theorists both view the law as a mechanism by which human rights may be promoted. However, feminists also view the law as a site of power which is not easily accessible to vulnerable groups like women inmates. They propose women-centred interventions that enable women to effectively engage with the law and use it to protect their rights. These interventions differ depending on the women involved and their power or lack of it to use the law. By amalgamating feminist theories of rights and citizenship, women inmates can be included in a correctional health system that recognizes their diversity, rights and interests and empowers them to claim their rights. From the study findings, women inmates' limited understanding of health rights couched in terms of the medical approach has the effect of limiting their realisation of health rights. As Chapter five shows, health determinants of women inmates would be better realised if women inmates were meaningfully involved in identifying their health determinants, knowing their health rights and exploring solutions to realise them. This would cultivate active citizenship for health promotion as demonstrated in Chapter three.

Although the Zambia Correctional Services Act contains some progressive provisions, as shown in Chapter three, these provisions are insufficient for implementing a woman-centred citizenship participation model for women inmates' health. This is because many health determinants for women inmates are subject to a myriad of laws and administrative systems that do not favourably respond to the health determinants. Anchoring prison legislation within the broader regulatory framework helps to ensure that laws, policies, institutional and administrative interventions support the creation of a conducive regulatory environment for establishing and maintaining women inmates' participation in health. As expressed by many women inmates in the study, the realisation of women inmates' health rights requires collaboration and coordination among various government line ministries, and quasi and non-governmental institutions. If neither the

[884] Anyangwe op cit note 244 at xi-xii

[885] Robtel Neajal Pailey *Women, equality and citizenship in contemporary Africa* 26th April 2019 University of Oxford available at https://doi.org/10.1093/acrefore/9780190228637.013.852

regulatory framework for correctional settings nor the broader national regulatory framework on women's rights, gender equality and health firmly establish mechanisms for collaboration and coordination among governmental and non-governmental institutions, as is currently the case, women inmates will continue to be rendered invisible in the correctional health governance system and will always have to fight for equal recognition.[886]

Chapters five and six show that there are opportunities for asserting rights for women inmates through spaces for their participation such as the daily complaints forum, use of complaints tables, monitoring visits, peace clubs and use of representatives. Women inmates' opportunities for asserting rights may enhance their recognition as rights-holders within the Zambian regulatory framework. It should, however, be noted that asserting rights come at a high cost for most women inmates.[887] Examples of cost associated with asserting rights include the financial costs of litigation and other forms of dispute resolution, the social cost of being identified as inmates through such public spaces as courtrooms and the long duration of time associated with asserting rights among others. As argued by feminists such as Carol Smart, asserting rights is a daunting task for persons whom they were meant to protect.[888] In the end, marginalised and vulnerable groups like women inmates fail to enjoy protection created by human rights frameworks. Thus, creating a regulatory framework which from the onset recognises women inmates as rights-holders and empowers them and duty-bearers to facilitate the enjoyment of such rights is cardinal. This entails that women inmates and State actors must collaborate to minimise women inmates' vulnerability and firmly endorse them as entitled to the enjoyment of rights on any equal basis as members of general population society.[889]

7.2.2 Second element: Fostering effective partnership between women inmates and the State

One of the social determinants of women inmates' health which is not adequately addressed in the Zambian correctional facilities is women inmates' relationships with each other, correctional officials and State and non-State actors. From the study, women

[886] Topp, Sharma,Chileshe op cit note 125
[887] Buck and Tomczak op cite note 856 at 149
[888] Smart op cit note107 at 144-146
[889] Buck and Tomczak op cit note 856

inmates' relationship with non-State actors is relatively good considering that many of their medical supplies and other health determinants such as soap, sanitary pads, food and health information are provided by non-State actors. Women inmates' relationships with the State, including correctional officers, is not as good, with some inmates describing it as "non-existent".[890] The State has obligations at national and international levels to ensure enjoyment of human rights and citizenship rights by women inmates. This means State institutions, quasi-government institutions and their officers must establish relations with women inmates guided by values that guarantee mutual benefits for the women inmates and the State.[891] From the views of the study respondents shared in Chapter five, such values would include mutual respect and commitment, recognition of the dignity of the weaker party (i.e. women inmates), active participation and accountability. A partnership between the State and women inmates must thus reflect equal commitment to establishing an effective and mutually beneficial relationship.

Inmates' health and health-seeking behaviour is often influenced by relational factors which determine the distribution of powers, privileges, and access to resources.[892] In addition, women inmates often indulge in relationships and social networks to have access to healthcare and health determinants such as food, medicines, visitation privileges and communication with family.[893] From this study's findings, it is evident that many women inmates do not have the opportunity to influence health-related decisions and programmes unless they possess the requisite power. This leaves them vulnerable to health-rights violations. Since access to healthcare forms a big part of women inmates' citizenship struggle, it is necessary to legally recognise women inmates' participatory rights in health.[894] Effective partnership between the State and women inmates would also enhance the forms and quality of spaces for women inmates' participation in correctional facilities. Doing so would enhance access to State-sanctioned healthcare, which is accessible, available, affordable and of good quality. Effective partnership between the State and women inmates would enable women inmates put their health issues on the

[890] Participants TC006, CC017
[891] Buck and Tomczak op cit note 856
[892] Topp et al op cit note 19 at 6
[893] Ibid
[894] Butler J 'The Force of Nonviolence: An Ethico-Political Bind' (2021) at 24 . see also Buber, M 'Between Man and Man' (1985)

national agenda. Women inmates would also be in a better position to learn about government's agenda for addressing their health needs and the challenges that the State experiences in meeting women inmates' needs. Effective partnership between the State and women inmates thus has the potential to facilitate better health outcomes for women inmates by acknowledging women inmates as rights holders entitled to claim their health rights like any other citizen of Zambia.

7.2.3 Third element: Promoting systematic, active and woman-centred interventions for participation in health governance

Existing laws, policies, administrative practices and systems for women inmates' health do not create an enabling environment for women inmates' effective participation in health governance in Zambia. The Zambian legal framework contains a few progressive legislative provisions for promoting women inmates' health rights as discussed in Chapter three. However, there are some gaps in the law such as making access to health services a duty of correctional officers without legally recognising women inmates' right to health thereby failing to clearly stipulate women inmates' legal entitlement to health rights. Another gap in the law is the failure to legally establish formal and inform spaces for women inmates' participation in health governance. Whereas systems and procedures for effective participation in health governance have been created in general laws for women in the general population, no equivalent mechanisms exist for women inmates. Due to these gaps in the law, women inmates' effective participation in health decisions and programmes is sporadic and often not driven by women inmates themselves. As evidenced by the views of study respondents in Chapter five, the Zambian correctional system has largely insufficient systems for rectifying the historical social exclusion of women inmates and facilitating their inclusion in health-related decision-making and programming.

The women inmates' views on the impact of State-centred health services and programmes in Zambian correctional centres discussed in Chapter five demonstrate that benefits of such programmes are often misconstrued by outsiders. Women inmates who are not HIV positive think State interventions for HIV positive inmates are comprehensive. Similarly, inmates who are neither pregnant nor have children in prison with them construe expectant mothers and those with children in prison with them as being better cared for by the State. On the other hand, women inmates targeted for these

State interventions find them ineffective. HIV positive inmates lament about the poor food they are subjected to, even if it is considered by the State and other inmates as a special diet. They also lament about the limited access to treatment for opportunistic infection in comparison to the abundance of the State-provided ante-retro viral drugs. Similarly, expectant mothers and women with children in prison are allocated their own prison cells, but these are equally crowded and not suitable for them. The food provided by the State is not sufficient for them and often not appropriate for small children. Inmates who are not experiencing the effects of State-centred health services and programmes, including the single agency administrator who plans and implements them, often view such services and programmes as yielding good results. However, the women inmates targeted for such services and programmes do not fully appreciate them due to their limited impact. As a result, a State-centred approach to health fosters a poor implementation of health programmes and services and decreases their effectiveness.

The State-centred approach used by the Zambia Correctional Service has a limited impact on women inmates' health rights as it does not take into account the views and experiences of women inmates in the design and implementation of State services and programmes. This depicts what Shammas refers to as "defects of total power." [895] Although the State has the power to make the health programmes in prisons, the prisoners have the power to ensure their success or failure.[896] For women inmates in Zambia, curing the 'defects of total power' entails, among others, consistent participation of women inmates in correctional health governance systems.

The consistent participation of women inmates in health governance cannot be dispensed with in a woman-centred citizenship participation model for health.[897] The experiences shared by study respondents show that the haphazard engagement of the State with women inmates yields minimal results. Thus, to yield the best attainable standard of health based on health goods that are accessible, available, affordable and of good quality, the engagement between the State or its agents and women inmates or their agents must be consistent. Such consistent engagement between the State and women inmates also has the

[895] Victor L Shammas 'Sykes: The Society of Captives' (2017) *The Encyclopedia of Corrections* at 2
[896] Ben Crewe 'Power, Adaptation and Resistance in a Late Modern Men's Prison' (2007) *British Journal of Criminology* 47 (2) 256-275 at 272
[897] Gatotoh, Briston & Dankitt op cite note 858. See also Jeremy Sarkin op cit note 916

potential to strengthen citizenship.[898] If either party lacks capacity to meaningfully engage in health governance, the rights-based approach must be employed to build their capacities as discussed in Chapter six.

The State and women inmates should jointly formulate regulations and other interventions that are friendly to women inmates and that facilitate their effective participation in correctional health governance.[899] Considering that women inmates have largely been invisible in the Zambia Correctional Service, the need to use participatory decision-making opportunities to ensure that health interventions are targeted at women inmates' needs and experiences cannot be overemphasized. There is also a need to protect women inmates' human rights to health, dignity, expression and their citizenship rights to achieve greater health equity. Women inmates are not a homogeneous group. They experience discrimination on account of their individual identities and circumstances as well as on account of being women inmates. Promoting health equity in Zambian correctional facilities helps to give voice and visibility to women inmates with different identities and circumstances and address their experiences of health-related discrimination in relation to male inmates and women in the general population.

A partnership between the State and women inmates also has the potential to increase the State's transparency and accountability to women inmates for health interventions. Such transparency and accountability may be achieved through the creation of systems and regulations akin to other democratic spaces like voting in national elections, citizens' participation in law-making and budgeting, town-hall discussions, and the President's reporting to Parliament and the public on the progress of realizing Constitutional values and principles. International and regional human rights treaties provide only the first steps in offering women inmates the protection needed for the enjoyment of human rights and citizenship. Treaties on the right to health guide States on the steps to take to achieve the highest attainable standard of physical and mental health through the enactment of legislative provisions and implementation of supportive administrative measures. Part of the standards provided in international human rights instruments include the realisation of health rights through participatory interventions as

[898] Ibid
[899] Ibid

discussed in Chapter three of this thesis. In the next section, supportive administrative measures for enhancing women inmates' health rights in Zambia in line with international and regional human rights treaties are presented.

7.3 HOW TO IMPLEMENT A WOMAN-CENTRED CITIZENSHIP PARTICIPATION MODEL TO HEALTH FOR WOMEN INMATES IN ZAMBIA

The woman-centred citizenship participation model for women inmates' health is not simply about adaptations of prisons to include women's health needs, interests and rights. It is about overhauling of the Zambia correctional system to address correctional laws, procedures, practices and systems that pose health risks to women inmates and prevent women inmates from enjoying their health rights on an equal basis with others and in line with international and regional human rights instruments. Thus, under this model, what happens with the male inmates is not a core measure for what should happen for women inmates. Their experiences are different and so are the requirements to achieve the best attainable standards of physical and mental health for them. To achieve a woman-centred citizenship participation model to health for women inmates in Zambia, several complementary measures must be put in place, which are discussed next.

7.3.1 Formulating standard-setting norms for participation in health in correctional settings

One of the major challenges women inmates face in the correctional health governance system is the lack of or limited norms for them to participate in decision-making and programmes.[900] The United Nations and African Union, like many other human rights political organisations, often hold the view that human rights are best protected in laws, policies, and practice.[901] Protection of the right to health is thus often done through the promulgation of law, policies, and administrative systems. However, as was shown in Chapter three, the Zambian legal framework largely does not create a women-friendly environment for the protection of health rights for women inmates, and more specifically their right to participate in health governance. Further, Chapter five showed that correctional health facilities have limited spaces for women inmates to effectively

[900] Skarbek op cit note 859

[901] Ebenezer Durogaye *An analysis of the contribution of the African human rights system to understanding of the right to health* (2021) 21 African Human Rights Law Journal 441-468 available at https://dx.doi.org/10.17159/1996-2096/2021/v21n2a30

participate in health decisions and programmes. Many study respondents felt that this was because of the gaps in the correctional law that perpetuate women inmates' low social standing and render them invisible thereby violating their health rights. Addressing the gaps in the Zambia Correctional Service Act and the negative attitudes that perpetuate the treatment of women inmates as second-class citizens are critical for promoting women inmates' participation in health decisions and programmes as discussed below.

a) Strengthening Zambia's legislative response to women inmates' participation in health governance

The Zambia Correctional Service Act should be amended to provide for women inmates' right to participate in health decisions and programmes. This will set clear standards for women inmates' participation in health decisions and programmes that are supported in law. The modern trend in drafting laws affecting vulnerable groups in Zambia embody fundamental rights of the targeted vulnerable groups. This is so even in the absence of constitutional guarantees of fundamental rights. For example, the Children's Code Act provides for "rights and responsibilities of the child",[902] the Mental Health Act provides for "legal capacity and rights of mental patients,"[903] the Persons with Disabilities Act provides for "rights of persons with disabilities"[904] and the Gender Equity and Equality Act provides for various human rights in the promotion of gender equality, including the right to political and public participation.[905]

All of these statutes provide for the right to participate in decision-making or the right to public and political participation by children, women and persons with disabilities. The statutes further use historical experiences of discrimination against children, women, and persons with disabilities to proscribe discrimination in their enjoyment of the right to participate in decision-making. For example, the Gender Equity and Equality Act guarantees to a woman, "on an equal basis as a man, the right to participate in public decision making and formulate and implement Government policies and programmes."[906] This recognises women's historical discrimination in relation to men in public decision making and in the formulation and implementation of government policies and

[902] See Part II of Act no. 12 of 2022
[903] See Part II of Act no. 6 of 2019
[904] See Par II of Act no. 6 of 2012
[905] See sections 14, 24 and 29 of Act no 22 of 2015
[906] Ibid at Section 29(1)(b)

programmes.[907] Similarly, the Persons with Disabilities Act requires adjudicating bodies to take into account the condition of a person with disability to facilitate their effective participation in the proceedings and enhance their enjoyment of the right to access to justice.[908] This recognises the historical discrimination against persons with disabilities in the justice sector that prevented them from actively participating in asserting their legal rights on an equal basis as others in society.

By contrast the Zambia Correctional Service Act of 2021 does not expressly guarantee rights to inmates generally and to women inmates more specifically. Instead, like its predecessor, it provides for "functions, powers and privileges of correctional officers", "admission and control of inmates", "discipline of inmates" and other aspects of administration of correctional facilities. This legislative framework for correctional facilities reinforces the negative attitudes towards women inmates that perpetuate their treatment as second-class citizens in the Zambian society.

By legally endorsing women inmates' equal entitlement to human rights, an enabling environment can be created for shifting negative social attitudes about women inmates to more positive attitudes that acknowledge women inmates as rights-holders entitled to assert their rights.[909] The study findings reveal that negative social attitudes against women inmates perpetuate their low human rights and citizenship status and serve as a barrier for their participation in health-related decisions and programmes at individual and community level. Similarly, women inmates' self-stigma and the stigma and discrimination they experience at the hands of correctional officers and other State actors as well as members of the public negatively impact on women inmates' ability to participate in health governance. Some women inmates submitted that they did not feel worthy to participate in health decisions and programmes or make any demands on the State since they had committed offences. Others felt that the State does not care about them and therefore has not established mechanisms for women inmates to share their views on their health rights and interests and the challenges they experience in the correctional facilities. Women inmates also felt that correctional officers were often not supportive of inmates participating in State and CSO-facilitated consultation programmes

[907] Tsanga and Stewart op cit note 489
[908] Section 8 of Act no. 6 of 2012
[909] Shammas op cit note 895 at 2-3

aimed at documenting their views and experiences on health-related issues in the correctional facilities. These experiences reinforced the perception among many inmates that their views do not matter.

Creating legally sanctioned systems for participation of women inmates can be useful to mitigate the barriers to participation for women inmates. It should be noted however that general legal provisions such as constitutionally guaranteed rights may also be a pathway for advancing women inmates' participation in health. For example, women inmates' freedoms of expression, association and assembly may be invoked to assert the establishment of peer support groups even though these are not provided for under the regulatory frameworks applicable to correctional facilities. As shown in Chapter three, the Zambian cases of *George Peter Mwanza and Melvin Beene v. the Attorney General*[910] and *Godfrey Malembeka v. The Attorney General and the Electoral Commission of Zambia,*[911] are illustrative of how general provisions from the Constitution have been used to assert specific rights for prisoners in Zambia. In the *Malembeka case* the Constitutional Court held that the right to vote is guaranteed to all Zambians aged 18 years and above, holding a green national registration card (NRC).[912] Sections 8, 9(e), and 47 of the Electoral Process Act[913] proscribe inmates from voting. The court relied on article 46 of the Constitution and other constitutional provisions to find that sections 8, 9(e) and 47 of the Electoral Process Act were unconstitutional. The Court took a holistic approach to interpreting article 46 of the Constitution on citizen's rights to vote and extended its protection to inmates. Similarly in the *Mwanza case*[914] the Court upheld the right to food and health of inmates as an extension of the right to life. Although the right to food and health are not guaranteed in the Zambian Constitution, the right to life is guaranteed. HIV positive inmates petitioned the Court for, among others, a declaration that the failure of the Zambia Correctional Service to provide adequate food to HIV positive inmates negatively impacted on their health and thus threatened their right to life.[915]

[910] Supra note 401
[911] Supra note 460
[912] This is the national identification document issued to citizens by the Zambian government
[913] Act no. 35 of 2016
[914] Supra note 401, para 13.10
[915] Ibid, para 16.2-8

The petitioners in both the *Malembeka* and *the Mwanza cases* relied on generic constitutional provisions on the right to vote and the right to life. Neither the Constitution nor the Zambia Correctional Service Act expressly provide for specific rights of prisoners including their right to vote and their right to food. Prisoners' right to vote and right to food were upheld by the Court even in the light of the weak legal framework on prisoners' rights. It is undisputed that weak regulatory frameworks potentially limit the impact of health programmes that are implemented in correctional facilities, especially in contexts where women inmates are viewed as less deserving of legal and human rights. As was noted by several study respondents, including women inmates, health interventions that are generic to the general population have limited impact on women inmates on account of their status as inmates. This is because generic programmes do not respond to women inmates' lived realities of seclusion, discrimination, limited access to resources and unique health requirements compared to circumstances of women in the general population.

Further, the importance of having specific regulatory provisions for correctional facilities was buttressed by study respondents who felt that correctional officers are more responsive to the laws and policies that are prison-based and relatively more open to facilitating women inmates' participation in health through prison-based regulations.[916] General laws may attract hostility from correctional officers on account that they are not meant for correctional settings. This could have the impact of punishing inmates for attempting to assert their rights within the correctional facility and ultimately discouraging women inmates' participation. As already illustrated, if implementation of health decisions and programmes is received with hostility by correctional officers, women inmates do not feel safe enough to rely on generic laws like the constitutional protection of freedom of expression.

Another issue worth noting is that formal laws and policies are not always well suited to respond to barriers that women inmates face in participating in health governance. This is because women inmates often have little to no access to laws and policies thereby limiting women inmates' ability to assert their legal rights. Women inmates who participated in this study attested to the fact that they do not use laws and policies to assert their rights. This was in part because they did not know the relevant laws

[916] See study findings in Chapter five of this thesis

and in part because they feared punishment from correctional officers who perceived assertion of rights as deviant behaviour and disrespectful to authority.[917] Despite this, some women inmates identified the law as being cardinal for facilitating their participation in health decisions and programmes. They felt that if the law contained provisions that permitted women inmates to participate in health-related decision-making, then they would do so.

One way of addressing ignorance of the law as a barrier to the use of formal laws by women inmates' is to empower them to participate in law and policy making.[918] When women inmates participate in law making and policy making, they become aware of the regulations and are more likely to use them. Further, when women inmates participate in the formulation of laws and policies, the quality of such regulations would be enhanced for the benefit of women inmates. This is because the regulations would reflect matters that are relevant for women inmates and would be a product that arises from a process of mutual learning.[919]

It is interesting to note that women inmates who were not able to cite any relevant laws that impact on their participation in health governance somehow felt that there is no existing law to facilitate such participation. In line with the views of some study respondents, this position by women inmates stems from their own experiences of what is permitted in the correctional facilities. It appears that women inmates perceive acceptable standards of behaviour in correctional facilities as having been set by law. Their experience of the law is determined by the behaviour of State officials and their agents, especially correctional officers. If correctional officers, cell captains and long-serving inmates accept an inmate's behaviour, then the inmates assume that that behaviour is in accordance with the law. If they reject an inmate's behaviour, then the inmates assume it is against the law.[920] Women inmates could participate in law-making by making submissions on a proposed law to the Zambia Law Development Commission. The Commission would have to visit correctional facilities in a similar manner to how it visits communities and holds stakeholder consultations in their ordinary law-making processes.

[917] See Participant TC004 and Observation note 1 of 27th November 2019
[918] Observation note 1 of 27th November 2019
[919] Czapansky, Syma and Manjoo op cit note 303
[920] Participant TCT004

Women inmates could also participate in law-making through their representative CSOs or engage with their local Member of Parliament in the area where the correctional facility is located. Additionally, most women inmates perceived 'the law' as being the correctional law, the law that is expressly applicable to correctional settings. Many of the women inmates' submissions were couched in the language of 'them' versus 'us', referring to correctional officers (or other State officials) versus women inmates. Others used the language of 'in here' versus 'out there' referring to regulations affecting women inmates versus the regulations affecting the general population. For example, one inmate stated that "laws about prison must not be made without women inmates as we know what we experience and what kind of legal protection we need more than people who have not been incarcerated."[921] This participant viewed prison laws as laws regulating inmates and therefore such laws were a preserve of inmates. She neither viewed other laws in the same light as prison laws nor did she see the importance of women inmates participating in the development of other laws of general character that potentially impacted on them. Similarly, other inmates averred that "in here there is nothing we can do to change our situation"[922] and that "in here everything is in the hands of the Officer-in-Charge."[923] An institutional participant augmented these views by stating that "for women inmates, what the correctional officers say is the law."[924]

It is evident that informal rules on when women inmates can participate in health-related decisions and programmes are as important as formal rules in setting acceptable legally-binding standards. This study shows that where formal rules are lagging, practices emerge to fill in the gaps. Thus, if the formal law is silent on how often and in what manner women inmates may communicate with their family members, the correctional officers will promulgate rules for this purpose or a practice may emerge in the correctional facility on acceptable communication with family. This not only subjects women to the dictates of correctional officers, but also creates different standards across correctional facilities without just cause. For instance, within one facility, different prison rules regulating the involvement of women inmates' in health-related decisions were made by

[921] Participant TCT004
[922] Participant CC022
[923] Participant CCT023
[924] Participant KU008

two successive Officers-in-Charge (OICs). Women inmates who lived through the tenure of both OICs were able to compare which rules were more favourable to them and which OIC they preferred having in their facility. Similarly, women who had been imprisoned in more than one facility were able to compare prison practices that impacted on their health between the different facilities and determine which facility had "better food" than the other[925] or which facility "enabled women inmates to easily communicate with their family" than the other.[926]

It should be noted that some of the practices that comprise the informal laws were positive for facilitating women inmates' participation in health governance. One example is the practice of creating prison health committees consisting of inmates, civil society organisations and correctional officers to collectively address emerging issues impacting on prison health and other living conditions. Some of the practices were, however, negative. For example, the shifting of responsibility for correctional health and sanitation from correctional officers to cell captains without prescribing such responsibility in formal rules.[927] These experiences of the law speak to the need to ensure that the plurality of laws obtaining in correctional facilities create a conducive regulatory framework for women inmates' participation in health decisions and programmes.

To regulate the development of favourable practices that enhance women inmates' participation in health decisions and programmes, all practices that develop must be subject to administrative law principles of fairness, reasonableness, and due process. Since such rules are usually developed using discretionary powers of OICs, the same principles of administrative law on the use of discretionary powers must be adhered to by the OICs and checked using established administrative law procedures.[928] Legal and administrative procedures, whether formal or informal, cannot be arbitrary. If practices emerge which, in essence, have the same force of law or have an even greater impact than the formal law, they should at the very least be subjected to similar controls. Allowing all administrative rules and resultant practices to exist without checks and balances has the potential to circumvent the legal protections offered to women inmates. If administrative rules and

[925] Participant CC022
[926] Participant CC014
[927] Participant TC006
[928] Patel v. Attorney General (1968) ZR 99 at 128-129; Pumbun and Another v. Attorney General and Another (1993) 2LRC 317

prison practices that emerge from use of discretionary powers of OICs fail to comply with the control measures, they must not be upheld by the State and must be challengeable through administrative and judicial procedures.[929] Systems for such challenges should be created within the correctional facilities as discussed later in this section.

The Zambia Correctional Service Act grants wide powers to the OIC, correctional officers and correctional medical officers without setting adequate limits on the use of such powers thereby stifling the voice of women inmates in correctional health governance. It is not sufficient to assume that administrative rules for challenging excessive uses of power are available to women inmates as women inmates are often incapable and, in most cases, are unwilling to confront correctional officers and other State officials. The guiding principles of Zambia Correctional Service stipulated in the Act are instructive on treatment to be accorded to inmates. In particular, the principles requiring the ZCS to adopt least restrictive measures for protecting society; the principle requiring the respect for inherent dignity and value of human beings, the principle recognising the retention of rights of citizens by inmates and the principle recognising the need for "correctional decisions to be made in a fair and forthright manner, with access by an inmate to an effective grievance procedure." [930] The guiding principles can thus be useful, if supported by substantive provisions recognising women inmates' human rights, for curbing abuse of power in respect of both formal and informal spaces for participation in health. In the next section, the spaces needed for women inmates' participation are analysed.

b) Creating spaces for women inmates to participate in health decision-making and programmes

As provided in the Gender Equity and Equality Act "all public and private bodies shall, within their ambit of responsibilities, develop special measures to…attain meaningful participation of women in decision-making structures." [931] It is thus envisaged that the Zambia Correctional Service, as a public body, will facilitate women inmates' participation in health decisions and programmes. The previous section shows that formal and informal spaces for women inmates' participation in health decisions and programmes

[929] Dawn Oliver 'Common values and the Public-Private Divide' 1999
[930] Section 4 of the Zambia Correctional Service Act no. 37 of 2021
[931] Section 24 of the Gender Equity and Equality Act no 22 of 2015

must be prescribed in law and policies to secure women inmates' participation. For formal spaces, laws and policies must prioritize dialogic forms of participation. From the study, it was evident that women inmates' most common forms of participation are dialogic. Thus, the Zambia Correctional Service Act and correctional policies should prescribe oral communication to cell captains and correctional officers on one's health needs, women inmates' participation in monitoring visits by visiting justices and other State and non-State actors, use of table complaints,[932] use of peer educators, and peace club activities[933].

Prescribing spaces of participation will help set standards on how these spaces are used and promote the State's involvement. When prescribing spaces for women inmates' participation in health, women inmates must be engaged and possibly be in the forefront of defining what women-friendly spaces entail. For example, since lack of privacy in existing spaces for participation is a major concern for women inmates, the Zambia Correctional Service Act may provide that in all spaces for women inmates' participation in health decisions, privacy and confidentiality is paramount. It can also prescribe instances in which privacy and confidentiality may be waived or restricted. This way, women inmates and State institutions know what to expect in these spaces, thereby creating a more transparent and user-friendly environment for realising women inmates' participation in health.

When prescribing women inmates' spaces for participation in health, due consideration must be given to their diverse needs and capabilities. Correctional laws and policies must provide for individual, communal and public participation of women inmates as discussed in Chapter 2. None of the women inmates experienced public participation and thus could only discuss the forms of participation they had experienced at individual and community level within the correctional facility. Some institutional participants, however, identified some spaces in which women inmates can participate at the public level. For instance, the Zambia Correctional Service Act or policies of the Zambia Correctional Service must prescribe how women inmates' views on the national budget will be solicited for consideration by the State. Facilitating women inmates'

[932] Desks set up by quasi-governmental and non-governmental organisations for addressing inmates, including health-related complaints (see Chapter five of this thesis)

[933] Clubs set up by NGOs to encourage women inmates to resolve any disputes they may have among themselves (see Chapter five of this thesis)

participation in the national budget can help carry their voices into the national budget and facilitate women-centred responses to their health needs and determinants. Like the law-making process, the Ministry of Finance can hold budget consultation sessions in correctional facilities as it does with members of the public.

The regulatory framework could provide for direct participation or participation through their women inmates' representatives. The regulatory framework may also provide for how women inmates make submissions to Parliament on proposed laws that impact on their lives, including through female parliamentarians who are presumed to relate better with issues affecting women inmates. Some study respondents indicated that organisations of ex-prisoners are often invited to make submissions to Parliament on proposed laws. These organisations must be obliged to obtain women inmates' views on matters that affect them. Further, the State must also provide for direct submissions from women inmates through mobile hearings of Parliamentary Committees which would require them to visit correctional facilities in the same way as when they are conducting study or monitoring visits in correctional facilities. A representative or representative groups can be selected from among women inmates to speak on behalf of the women inmates. The participation of civil society organisations and the direct participation of women inmates could address the concerns of women regarding self-regulation as women inmates would be able to exercise agency in matters that affect them. Internal representatives from among women inmates and external representatives from among parliamentarians and other interest groups can also help address issues relating to the legitimacy of the representatives' actions and the representation of the voice of women as they would have women inmates' authority to represent their views and ensure that they are considered in the formulation of the national agenda.

Women inmates come and go from one facility to the next and from correctional facilities back into society.[934] Their experiences and needs are different within correctional facilities. In furtherance of the creation of meaningful spaces for participation for women inmates supported by the woman-centred model for citizenship participation in health, it is important to continuously refine the standards and spaces for such participation. This requires that existing spaces for participating in health decisions and programmes are

[934] Participant KA005

monitored. It also requires that capacity gaps of inmates and correctional officers are continuously identified and the means of addressing them are designed and implemented.[935]

Prescribing formal and informal spaces for women inmates to participate in health decisions and programmes is also beneficial for mitigating excessive power by State officials, their agents, and women inmates who exercise power over other women inmates. Informal spaces for participation in health cannot be exhaustively regulated, hence the need for prescribing guiding principles for how they will operate. While informal spaces for participation are valuable for facilitating women inmates' participation in health governance, they are often created by those who wield power and may thus be used to exacerbate vulnerability to health-rights violations rather than enhance the enjoyment of rights. This was evident in the study from the numerous complaints women inmates had concerning correctional officers, cell captains and women inmates who had control over resources and access to beneficial social networks. The next section considers how mitigating the effects of power imbalances in correctional facilities can facilitate a woman-centred citizenship participation model to health.

7.3.2 Addressing effects of power imbalances within correctional facilities

Power imbalances between the State and women inmates is highly prevalent in correctional laws, policies and practice. This negatively impacts how inmates view themselves and how the State and members of the public view women inmates. To improve the relationship between the State and women inmates as well elevate women inmates' low social standing the effects of power imbalances must be mitigated.[936] Mitigation of effects of power imbalances depends on the source or instrument of the power. For instance, if the Zambia Correctional Service Act bestows power on an Officer-in-Charge or a correctional medical officer to facilitate access to healthcare for an inmate only when she is unwell, the law provides the source of power by which an Officer-in-Charge or a correctional medical officer acts. On the other hand, the status of a correctional officer, a cell captain or an inmate with access to resources is the relevant source of power for each of these. By virtue of being a correctional officer, a person has

[935] Margaret Wanjiku Ngunjiri 'Citizenship participation in local governance in Africa: A selection of case studies' 2023 *International Institute for Democracy and Electoral Assistance Sweden* available at http://www.idea.int/sites/default/files/publications/citizen-participation-local-governance-africa.pdf

[936] Preece op cite note 100 at 31

power over an inmate. Similarly, being a cell captain or an inmate with access to resources that impact on one's health provides a means by which an inmate acquires power over other inmates.

Power held by a correctional officer or inmate influences other inmates' health-seeking behaviour in positive and negative ways.[937] It also influences whether and how women inmates participate in health-related decisions and programmes as illustrated in Chapters five and six. In Chapter five, participants discussed how excessive power negatively impacts on women inmates' individual participation in health decisions and programmes. The Chapter also shows how those in positions of power could facilitate women inmates' participation in health governance. From Chapter six, it is evident that the resources needed for women inmates to participate in health governance identified by study respondents were informed not only by women inmates' inability to engage duty-bearers on matters that affect them, but also by the need to mitigate excessive power by those who hold it. Recommendations from study respondents on the use of law to permit women inmates to participate in health governance show the need to mitigate excessive power by the State. The discussion on the need for representatives to speak on behalf of women inmates also demonstrates the challenges women inmates face in health governance if they do not have the support of those with power.

Addressing excessive power in the Zambia Correctional Service Act and other legislative frameworks that empower State institutions to work in correctional settings is important for curbing discriminatory attitudes and facilitating women inmates' participation in health governance. Reducing the powers of correctional officers and other State officials must be balanced with the need to ensure that correctional officers are sufficiently capacitated to maintain peace and order in correctional facilities. Creating an environment in the correctional facilities where mutual respect between women inmates and State institutions and their agents exists is cardinal for peace and order and in many ways more effective for receiving inmates' cooperation. This in turn promotes the much-needed safety and security in prisons. There is thus a need to explore more ways of

[937] Bird & Albertson op cit note 288 at 97

curbing excessive power of the State, while balancing security concerns that may arise in prisons.[938]

7.3.3 Getting women inmates organised

In this section, a discussion on the impact of women inmates' lack of organisation on their ability to participate in health governance is considered. Many women inmates who participated in this study submitted that they needed to be united and work together if they were to effectively participate in health governance. Even if women inmates use internal and external representatives, they still need to be organised and coordinated within their facilities. This helps to build consensus on matters that affect them as a group and strengthens advocacy efforts. It also helps to effect capacity-building interventions for women inmates, such as training them on their legal rights and how they can claim them.

Article 20 of the Zambian Constitution entitles every person to express themselves, including receiving and sharing ideas. Article 21, on the other hand, empowers individuals to form associations in furtherance of their interests. As earlier stated, the Gender Equity and Equality Act guarantees to a woman, on an equal basis as a man, the right to "participate in public decision making and formulate and implement government policies and programmes."[939]

These provisions on women's participation in governance are progressive as they make women visible in society, promote their human rights, and recognise their citizenship rights on an equal basis as men. By prescribing how women can participate in government, the Gender Equity and Equality Act also contributes to improving governance and enabling women to contribute to designing and utilising their seat at the decision-making table. This in turn strengthens the relationship between government and women in the general population. However, such provisions must be contextualised to women inmates. As can be seen from the Gender Equity and Equality Act, the promotion of women's participation in governance is based on experiences of women in the general population as the provision does not consider women inmates' intersectional grounds of discrimination and the various ways in which women inmates may participate in political

[938] Alison Liebling 'Prison officers, policing and the use of discretion' (2000) 4:3 *Theoretical Criminology* available at http://www.researchGate.net/publication/258192321_Prison_Officers_Policing_and_the_Use_of_Discretions
[939] Supra note 397, Section 29(1)

and social governance structures that impact on their health. It is evident from the study findings that women inmates' ability to organise for health governance is limited hence they do not have many lessons from which to draw to inform legislative interventions. It was also clear from the study findings that women inmates need to agree on their leadership structures, powers to be ascribed to leaders, and channels for communicating their interests. This information is important for mitigating potential conflict inherent in processes for selecting representatives.

The law should make it mandatory for vulnerable groups like women inmates to be given spaces to organise and mandate the State to create a conducive regulatory environment for this to happen. However, the law must also allow vulnerable groups to decide how they would like to organise themselves, giving due consideration to their circumstances. For example, for women inmates, due consideration should be given to security and protection of the public. Establishing legal protection for women inmates to organise themselves for participation in health would allow for continuous dialogue between women inmates and the State about what the regulatory framework should provide for at any given time. As women inmates figure out what works for them, they negotiate with the State on the requisite regulation, facilitating the necessary changes as required.

7.3.4 Building allies for women inmates

As discussed in Chapter five of this thesis, women inmates need allies to amplify their voices. Women inmates also need allies to help them implement activities that protect their health rights and interests. The role played by women inmates' allies are what Krook and Gray refer to as "critical mass" and "critical acts".[940]Critical mass refers to the number of voices calling for action, in this case with regards to women inmates' health rights. On the other hand, the "critical acts" refers to the actions taken to ensure actual assertion of women inmates' health rights." Women inmates' citizenship and health rights can thus be asserted within the woman-centred citizenship participation model for health by building allies. Women inmates must identify allies from the government, quasi-government and non-governmental organisations that visit their correctional facilities. Sometimes allies

[940] Mona Lena Krook and Sandra Gray 'Critical perspectives on gender and politics 'Do women represent women? 'Rethinking the 'critical mass' debate' *Politics & Gender 2 (2006) 491-530* at 510

may express interest to work with women inmates. It is important for women inmates to be able to identify strategic partners based on their health needs and interests and engage them as required. Currently, women inmates work with any organisation or individual who meets any of their many needs due to the dire situation they are in.

It is important for there to be consistent interactions between women inmates and identified allies. Consistent interactions between women inmates and identified allies help to building rapport between women inmates and their allies. Consistent interactions between women inmates and their allies can also help with sharing information on women inmates' health issues and their allies' ability to support women inmates' assertion of health rights. Consistent interactions are important for managing expectations of what the partnership between women inmates and their allies can achieve.

Lastly, consistent interactions can also help to identify capacity gaps among women inmates and their allies. Chapters five and six of this thesis reveal how women inmates, CSOs, correctional officers and other government officials lack capacity in areas such as women inmates' health needs and challenges, available human right protections, legal and administrative procedures for guaranteeing inmates' health rights and ways in which women inmates can practice active citizenship. Through consistent interactions women inmates and their allies would also be better placed to identify ways and requisite resources for filling these capacity gaps, including capacity-building training, dialogue sessions and prison orientation programmes. The next section discusses how strengthening interactions between the State and women inmates can advance a woman-centred citizenship participation model to health.

7.3.5 Strengthening relationships and interactions between State institutions and women inmates

To facilitate a woman-centred citizenship participation model for health, the State and women inmates need good working relations. The State often establishes enforcement mechanisms in laws and policies to address human rights of people under its jurisdiction. In the Zambian context, this includes institutions such as the Human Rights Commission, the Gender Equity and Equality Commission, various Parliamentary Committees, the Legal Aid Board, and the Judiciary. All these enforcement and monitoring mechanisms

play a role in facilitating women inmates' health rights and should thus be strengthened to facilitate women-friendly and meaningful participation in prison health governance.

The laws and institutions established to enforce them must be effective for facilitating the enjoyment of human rights of women inmates. Many institutions stated that they use existing laws to conduct their lobbying and advocacy work in the general population in furtherance of their mandates. As has been shown in Chapters of three, five and six of this thesis, correctional laws enable the Judiciary, Human Rights Commission and religious institutions to conduct monitoring visits in correctional facilities. Similarly, Standing Orders of Parliament enable the National Assembly to conduct study visits in correctional facilities. As discussed above, the majority of the women inmates were sceptical about whether the law would offer them sufficient protections for their active participation in health. The need for awareness-raising on the use of the law to assert rights for both women inmates and organisations that promote their rights is thus cardinal. This must be coupled with building capacities of women inmates and their allies to use existing structures and spaces for participation in decision-making.

In recognition of such interventions as cardinal to the promotion of women's participatory rights, the Gender Equity and Equality Act empowers the minister responsible for gender to develop capacity-building measures to enable women to participate in decision-making in public and private institutions.[941] Through the provisions of the Gender Equity and Equality Act that compel public bodies to curb discrimination against women in decision-making and ensure their active and effective participation, the Zambia Correctional Service and other government and quasi-government institutions must be compelled, by the Gender equity and Equality Commission, as the relevant oversight body, to develop a conducive regulatory framework and structures for participation in health. The relevant State institutions must also be required to demonstrate on a periodic basis how they are fulfilling their obligations to facilitate participation in health-related decision-making in correctional facilities through systems developed for this purpose under each relevant statute.

Institutions such as the Judiciary, Parliamentary Committees, Human Rights Commission, Legal Aid Board, Members of Parliament of constituencies where prisons

[941] Supra note 397, Sections 24 and 29

are located, and portfolio ministers such as Ministers responsible for Gender, Home Affairs and Internal Security, Health, and Local Government have been carrying out monitoring visits to correctional facilities, albeit inconsistently. This enables them to interact with the women inmates and in some cases address them on issues affecting women inmates. However, women inmates have not seen the benefit of such engagements and have gradually reduced their active participation as a result. The aforementioned institutions have historically had the mandate and have been legally empowered to carry out monitoring visits in prisons. They should be obligated to meaningfully engage with women inmates or their agents or to serve as a conduit of information to other government institutions for issues that fall out of their mandate that are brought to their attention in the course of their monitoring visits. Therefore, they should hear women inmates' health and other experiences and complaints, facilitate information-sharing to other institutions with the mandate to address the concerns raised and report back to inmates on measures they have taken to respond to women inmates' issues. This procedure is necessary considering that women inmates have limited contact with the outside world and cannot make demands on government institutions as do persons in the general population.

Women inmates' inability to communicate with the outside world is exacerbated by the fact that government institutions responsible for health, sanitation, gender, children's welfare, community development, justice, citizenship participation, and governance do not operate in correctional settings as a matter of their routine work. Creating a two-way flow of information between women inmates and the relevant authorities could increase interaction between the State and women inmates and create an avenue through which women inmates can participate in public life.

7.3.6 Create coordinating mechanisms for State institutions involved with women's health, incarceration or citizenship rights

Many study respondents identified State institutions that had a bearing on the enjoyment of women inmates' health rights as including the Ministry of Health, Ministry of Home Affairs and Internal Security, Ministry of Community Development, the Ministry of Gender and the Human Rights Commission. Some of these institutions were already working in correctional settings whereas others were not. For instance, the Ministry of

Health was said to be the custodian of all health facilities in Zambia, but it does not have a health governance structure for correctional facilities equivalent to that of public health institutions in the general population. The Ministry of Health's engagement with community structures and creation of community health systems has not been replicated in correctional settings.[942]

The Ministry of Gender, as it then was, had not done any work in correctional settings even though it works extensively at community level in the general population to mainstream gender and promote the equal participation of women in social, political and economic life of the country.[943] Similarly, the Ministry of Local Government and Rural Development, which is mandated to ensure devolution of power and decentralisation of government structures for increased community participation has not done any work in correctional facilities.[944] The Ministry of Home Affairs, which is the portfolio ministry for correctional facilities does not routinely work with other line ministries, to promote women inmates' participation and health rights. It also does not routinely work with quasi government departments like the Human Rights Commission, the Legal Aid Board, the National Assembly or local Members of Parliament where the correctional facilities are located to ensure that the necessary relationships and platforms for women inmates to share their health issues are established. This means all the work (planned and haphazard) done by State and quasi-State institutions for the promotion of women inmates' health rights and determinants is uncoordinated.

As shown in this study, the lack of coordination among key State and quasi-State institutions whose work directly impacts on health rights of women inmates weakens the State's prevention and response interventions towards women inmates' health challenges. Strengthening the capacities of State and quasi-State institutions to promote women inmates' health and participation in health rights would be incomplete if these institutions do not coordinate their work.[945] This is because the scarcity of resources "and fierce competition for those scarce resources to accommodate the various social needs in African

[942] Participants KU001
[943] Participant KA006
[944] Participant KA012
[945] Jeremy Sarkin 'Prisons in Africa: An evaluation from a human rights perspective' Legal Studies Research Paper Series: Research Paper no. 09-13 (2009) *Sur International Human Rights Journal 9 at 25 and 31 available at http://ssrn.com/abstract=1368922*

countries"[946] requires that State institutions liaise how they will work in correctional facilities to avoid overcrowding or underserving the prison community. Effective coordination among these institutions would instead contribute to the prudent use of limited resources for correctional health. It would also enable State institutions to provide leadership for addressing shortcomings of the prison system by hold each other accountable for facilitating women inmates' enjoyment of health rights. Effective coordination of State and quasi-State institutions could thus contribute to the progressive realisation of women inmates' health rights, strengthen the State's response to women inmates' health rights and systematically identify and evaluate the State-sanctioned spaces for women inmates' participation in health. This would ultimately contribute to the effective implementation of the woman-centred citizenship participation model to health for women inmates in Zambia.

7.4 CONCLUSION

This Chapter demonstrates that because traditional and non-traditional sites of power have a huge bearing on the extent to which women inmates enjoy their human rights, such sites must be re-evaluated and re-organised to ensure that women inmates' right to participate in health and the barriers to such participation are addressed. Laws, policies and institutions are some of the most influential sites of power that must be interrogated and re-shaped with the aim of directly responding to the needs of women inmates and facilitating a conducive environment for the realisation of a woman-centred citizenship participation model for their health. While acknowledging that laws, policies and institutions have limitations in fostering a woman-centred citizenship participation model for health, inmates' participation in national elections demonstrates the power that lies in such sites as they facilitate visitations to prisons, that otherwise would not happen, by State institutions such as the Electoral Commissions, and by politicians who are seeking inmates' votes. Women inmates thus are given opportunities to participate at all three level of decision-making: individual, community and public, thereby strengthening their citizenship status.

In this Chapter, Zambia's newly developed correctional model was examined and how it impacts on women inmates' health rights and participation in health decisions. The

[946] Sarkin (2008) op cit note 90

findings are that the paradigm shift from a purely punitive system to a hybrid of punitive and correctional model has not been accompanied by adequate legal and systemic changes that reflect the experiences of women inmates. This Chapter has shown that because women inmates' health rights are a key indicator of their enjoyment of citizenship rights it is necessary for Zambia's correctional system to facilitate women inmates' effective participation in health decisions and programmes. On this basis a woman-centred citizenship participation model for health is proposed for women inmates in Zambia.

I propose a woman-centred citizenship participation model to health for women inmates in Zambia. This model is one which considers women inmates' historical and current health rights situations and experiences and, together with women inmates, explores ways of empowering women inmates and the State to facilitate women inmates' effective involvement in health. The woman-centred citizenship participation model comprises three elements. The first one is the amalgamation of rights-based and citizenship participation-based approaches to health through the feminist lens. The second element is the effective partnership between women inmates and the State. The last element, closely related to the previous one, it the need to promote systematic, active and women-centred interventions for participation in health governance.

The three elements are supported by six sub-elements that underpin how the woman-centred citizenship participation model for health of women inmates is realized namely, agency, visibility, accountability, transparency, inclusion, and diversity. A woman-centred citizenship participation model for health of women inmates is not about fitting women into existing prison systems, but reshaping and re-designing correctional health systems to ensure women inmates' health rights are and remain an integral part of the correction system. It further ensures that women inmates' health rights and interests continuously inform the State's health rights interventions.

CHAPTER EIGHT
CONCLUSION

8.0 INTRODUCTION

This study set out to examine the role of participation of women inmates in decision-making and programmes to enhance their enjoyment of the right to health and to examine how the Zambian regulatory framework can effectively guarantee such participation. The research question that guided the study was "how can participation of women inmates in decision-making enhance their right to health and what is the role of the Zambian regulatory framework in facilitating such participation?" This broad question was broken down into the following sub-questions:

a) What does participation in health-related decision-making entail?
b) What is the role of participation in realising the right to health?
c) What standards and norms exist within prison management and prison health governance for the participation of women inmates in health-related decision-making?
d) How does the current Zambian regulatory framework impact on women's participation in correctional settings for better realisation of their health rights?
e) How is the health of women inmates affected by the failure of the correctional healthcare system to provide for the peculiar needs of women inmates in Zambia?
f) How can women inmates participate in decision-making that impacts on their health in the Zambian context?
g) What is the role of the Zambian legal framework in guaranteeing the participation of women inmates in decision-making and in shaping the regulatory framework applicable to correctional settings in Zambia?

The research question contributed to realising the following objectives:

a) To examine the link between women inmates' participation in decision-making in correctional settings and their access to health.

b) To determine how the participation of women inmates can address the social and institutional factors in correctional facilities that impact on women inmates' access to healthcare.
c) To analyse the role of law in supporting women's participation in decision-making in correctional settings.
d) To consider how situating Zambia's legal response to health needs and challenges of women inmates in the participatory rights framework can enhance their access to healthcare.
e) To consider how the health governance system in the Zambian correctional facilities can be enhanced by the participation of women inmates.

The research questions and objectives were informed by a preliminary review of existing literature and examination of various laws and policies regulating prisons and healthcare. This data established that women inmates were not in the contemplation of the designers of the Zambian prison system.[947] Further, the prison facilities, rules, procedures and practice do not consider women inmates' unique needs and circumstances. For example, women inmates' biological makeup requires that they have access to sanitary wear and sanitation for their menstruation. Many Zambian prisons do not routinely provide these for women inmates. Similarly, women inmates' socio-cultural roles such as child-raising and care-giving requires that inmates who are imprisoned with their small children have suitable accommodation for taking care of their children, appropriate and adequate nutrition and adequate time to tend to their children. Failure of the Zambia Correctional Service to consider women inmates' unique positions and circumstances subjects women inmates to health risks and violation of their health rights.

The literature also shows that women inmates have limited access to health facilities, goods and services and experience many health rights violations. Structural barriers such as poor prison infrastructure, weak health governance, inadequate funding and poor planning and coordination are partly responsible for women inmates' health-rights violations. In the other part, women inmates' low socio-economic status subjects them to health rights violations. Women inmates in Zambia are said to occupy one of the

[947] Baker & DIGNITY op cit note 10

lowest socio-economic statuses in the country.[948] This exacerbates their health risks and susceptibility to health rights' violations. Women inmates' low socio-economic status limits their ability to access health facilities, goods and services and disempowers them from making decisions that promote good health outcomes.[949] Women inmates' low socio-economic status is also perpetuated by negative societal attitudes that treat them as second-class citizens. Negative societal attitudes present a barrier to women inmates' enjoyment of citizenship rights, including their access to public health goods and services on an equal basis as other members of the Zambian society. The negative attitudes towards women inmates are reflected in prison rules, policies and practice either expressly or implicitly through the gender-neutral stance they take.

Although the Zambian government has recently implemented some penal reforms that have shifted its approach from a purely punitive one to a hybrid of punitive and corrective approach, it has not adequately addressed the historical exclusion of women inmates from the correctional system. Women inmates continue to suffer social exclusion and health rights violations by the existing correctional system. This necessitates an inquiry into the changes that are needed for the Zambia Correctional Service to effectively respond to women inmates' health needs and the role women inmates must play in shaping the Zambian correctional system to recognise them as citizens and be responsive to their needs and experiences.

The significance of this study is that it adds to the nascent literature on women inmates in Zambia by documenting the women inmates' health experiences and proposing practical solutions for addressing the health rights violations experienced by women in correctional settings in Zambia. Further, this study has the potential to inform policy, institutional and legal reforms that may arise from Zambia's paradigm shift from a punitive system to a hybrid of punitive and corrective system. The study also documents the unique experiences of women inmates on how they are affected by the existing healthcare system in Zambian prisons, the social determinants that affect their health status, and their recommendations for improving the regulatory and administrative systems to enable them to enforce their right to health. These perspectives have been absent from

[948] Republic of Zambia op cit note
[949] Douglas, Plugge & Fitzpatrick op cit note 14

mainstream research which tends to focus on experiences on male prisoners and then generalised to all populations. The study used qualitative research methods to answer the research question. Desk-based research was conducted to examine available literature on the subject. Empirical research was also conducted with women inmates, prison administrators, government line ministries, quasi-government institutions and civil society organisations. The institutional participants were selected on account of their institutional mandates to promote either women inmates' health rights and interests or their citizenship rights. A semi-structured interview guide was designed to collect the views of study respondents.

This chapter summarises the findings of the study on the value of participation in decision-making within prison settings as a tool for enhancing the enjoyment of the right to health for women inmates in Zambia. It advances a woman-centred citizenship participation model as a practical tool for addressing women inmates' medical and social determinants of health. It ends with a reflection on the limitations of the study and identifies key areas for future research on the subject.

8.1 FINDINGS OF THE STUDY

The study found that participation in health-related decisions and programmes is a core component of the right to health. While treaties promulgated under the UN and AU set minimum standards for the realisation of the right to health, such standards do not explicitly recognise the right to participate in health governance as a core component of the right to health. However, the work of enforcement mechanisms created under the various international and regional human rights treaties allude to participation in health-related decision-making and programming as being core to the realisation of the right to health and health interests. Documents such as the General Comments 14 of 2000 by the United Nations Committee on Economic, Social and Cultural Rights[950] and General Comment on Article 14(1)(d) and (e) of the Maputo Protocol developed by the African Commission on Human and Peoples' Rights[951] are instructive. Similarly soft law such as the Declaration of Alma Ata and the Pretoria Declaration are instructive on the role of participation in enhancing health rights at international and regional levels. Such

[950] Supra note 308
[951] Supra note 349

supporting documents reveal that there is a close relation between civil and political rights including the right to participate in governance, and social rights such as the right to health.

The research findings are reported under four themes that respond to the sub-questions that the study asks. First, the international standard on the right to health and participation. Second, Zambia's legal framework and administrative practices regulating the right to health and participation in health-related decisions. Third, participation of women inmates in health-related decision making and programming and the impact of their exclusion on their enjoyment of their right to health. Fourth, the role of law in facilitating the participation of woman inmates in health-related decision making and programmes.

8.1.1 International standards on the right to health and participation

At international and regional level, the right to health guarantees the highest or best attainable standard of physical and mental health.[952] Social factors are a key determinant of health and affect the extent to which a rights-holder enjoys the highest attainable standard of physical and mental health. As the State plans and implements health interventions, it must consider, among others, social determinants of health. Social determinants of health include one's gender, age, physical condition, education, income and residence. The State cannot effectively address the social determinants of health without engaging the people affected by them. The study findings show that international and regional human rights standards on the rights to health envisage participation in health as entitling rights-holders to share their health interests, concerns and experiences with duty-bearers. [953] Duty-bearers must consider this information in their design and implementation of health interventions. International and regional human rights treaties particularly require that vulnerable groups like women inmates are involved in health governance as a way of promoting their right to health. States parties to international and regional human rights treaties have the obligation to take administrative, legislative and

[952] Supra note 841
[953] Supra note 308, Para 54. See also Ruger op cit not 354 at 1079

other measures to ensure that spaces are created for rights-holders to participate in health decisions and programmes.[954]

International and regional human rights treaties not only envisage the role of participation in health decisions and programmes as a means of designing effective interventions for achieving the highest attainable standard of health, but also as a means by which rights-holders can hold the State accountable for their health rights obligations. The role of participation in health decisions and programmes is thus a means of promoting transparency and accountable by the State. Lastly, international and regional human rights treaties view participation as a means of promoting agency among rights-holders to claim their rights and improve their health-seeking behaviours.

The international and regional human rights standards on the role of participation in health can be realised in various ways including: asking women inmates about their health needs and determinants through dialogic and information-sharing interventions;[955] facilitating effective access to health goods, services and systems;[956] facilitating women-centred and inclusive strategies for addressing their health needs and interests;[957] working with women inmates to create health systems and programming that curb health discrimination based on gender and other intersectionalities;[958] creating political and social systems for advancing women inmates' health interests and promoting transparency and accountability in the provision of health services through democratic spaces of governance[959]; strengthening women inmates' ability to assert their rights as citizens;[960] involving women inmates in setting agendas for health priorities, evaluation and reform;[961] involving women inmates in ascertaining the health resources needed for improving their

[954] Supra note 334
[955] Supra note 308, Para 12
[956] Ibid Para 54-55. See also Supra note 349
[957] Supra note 324, Part VII (4). See also supra note 351, Para 11 on the meaningful involvement of civil society in policy-making and implementation of the right to health.
[958] Lister op cit note 133 at 35
[959] Resolution on Access to Health and Needed Medicines in Africa - ACHPR/Res.141(XXXXIV)08 available at Resolution on Access to Health and Needed Medicines in Africa - ACHPR/Res.141(XXXXIV)08 | African Commission on Human and Peoples' Rights (au.int) accessed on 20th February 2023
[960] Dorien Brosens, Flore Croux and Liesbeth De Donder 'Prisoners' active citizenship: An insight in European prisons' (2018) *Participation & Learning in Detention Research Group available at https://www.derodentraciet.be/wp-content-uploads/2018/07/Brosens-et-al.-2018-PAC-An-insight-in-European-prisons.pdf*
[961] Supra note 927

health outcomes;[962] upholding the dignity of the women inmates involved in health interventions by making them feel valued, included and respected;[963] and granting women control over their health choices.[964]

8.1.2 Zambian legal framework and administrative practices regulating women inmates' health

The study also explored the existing prison management and prison health governance systems for women inmates' participation in health decisions and programmes. It found that there are inadequate norms in prison management and prison health governance systems for the participation of women inmates in health decisions and programmes. The approach of the Zambia Correctional Service to health is State-centred in that the State solely decides the budgetary allocation for prison health. The State also drives the process and sets the agenda for stakeholder consultations conducted through correctional health committees and solely design spaces through which women inmates communicate their medical needs to correctional officers.

The State further develops and implements prison legislation and policies to the exclusion of women inmates. As a result, prison management and health governance systems are inadequate and, in some cases, inappropriate for facilitating women inmates' effective participation in health decisions and programmes. For example, the study reveals that although women inmates have a platform to communicate their medical needs to correctional officers on a daily basis, many of them are reluctant to use this platform for various reasons including lack of privacy, fear of mockery, fear of reprisal and stigma and discrimination associated with being identified in a public health facility as a prisoner. Another relevant example is the composition and functioning of correctional health committees. The correctional health committees comprise of women inmates, State institutions and civil society organisations, however the agenda of meetings is driven by the State. This limits the voice of women inmates and the extent to which they participate in agenda-setting on issues that affect their health.

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[962] Supra note 930

[963]The PAC (Prisoners'' Active Citizenship) Erasmus + EU Project ' Citizens inside: A guide to creating active participation in prisons' (2019) available at https://prisonerseducation.org.uk/wp-content/uploads/2019/11/citizens-inside-A-guide-to-creating-active-participation-in-prisons.pdf

[964]Para 33 of African Commission on Human and Peoples' Rights GC on article 14(1)(d) and (e) of the Maputo Protocol and Robtel Neajal Pailey op cite note 970

The study finding on the impact of the current Zambian regulatory framework on women inmates' participation in prison settings is that women inmates derived minimal to no benefit due to the inconsistent and unconducive regulatory framework. To illustrate these inconsistencies in Zambia's regulatory framework, Chapter three of this thesis shows that the Constitution embodies everyone's right to vote, freedom from discrimination, freedom of expression, and freedom of association and assembly. These rights support a conducive framework for women inmates to participate in health decision and programmes. Similarly, laws such as the Gender Equity and Equality Act,[965] Persons with Disabilities Act,[966] and the Mental Health Act[967]all expressly guarantee the right of women to effectively participate in decision-making and public life. The Gender Equity and Equality Act further requires public and private bodies to curb discrimination against women in decision-making and public participation and imposes a duty on these bodies to put in place measures for ensuring women's participation.[968] However, except the Mental Health Act, none of the aforementioned laws expressly guarantee the right to decision-making and public participation of women inmates. Hence, no mechanisms are created in law and in practice for the effective participation of women inmates.

Chapter three also shows that although there is a change in Zambia's criminal justice system from a punitive model to a hybrid of a punitive and correctional model, the Zambia Correctional Service Act has not adequately reflected such a paradigm shift. The Act does not guarantee women inmates' human rights, including their right to health and right to participate in health-related decisions and programmes, albeit the common trend in Zambia's laws of guaranteeing rights to vulnerable groups. The laws also fall short of the regulatory standards on human rights including citizenship rights under international and regional human rights frameworks to which Zambia is a party.[969]

The study findings further reveal that women inmates were not involved in the formulation of the Zambia Correctional Service Act which was passed in 2021. It is unsurprising then that the Act contains several provisions that negatively impact women inmates' participation in health decisions and programmes as well as their health

[965] Supra note 397
[966] Supra note 398
[967] Supra note 399
[968] Supra note 397
[969] Supra note 930

determinants. For example, the Act places the responsibility for health rights solely within the mandate of correctional officers without expressly recognising women inmates' right to health.[970] As a result of this formulation, the Act largely treats the provision of health goods and services to women inmates as obligations of correctional officers, thereby relegating women inmates to passive recipients of the State's medical interventions.

The negative provisions of the Zambia Correctional Service Act render ineffective the few progressive provisions in the Zambian legislation that promote women inmates' participation in decision making. The State-centred approach to health perpetuates the treatment of women inmates as second-class citizens making them vulnerable to frequent violation of health rights. Further, contrary to the existing practice as established in this study, the Zambia Correctional Service Act proscribes the sharing of food among inmates from private sources. The practice in correctional facilities is that women inmates form feeding groups and share food from both State and private sources thereby exercising their agency to mitigate their health needs.[971] The study findings also reveal that the Zambia Correctional Service Act does not adequately address women inmates' barriers to participation in health governance such as negative attitudes of correctional officers towards women inmates' participation in health, their fear of punishment, inadequate and inappropriate spaces for participation in health and discriminatory laws, policies and practices as identified by women inmates in this study.

8.1.3 Participation of women inmates in health-related decisions and programmes in Zambian correctional facilities

This study inquired on how women inmates' health is affected by the failure of Zambia's correctional health system to provide for women inmates' peculiar needs. The findings show that there is a negative impact on women inmates' health due to the inadequacy of the correctional health system in responding to women inmates' medical and social health determinants. Regarding the shortcomings of the correctional medical interventions, the first problem is that the Zambia Correctional Service does not have prison-based health facilities for women inmates. All existing prison-based clinics are built in the male section.

[970] Supra note 31
[971] See findings in Chapter five

Women inmates who need to access the clinics are taken to the male section. This causes delays in accessing medical services.[972] It also makes women inmates susceptible to sexual exploitation, abuse and violence. Correctional facilities that have stand-alone prison clinics are also ill-suited for women inmates as they are designed to fit the needs of male inmates. The study findings show that because women inmates were not contemplated by the designers of the correctional health system, they do not adequately provide for their health needs. Study respondents attested to the effects of such exclusion by stating that women inmates had limited access to medicines, random screening programmes for cervical cancer, limited mental health services, limited prevention and treatment interventions for vaginal fungal infections and lack of routine sexual and reproductive health services for women of child-bearing age. From the establishment of the Zambia prison system, neither the Zambia Correctional Service nor the Ministry of Health have employed a gynaecologist to address women inmates' sexual and reproductive health needs. The Zambia Correctional Service and Ministry of Health do not address the medical challenges of women inmates.

The study findings also show that although there are sporadic interventions to address women inmates', medical needs, most of these interventions were developed by the government and its partners and donors working in prisons exclusive of the involvement of women inmates.[973] Some of these interventions were also developed by correctional officers' individual efforts through working alone or in collaboration with women inmates. This led to the creation of a second problem experienced by women inmates, that of health-related discrimination. For instance, this study shows that the government and its agents and partners focused on creating a correctional health system which mostly addresses HIV infections in correctional settings. On this basis, many participants felt that HIV positive inmates were receiving relatively better medical interventions, such as consistent supply of ante-retroviral treatment. HIV positive inmates, on the other hand, felt that they were not adequately catered for regarding their dietary requirements and addressing opportunistic infections. Similarly, pregnant women were deemed to receive relatively better health services than inmates who were not pregnant,

[973] Participant KA002

and yet women of child-bearing age felt that they did not receive adequate and nutritious food nor have suitable accommodation in the correctional facility. Women inmates with physical illnesses were said to be treated better than women inmates with mental illnesses and women who were not on death row were deemed to receive better health services than those on death row.

Although the Zambia correctional health system predominantly addresses women inmate's medical needs like facilitating access to a health facility and access to medicines and medical procedures, its interventions promote health inequity. From the cross-sectional views of study respondents, the goods, services, facilities, and systems for accessing medical assistance by women inmates do not promote the best attainable standard of health for women inmates. Many women inmates and State institutions who felt otherwise were influenced by their limited understanding of the right to health standard at international and regional level.

Regarding the response of the Zambia correctional health system to women inmates' social determinants of health, the study found that the Zambian correctional health system hardly addresses them. Women inmates' social determinants of health go unattended, thereby exacerbating the health-rights violations they experience. Some of the key health determinants identified by study respondents include the weak relationship with the State; failure to take into account women inmates' diverse needs arising from their age, illness, pregnancy, disability, immigration status and a need for basic necessities such as provision for women inmates' children and dependents, appropriate accommodation for pregnant women, women with children and women with disabilities, food, sanitary pads, clean running water and cleaning supplies, violence, access to visitors and communication with family and friends.

8.1.4 The role of law in facilitating the participation of women inmates in health-related decisions and programmes

The failure of the Zambia correctional health system to facilitate women inmates' participation in health governance is exacerbated by a weak national regulatory framework on the right to health. The right to health is not guaranteed in the Zambian Constitution.[974] However, the Constitution protects the right to life and this has recently seen the Zambian

[974] Supra note 42

judiciary extend the right to life to inmates' health rights and protection of their health determinants such as food.[975] Through the Mwanza case, active assertion of inmates' human rights, including the right to life and the right to food, enhanced inmates' recognition in law as rights-holders.[976]It is thus unsurprising that many study respondents indicated that one of the effective pathways to realising greater protection of health rights and improve women inmates' social standing in society is through the Zambian legal framework. This is because the Zambian legal framework largely determines how inmates are treated and which rights are recognised and protected. The legal framework can also facilitate redistribution of power. Yet, Zambia's correctional law has historically lagged in its promotion and protection of women inmates' human rights and citizenship. It is, nonetheless, a key instrument for enhancing women inmates' access to healthcare as it has the potential to create a conducive environment for facilitating a woman-centred citizenship participation model for health for women in Zambian's correctional system.

Although the Zambian government recently changed its approach from a purely punitive model to a hybrid of punitive and corrective model, this paradigm shift has not sufficiently taken into account women inmates' health rights and experiences in the Zambian correctional facilities. This means women inmates' health needs and experiences in the Zambian correctional facilities largely remain ignored. This study proposes the woman-centred citizenship participation model for health to promote women inmates' participation in health decisions and programmes and improve their social standing in the Zambian society.

8.2 A WOMAN-CENTRED CITIZENSHIP PARTICIPATION MODEL FOR ENFORCING THE RIGHT TO HEALTH FOR WOMAN INMATES

The women inmates who were interviewed for this study felt that it was important for them to participate in decisions impacting on their health as they were most affected and they best understood the nature of health interventions they required. Most of the study respondents felt that with the right resources, women inmates could effectively participate in the correctional health governance system of Zambia. The following resources were identified by study respondents as essential for facilitating women inmates' participation

[975] Supra note 401
[976] Ibid

in health decisions and programmes in Zambia: creating spaces for women inmates' participation, capacity-building requirements for inmates and correctional officers, coordination among key stakeholders especially State institutions, collaboration between State institutions, women inmates and civil society in addressing women inmates health needs and concerns, financial support, and recreational and rehabilitation programmes. Women inmates also discussed the importance of a conducive legal framework that facilitates their effective participation in health-related decision-making and programming.

As earlier stated, the international and regional human rights framework view participation in health governance as a core component of the right to health. This entails the involvement of a rights-holders, either individually or collectively in health decisions and programmes. Implementing this participatory standard requires defining what is meant by health, identifying health needs, and determining and prioritising health resources.[977] Participation in health also entails giving opportunities to the rights-holders to communicate their health needs (both medical and social) to duty-bearers;[978] involvement in decisions and programmes of health governance structures such as health committees or boards;[979] taking part in health budgeting;[980] involving the rights-holders in designing, accessing and evaluating public health goods and services;[981] engaging in programmes and structures for accessing health information, training and other capacity-building interventions for rights-holders and duty-bearers;[982] taking part in decisions on one's health treatment;[983] being involved in health research;[984] and engaging in the enactment and review of a regulatory framework for health.[985]

This thesis proposes a woman-centred citizenship participation model as a means of addressing women inmates' medical and social determinants of health. To develop this

[977] Supra note 930
[978] Ibid
[979] Supra note 308, Para 54. See also Ruger op cit note 354
[980] Supra note 35, Article 11(v). See also Ruger op cit note 354
[981] Ngunjiri op cit note 903
[982] Ibid
[983] Julius Nuwagaba, Ronald Olum, Ali Bananyiza, Godfrey Wekha, Meddy Rutaysire, Keneth Kato Agaba, Gaudencia Chekwech, Jalidah Nabukalu, Genevieve Gloria Nanyonjo, Robinah Namagembe, Sylvia Nantongo, Margaret Lubwama, Innocent Besigye and Sara Kiguli 'Patients' involvement in decision-making during healthcare in a developing country: A cross-sectional study' Patient Preference and Adherence available at https://www.dovepress.com/on
[984] Supra note 346, Rule 32
[985] Supra note 349, Para 33 and 35

model, study respondents were asked about the impact of women inmates' participation in health decision-making on their health. The study findings reveal that women inmates had mixed feelings about the impact of their participation in health-related decision-making. These mixed feelings were borne from the barriers to participation which women inmates had experienced in correctional facilities. The barriers to participation by women inmates include excessive punishment by correctional officers, violence by correctional officers and fellow inmates, apathy toward health programmes by women inmates due to their past experiences of participation, limited participatory spaces, existence of a legal framework that does not provide a conducive environment for women inmates' participation in health governance, lack of resources and inadequate information by women inmates and correctional officers to enable effective participation in health decision-making processes. The woman-centred citizenship participation model for health seeks to promote women inmates' participation in health governance, while taking into account their lived realities.

The woman-centred citizenship participation model for health is one which comprises three elements and six cross-cutting sub-elements. The first element is that it amalgamates the rights-based and feminist approaches to citizenship participation. The amalgamated approach allows the harnessing of the benefits of the rights-based approach and the feminist approach to citizenship participation. Thus, even though the rights-based approach guarantees health rights to all, the citizenship participation approach recognises the need for social inclusion of marginalised groups such as women inmates. This allows for a health system that uses an amalgamated approach to inquire from marginalised populations about the factors that fuel their marginalisation and take these factors into account when formulating interventions. This ensures that health rights are actually enjoyed by marginalised populations or at least guarantees greater access to health rights for marginalised populations.

The second element it fosters is the effective partnership between target women inmates and the State for promoting the goals of a political or social governance agenda such as health. This helps to enhance women inmates' ability to engage the State on the provision of public health goods and services. Most of the identified forms of participation appropriate for women in correctional facilities are dialogic. This means that a lot of negotiations may occur in a woman-centred citizenship participation model for health.

Fostering effective partnerships between women inmates and the State would empower women inmates to participate in governance spaces and ensure that their health rights and interests are better protected.[986] The third element of the woman-centred citizenship participation model is that it promotes systematic, active and woman-centred participation in health governance. This entails a consistent engagement between the State and women inmates to facilitate consultations for health-related interventions. By consistently engaging with women inmates, State institutions become familiar with women inmates' experiences and health needs.[987] This places the State in a position to better respond to such needs. The process of soliciting women inmates' views and involvement in health governance and promotion programmes must itself be designed, implemented and evaluated with the input of women inmates. By so doing, spaces for participation would continuously be monitored and evaluated for their relevance to the affected group of women inmates.

To implement a woman-centred participation model that embraces women inmates in their diverse forms, the following should be undertaken. Firstly, the Zambian legal and policy framework should stipulate adequate and effective regulations for women inmates' participation in health governance. Such regulations should address discrimination against women inmates in accessing healthcare. They should also address the inconsistent regulatory framework on participation in health governance that currently exists. The formulation of a conducive regulatory framework would not only create standards and spaces for women inmates' participation in health decisions and programmes, but also ensure a woman-friendly environment for the protection of health rights of women inmates. This will allow for official and unofficial spaces of participation in health governance to co-exist, while addressing any security concerns that may arise from correctional facilities.

Those who wield power within the correctional facilities must be regulated in their use of power to ensure that they do not arbitrarily stifle women inmates from participation in health decisions and programmes. Creating legally sanctioned provisions for women

[986] United Nations Office on Drugs and Crime 'Enhancing NGO and government cooperation in the Iraq prison system' (2022) available at https://www.unodc.org/romena/en/Stories/2022/December/enhancing-ngo-and-government-cooperation-in-the-raq-prison-system.html

[987] Gatotoh, Briston & Dankitt op cite note 858 at 264

inmates' participation in health governance could also elevate women inmates' citizenship status and create an enabling environment for shifting negative social attitudes against women inmates. Legally sanctioned spaces for participation by women inmates in health rights would not only make women inmates more visible to society (as their interests will be included in a national agenda for health) but also make the State more visible to women inmates. This would strengthen the relationship between women inmates and the State. If women inmates are involved in the standard-setting process, they would become aware of existing legal and policy provisions that entitle them to participate in health governance and how to use such provisions. This would challenge the status quo where many women inmates are not aware of existing prison health governance regulatory provisions and are unable to use them. This way, women inmates' participation in health governance could have an empowering effect on them compared to situations where such provisions are enacted exclusive of women inmates' participation.

Secondly, a woman-centred citizenship participation model for health of women inmates may be achieved by building allies for women inmates. On their own, women inmates may lack the capacity to negotiate their health needs. Their seclusion from society makes them vulnerable to rights violations and maintains their status as second-class citizens. The development of a 'critical mass' that leads to 'critical acts' is cardinal for fostering a favourable institutional culture for women in correctional facilities, and to empower them to put their health needs and interests on the national agenda.[988] The woman-centred citizenship participation model for health of women recognises that it is important for women inmates to be able to identify strategic partners from government and civil society to increase the voices calling for the recognition of their health and citizenship rights. It is also important to identify strategic partners to ensure that women inmates' health rights and interests are actually realised through advocacy interventions. Consistent and increased interactions between women inmates and allies further improves information-sharing and trust between them, thereby maximising the benefits that come out of such relationships.

[988] Sandra Gray 'Critical perspectives on gender and politics: Do women represent women? Rethinking the 'critical mass' debate' Politics & Gender 2 (2006) 491-530

Thirdly, strengthening the relationship and interactions between State institutions and women inmates through the establishment of enforcement mechanisms for women inmates' health rights is key to fostering women inmates' effective participation in health.[989] In this study, it was found that women inmates were discouraged from using existing spaces for participation in health as they felt that such participation did not yield any benefits for them. To transform existing spaces for participation in health in correctional facilities, it is necessary to foster good relationships between women inmates and State and quasi-State institutions set up to protect human rights, women's rights, health interests and to promote citizenship.[990] Institutions such as the Human Rights Commission, the Gender Equity and Equality Commission, the various Parliamentary Committees, various line ministries, the Judiciary and the Legal Aid Board must be actively involved in extending their services to women inmates in a consistent manner. Good relationships must translate into tangible results for promoting women inmates' health rights, determinants and interests. What would amount to a 'good relationship' was not exhaustively explored in this study, However, it was evident from the women inmates who participated in the study that their relationship with the State would be deemed to be good if they received more regular monitoring visits, addressed women inmates concerns especially about their family members and created an environment in the correctional facilities where living standards were bearable. Not all institutions set up to enforce laws and policies created for such purposes routinely work in correctional facilities hence the weak relationship with women inmates.

Lastly, and closely related to the above, a woman-centred citizenship participation model for health of women inmates requires the creation of a coordinating mechanism for State institutions working on matters relating to women's incarceration, health or citizenship. The failure of State institutions to coordinate their interventions for women inmates' health and citizenship rights even in the face of scarce resources is an abrogation of the State's obligations under article 12 of the ICESCR. Failure to coordinate State institutions leads to inefficiencies in the delivery of health goods and services to women inmates and exacerbates health inequity. This is evident from the status quo where work

[989] Stern op cit note 226
[990] Op cit note 934

done in correctional facilities for women inmates' health rights is haphazard and thus has limited impact. A formal coordinating mechanism can also increase accountability and transparency among State institutions as well as between the State and women inmates. A coordinating mechanism for State institutions and quasi-State institutions could enable them to clearly define their roles and responsibilities with regard to women inmates' health rights. This would prevent a situation where one institution assumes the other will carry out the work or where more than one institution implements the same health-related programme to the exclusion of other similarly important health-related programmes. In the former case, no resources are allocated to women inmates and in the latter cases, a great deal of resources are invested in one programme instead of being shared.

Implementing a woman-centred citizenship participation model in Zambia's correctional settings requires a combination of complementary efforts that ensure the promotion of women inmates' agency, visibility, and inclusion in the Zambia correctional health system. This model also requires the State to recognise the diversity of women inmates' health needs and circumstances and be transparent and accountable to them in the provision of health goods and services and in the promotion of their fundamental rights and freedoms, including the right to health. In implementing the woman-centred citizenship participation model for health of women inmates in Zambia, the goal should be to enable women inmates to enjoy, without discrimination, their human rights and citizenship status. This can be achieved by changing entrenched institutional cultures in correctional facilities that keep women inmates suppressed and treat them as second-class citizens and ensuring the six sub-elements are realised in correctional facilities: promotion of agency, visibility, inclusion, diversity, transparency and accountability.

8.3 LIMITATIONS OF STUDY AND AREAS FOR FUTURE RESEARCH

One of the limitations of this study is the inability to ascertain holistic data on key determinants of health such as the establishment and functioning of the correctional health system, the selection and roles of cell captains and the spaces for health-related participation as factors likely to impact women inmates' participation in health-related decisions and programmes. The Prison audit of 2023 as well as the National Health Policy do not provide information on the establishment of the correctional health service. There is also limited data on how cell captains are appointed and how this impacts on women

inmates' health and spaces for participation. Although study participants spoke about various prison practices impacting women inmates' participation, the information obtained from them was not sufficient to provide all the necessary details. For example, no one could provide information on when table complaints or peace clubs started or who exactly initiated them. The high levels of mobility in and out of prisons means that the prison population is not static enough to record some of this information. This is true of the different times in which state and non-state actors start working in prison settings. Coupled with poor documentation, inconsistent and inadequate prison studies particularly related to women inmates, it was difficult to establish the missing information. Some of these initiatives were started informally and formalised later, making it hard to state when and by whom they were initiated. For example, the Directorate of Health Services is a creature of the 2021 Correctional Service Act and yet in 2019 when the interviews were done some institutional participants spoke about the use of correctional health committees set up to do work similar to that of the Directorate. It is not clear whether these have been subsumed in the Directorate or will continue existing informally as they did prior to the 2021 legislative provisions.

Another limitation of this study is that it did not investigate the likely impact of the woman-centred citizenship participation model to health for women inmates on the security concerns inherent in correctional facilities. The study acknowledges that the creation of women-friendly spaces for participation in health governance should be balanced with the need for peace, order and security for correctional facilities. How this balance is struck was not considered. This would require an inquiry into the common security breaches perpetuated by women inmates in the Zambian setting. Existing literature shows that women inmates across the globe are relatively less inclined to committing violent offences and their rate of recidivism is relatively lower than their male counterparts.[991] Although a few women attested to this, security concerns were not raised as a barrier to fostering women inmates' participation in correctional health governance hence it was not explored. Closely related to this limitation of this study is that it did not

[991] Caroline Agboola, Erasmus Kofi Appiah & Helen Namondo Linonge-Fontebo (2022) Women's pathways into crime and incarceration: insights from South Africa, Cogent Social Sciences, 8:1 available at https://www.tandfonline.com/doi/full/10.10.80/23311886.2022.2044123

investigate the impact of the woman-centred citizenship participation model on reducing re-offending by women inmates and on the newly introduced correctional approach in the criminal justice system of Zambia. Based on scholarly works of authors such as Hayden Bird and Katherine Albertson,[992] there is a positive correlation between prisoners' ability to express themselves on matters that affect them and reducing recidivism. This inquiry is important for considering justifiable limitations to rights by use of less intrusive measures acceptable in a democratic society as well as assessing the cost-benefit of implementing the woman-centred participatory model. The thesis did not, however, inquire into this as it was primarily concerned with ascertaining the role of participation in enhancing access to healthcare for women inmates.

Lastly, the thesis did not examine the structures that would be needed to harness women inmates' newly acquired political power to advance their social rights and participation. Following the Court's decision in the *Malembeka case* recognising inmates' right to vote in national elections, and the fact that women inmates participated in national elections for the first time in 2021, a women-centred assessment of the requisite structures and regulations needed for registration of voters, political campaigns by all political parties, voting and other election practices is cardinal. Further research in these areas is thus required.

[992]Bird & Albertson op cit note 288

ANNEX 1

INTERVIEW GUIDE FOR WOMEN PRISONERS

1. RESPONDENT INFORMATION
1.1. Region /province:
1.2. Name of correctional facility:
1.3. Full Name (optional):
1.4. Occupation:
1.5. Income earned before imprisonment:
1.6. Marital status:
1.7. Number of children:
1.8. Area of Residence prior to incarceration:
1.9. Which of the following are applicable to you: (tick)
a. You are an expectant mother.
b. You have at least one child in prison with you.
c. You are an illegal immigrant
d. You have a terminal illness
e. You have a disability
f. You are incarcerated in a town far from your home town
g. Other:
2. Health Determinants and Access to Healthcare for Women Prisoners
2.1. What do you think the right to health means?
2.2. Which group of female prisoners do you think are most in need of healthcare goods and services? Explain.
2.3. Describe your experiences in accessing healthcare in your correctional facility?
2.4. What are the common health concerns for women prisoners in your facility?
2.5. What values do you think are necessary for improving access to healthcare for women prisoners?
2.6. How do you think the healthcare system in your facility affects your health?
3. SOCIAL STANDING AND CITIZENSHIP.
3.1. How would you describe the relationship between women prisoners and the State?
3.2. What do you think about women prisoners participating in decision-making on health matters in prison settings?
3.3. How does imprisonment affect women prisoners' enjoyment of public goods and services?
3.4. The government has changed its approach from punishing prisoners for their crimes to seeking to reform them. What does this mean for you?
3.5. What do you think is the role of women prisoners in improving access to healthcare goods and services?
4. UNDERSTANDING WOMEN'S PARTICIPATION IN HEALTH-RELATED DECISION-MAKING
4.1. How do you address access to healthcare challenges in your facility?
4.2. How do you think your participation in health-related decisions can impact on your health?
4.3. What kind of resources do you need to participate in health-related decision making?

5. ROLE OF LAWS, POLICIES AND INSTITUTIONS

5.1. How do you use laws and policies to improve your access to healthcare?

5.2. What can the law or policies do to improve your access to health in your facility?

5.3. What State institutions affect the enjoyment of health by women prisoners?

5.4. What changes in your correctional facility do you think will help women prisoners to their participation in health-related decision-making and activities?

Thank you for your assistance.

All personal information will be treated as confidential.

By participating in this study you agree to Chipo Mushota Nkhata using the above information for her PhD research paper as well as any subsequent publications (where requested, excluding any reference to the names of any individuals, which will be anonymised or excluded).

ANNEX 2
INTERVIEW GUIDE FOR CIVIL SOCIETY ORGANISATIONS

1. RESPONDENT INFORMATION
1.1. Region /province:
1.2. Organisation type:
1.3. Organisation's target group:
1.4. Organisational name:
1.5. Respondent's full name:
1.6. Respondent's designation:
1.7. Institutional contact details:
2. Health Determinants and Access to Healthcare for Women Prisoners
2.1. What do you understand by the phrase "access to healthcare"?
2.2. Which group of female prisoners do you think are most in need of healthcare goods and services? Explain.
2.3. What are the common health concerns for women prisoners in Zambian correctional facilities?
2.4. What work is your organisation doing to enhance access to healthcare for women prisoners?
2.5. How is the health of women prisoners affected by the health governance system applicable to correctional facilities in Zambia?
3. SOCIAL STANDING AND CITIZENSHIP.
3.1. What is your opinion about the human rights status of women prisoners?
3.2. What do you think about women prisoners participating in decision-making on matters that affect their health in prison settings?
3.3. What is your opinion on the effect of imprisonment on the entitlement and enjoyment of public goods and services by women prisoners?
3.4. The government has changed its approach from focussing mostly on punishing of prisoners for their wrongdoing to seeking to rehabilitate them. What does this mean for women prisoners?
3.5. What is the role of women prisoners in facilitating access to healthcare goods and services?
4. UNDERSTANDING WOMEN'S PARTICIPATION IN HEALTH-RELATED DECISION-MAKING
4.1. How has your organisation involved women prisoners in developing programmes aimed at enhancing their health rights?
4.2. How does participation in health-related decisions by women prisoners impact on their access to healthcare?
4.3. What kind of support/resources do women prisoners need to effectively participate in health-related decision-making?
5. ROLE OF LAWS, POLICIES AND INSTITUTIONS
5.1. What standards and norms exist in management and health governance systems of correctional facilities for participation of women prisoners in health-related decision making?
5.2. How does your organisation use existing laws and policies to address health concerns for women prisoners?
5.3. What is the role of the Zambian legal framework in guaranteeing participation of women prisoners in decision-making and shaping the regulatory framework applicable to prison settings in Zambia?

5.4. What State institutions, other than correctional facilities, directly impact on access to healthcare for women prisoners? Explain.
5.5. What institutional arrangements or systems do you think will help women prisoners to maximise their participation in health-related decision-making and governance?

Thank you for your assistance.

All personal information will be treated as confidential.

By participating in this study, you agree to Chipo Mushota Nkhata using the above information for her PhD research paper as well as any subsequent publications (where requested, excluding any reference to the names of any individuals, which will be anonymised or excluded).

ANNEX 3
INTERVIEW GUIDE FOR STATE AND QUASI-STATE INSTITUTIONS

1. RESPONDENT INFORMATION

1.1. Region /province:

1.2. Institution type:

1.3. Institution's core mandate:

1.4. Institution's name:

1.5. Respondent's full name:

1.6. Respondent's designation:

1.7. Institutional contact details:

2. Health Determinants and Access to Healthcare for Women Prisoners

2.1 What do you understand by the phrase "access to healthcare"?

2.2 Which group of female prisoners do you think are most in need of healthcare goods and services? Explain.

2.3 What are the common health concerns for women prisoners in Zambian correctional facilities?

2.4 What work is your institution doing to enhance access to healthcare for women prisoners?

2.5 Describe the health governance system applicable to correctional facilities in Zambia.

2.6 In your opinion, what is the impact of the health governance system in correctional facilities on women prisoners in Zambia?

3 SOCIAL STANDING AND CITIZENSHIP

3.1 What is your opinion about the human rights status of women prisoners?

3.2 What do you think about women prisoners participating in decision-making on matters that affect their health in prison settings?

3.3 What is your opinion on the effect of imprisonment on the entitlement and enjoyment of public goods and services by women prisoners?

3.4 What is the role of women prisoners in facilitating access to healthcare goods and services?

4 UNDERSTANDING WOMEN'S PARTICIPATION IN HEALTH-RELATED DECISION-MAKING

4.1 How has your institution involved women prisoners in developing programmes aimed at enhancing their health rights?

4.2 What do you think is the impact of women's participation in health-related decision-making on their access to healthcare?

4.3 What kind of support/resources do women prisoners need to effectively participate in health-related decision-making?

5 ROLE OF LAWS, POLICIES AND INSTITUTIONS

5.1 What standards and norms exist in management and health governance systems of correctional facilities for participation of women prisoners in health-related decision making?

5.2 How does your institution use existing laws and policies to address health concerns for women prisoners?

5.3 What do you think is the role of the Zambian legal framework in guaranteeing participation of women prisoners in decision-making and shaping the regulatory framework applicable to prison settings in Zambia?

5.4 What personal and institutional values do you think are necessary for realising greater access to healthcare for women prisoners?

5.5 What State institutions, other than correctional facilities, directly impact on access to healthcare for women prisoners? Explain

5.6 What institutional arrangements or systems do you think will help women prisoners to maximise their participation in health-related decision-making and governance?

Thank you for your assistance.

All personal information will be treated as confidential.

By participating in this study, you agree to Chipo Mushota Nkhata using the above information for her PhD research paper as well as any subsequent publications (Where requested, excluding any reference to the names of any individuals, which will be anonymised or excluded).

ANNEX 4
INTERNATIONAL AND REGIONAL HUMAN RIGHTS TREATIES ON THE RIGHT TO PUBLIC PARTICIPATION

INTERNATIONAL COVENANT ON CIVIL AND POLITICAL RIGHTS

25. Every citizen shall have the right and the opportunity, without any of the distinctions mentioned in article 2 and without unreasonable restrictions:

(a) To take part in the conduct of public affairs, directly or through freely chosen representatives;

(b) To vote and to be elected at genuine periodic elections which shall be by universal and equal suffrage and shall be held by secret ballot, guaranteeing the free expression of the will of the electors;

(c) To have access, on general terms of equality, to public service in his country.

AFRICAN CHARTER ON HUMAN AND PEOPLES' RIGHTS

13 (1) Every citizen shall have the right to participate freely in the government of his country, either directly or through freely chosen representatives in accordance with the provisions of the law.

(2) Every citizen shall have the right to equal access to public service of his country.

(3) Every individual shall have the right of access to public property and services in strict equality of all persons before the law.

ANNEX 5

PART IV CORRECTIONAL HEALTH SERVICE

13. (1) The Commission shall appoint as public officers, the Director responsible for providing and administering healthcare services to a prison or correctional centre and other officers as the Commission shall consider necessary. (2) The Director appointed under subsection (1) is responsible for the— (a) day-to-day administration of healthcare services to a prison or correctional centre; and (b) supervise a health practitioner appointed under section 14.

14. (1) The Commission shall, in consultation with the ministry responsible for health, appoint a health practitioner for a prison or correctional centre as is necessary for the provision of healthcare to the inmates and correctional officers at that prison or correctional centre. (2) Subject to this Act, a health practitioner appointed under subsection (1) shall visit a prison or correctional centre daily, where practicable, or when called on by an officer-in-charge. (3) A health practitioner shall, where it appears that an inmate requires treatment on medical or health grounds, submit a report to the officer-in-charge. (4) A public officer appointed as a health practitioner by the Commission in a district shall, in the absence of a health practitioner appointed under subsection (1), provide healthcare services to inmates and correctional officers at a prison or correctional centre in that district, as prescribed.

15. (1) A health practitioner shall carry out medical examination of an inmate on admission to, and before discharge from, a prison or correctional centre, and shall perform other duties as prescribed. Deployment of correctional officers to prison or correction centre Director Correctional Health Services Appointment of health practitioner Medical inspection Zambia Correctional Service [No. 37 of 2021 371]

(2) An officer-in-charge shall, where an inmate has not been examined by a health practitioner on admission to a prison or correctional centre, be kept apart from other inmates.

16. A health practitioner shall, on each visit to a prison or correctional centre, examine and observe the mental condition of an inmate under a sentence of death or charged with a capital offence, and submit a report to the officer-in-charge as prescribed.

17. A health practitioner shall ensure that an inmate under a sentence of death, or charged with a capital offence, or in separate confinement, or in a health facility in prison, is medically examined each day on which the health practitioner visits the prison or correctional centre.

18. An officer-in-charge may order an inmate to submit oneself to medical examination and treatment as often as that officer –in-charge considers necessary.

19. A health practitioner shall keep and maintain a register of the death of an inmate, otherwise than by lawful execution, which shall include —

(a) the day on which the deceased inmate was sentenced;

(b) the day on which the deceased inmate was admitted to a prison or correctional centre;

(c) the day on which the deceased inmate first complained of illness, or was observed to be ill, the labour, if any, on which the inmate was engaged in and the scale of that deceased inmate's diet on that day;

(d) whether, and if so the day on which, the deceased inmate was admitted to a health facility;

(e) the day on which the health practitioner was first informed of the illness;

(f) the nature of the disease;

(g) when the deceased inmate was last seen by the health practitioner before the inmate's death;

(h) when the inmate died and, where a postmortem examination is made, details of the appearance of the deceased inmate, together with any special remarks that the health practitioner considers necessary; and Observation of inmate charged with capital offence Examination of inmate in separate confinement or in health facility

(i) the health practitioner's opinion as to the cause of death of the inmate.

20. An officer-in-charge shall, on the death of an inmate in a prison or correctional centre, immediately notify a magistrate.

PART VIII REHABILITATION, REINTEGRATION AND EMPLOYMENT OF INMATES

50. (1) The Service shall provide rehabilitation programmes including educational, work and social programmes which shall, as far as possible, improve the inmate's possibility of successful reintegration in the community after discharge.

(2) Subject to the Constitution, a person shall not be barred from consideration for employment by a public or private body by reason of having previously served a term of imprisonment.

(3) For the purpose of this section— "private body" has the meaning assigned to the words in the Statistics Act, 2018; and "public body" has the meaning assigned to the words in the Public Finance Management Act, 2018.

51. (1) Subject to subsections (2) and (3), a criminal inmate shall engage in work within or outside the precincts of a prison or correctional centre, as directed by the officer-in-charge and, as far as is practicable, the work shall take place in association with other inmates, except that a health practitioner may excuse an inmate from work or order that the inmate perform light work, on medical grounds.

(2) The Commissioner-General may direct inmates to perform tasks on public works as may be considered necessary.

(3) A female inmate shall not, except on the approval of the Commissioner-General, be employed outside a prison or correctional centre.

(4) A civil inmate and an unconvicted inmate may elect to work and, if the inmate so elects, shall receive payment at rates as prescribed.

52. (1) A civil and an unconvicted inmate shall be required to keep their cells, the precincts, furniture, clothing and utensils clean.

(2) An appellant inmate shall be required to keep an appellant inmate's cell, the precinct, furniture, clothing and utensils, clean and to perform labour as the officer-in-charge may, with the approval of the Commissioner-General, direct.

(3) The Commissioner-General may authorise a registered institution, person or body to employ or offer training to inmates under a sentence of imprisonment on terms and conditions that may be determined.

PART X CIVIL AND UNCONVICTED INMATES

63. A civil or an unconvicted inmate may be permitted to maintain oneself and to arrange for the purchase of, or receipt from, private sources at prescribed hours, food, clothing, or other necessaries that the Commissioner-General may, determine.

64. (1) An inmate that purchases or receives food, clothing, or other necessaries under section 63 shall not hire or sell to any other inmate.

(2) A person who contravenes this subsection is liable to lose all privileges provided under section 63 as the officer-in-charge may determine.

65. Where a civil inmate or an unconvicted inmate does not provide oneself with food and clothing, the inmate shall receive the normal food, clothing and other requirements provided by a prison or correctional centre.

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