

EHP SA Case Study Series:
Included! How change happened for key populations and HIV prevention

Cracks in the walls

**Access to improved services for HIV in
Zambian prisons**



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1. INTRODUCTION

This case study reviews how the high rate of AIDS-related mortality in Zambian prisons made the first ‘cracks in the walls’ between the prison administration and health-service organisations, and in time opened up Zambian prisons to major interventions to address HIV.

The Zambian prison administration had been focused on security and was highly secretive but the high HIV-related mortality in prisons forced the institution to acknowledge that it was unable to adequately respond to the devastating effects of HIV. It became more open to the situation in prisons and to the possibility of working with external actors who were able to deliver essential HIV services.

The case study explores how various actors in the Zambian context responded to the HIV crisis such that the prison administration transformed from being closed to the health problems of the late 1990s to the situation from 2010 onwards, where a range of civil society organisations have successfully delivered significant levels of HIV services.

About this paper

This paper is part of a series, *Included! How change happened for key populations for HIV prevention, commissioned by EHPSA to Nordic Consulting Group*. The full series of nine case studies and discussion paper will be made available on the EHPSA website as they are completed at <http://www.ehpsa.org/critical-reviews/included>.

The series was based on both literature research and interviews with key actors and focuses on examples from eastern and southern Africa. In-depth interviews for this case study were conducted with representatives of the Zambian Correctional Services and Zambian NGOs working in prison health. The full list of interviewees is given in Annexure 1 on page 11.

About EHPSA

Evidence for HIV Prevention in eastern and southern Africa (EHPSA) is a catalytic intervention, contributing to national, regional and global processes on HIV prevention for adolescents, men who have sex with men (MSM) and people in prison, through generating evidence of what works and why, and developing strategies to inform policymaking processes. It is a five-year programme funded by DFID and managed by Mott MacDonald.

2. CONTEXT

Despite significant progress in recent years, HIV is still a major threat to health and development in Zambia, with national prevalence in 2016 at 12.4% of adults aged 15-49.¹ The Zambian epidemic is driven largely by unprotected heterosexual sex and the country has adopted a combination prevention programme to combat this. Although the latest National HIV and AIDS Strategic Framework (2017–2021)² identifies prisoners as a key population, it does not offer any programmes targeted at HIV prevention among prisoners.

According to UNAIDS, prisoners are one of the most vulnerable – yet overlooked – risk groups in terms of HIV infection. Although it is unclear to what extent prisoners acquire HIV infection before or during incarceration, HIV prevalence in prisons matches the rate in communities with the highest national prevalence. HIV preva-

1 UNAIDS Zambia Overview, Geneva, UNAIDS (<http://www.unaids.org/en/regionscountries/countries/zambia>)

2 Republic of Zambia National HIV/AIDS/STI/TB Council, National HIV and AIDS strategic framework 2017-2021, Lusaka, 2017

lence in Zambian prisons was estimated at 27.4% in 1999³ and again in 2010.⁴ This was during a period when the prevalence for adult men in the general population had stabilised at between 12 and 13%.⁵

Male-to-male sex in prisons is relatively common. However, under-reporting or over-reporting is likely because of the delicate nature of the topic, so it is difficult to be precise about its extent. Zambia prides itself on being a Christian country; the influence of conservative Christian values and traditional attitudes towards homosexuality mean there is a reluctance to address the reality that same-sex relations occur in prison. This is underscored by the legal context; under law, attempting to commit sodomy, or being convicted for sodomy, is punishable by imprisonment of up to 14 years.

Prisons and prison health

Zambia has 90 prisons, of which 35 are 'open-air' or farm prisons and 55 are 'standard' prisons. There are two reformatory institutions for juveniles. The official capacity of the prisons is approximately 8 000, after new facilities were opened in 2016. In March 2017, the prison population reached an all-time high of more than 20 000 inmates. In some prisons, the number of prisoners is more than four times the official capacity. Extreme overcrowding contributes significantly to poor health. Sleeping arrangements are a breeding ground for tuberculosis and other respiratory infections, fungal infections, scabies and lice. AIDS-related diseases and tuberculosis (TB) are widespread, as are various forms of diarrhoea, and contribute to the high morbidity and mortality rates in Zambian prisons.^{6,7,8,9}

The general state of malnutrition and poor health among prisoners is exacerbated by HIV. Prisoners are also often co-infected with TB and hepatitis B or C, which are very common. In one study¹⁰ the TB infection rate was 18 times higher in one of Zambia's largest prisons (Lusaka Central Correctional Facility) than in the outside community; 6.4% of inmates were infected with TB.

Infectious diseases from inside the prisons are transmitted to the community via prisoners leaving the prison, and by prison staff and visitors. High mobility between prisons and the communities means that prison health problems become community health issues.

3. THE CHANGE PROCESS

A series of events over a period of ten years led to significant changes in the Zambia Prisons Services (ZPS)¹¹ approach to HIV. By 2010 there was an openness that allowed NGOs to operate within prison facilities to provide HIV services, in coordination with ZPS.

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- 3 Simooya O et al. 'Behind walls': A study of HIV Risk Behaviours and Seroprevalence in Prisons in Zambia. *AIDS*, 15 (Issue 13):1741-1744
 - 4 Simooya O et al. 'Aggressive Awareness Campaigns May Not be Enough for HIV Prevention in Prisons - Studies in Zambia Suggest Time for Evidence Based Interventions', *The Open Infectious Diseases Journal*, 2014, 8, 1-7
 - 5 Republic of Zambia National AIDS Council Zambia Country Report. Monitoring the declaration of commitment on HIV and AIDS and the Universal Access. Biennial Report. Lusaka, 31 March 2014
 - 6 Egelund, A. *Surviving Zambian Prisons – Inmate Experiences, Coping Strategies and Sex in Prison* [thesis]. Roskilde University, 2016
 - 7 Topp SM, Moonga CN, Luo N, et al. 2016 (a); Mapping the Zambian prison health system: An analysis of key structural determinants, *Global Public Health*, 12:7, 858-875
 - 8 Zambia Prisons Service. *Health Strategic Plan 2011-16*. Kabwe, 2011
 - 9 Topp SM, Moonga CN, Luo N, et al. 2016 (b); Exploring the drivers of health and healthcare access in Zambian prisons: a health systems approach, *Health Policy and Planning*, Volume 31, Issue 9, 1250–1261
 - 10 Maggard KR et al. Screening for tuberculosis and testing for human immunodeficiency virus in Zambian prisons, *Bull World Health Organ* 2015, 93:93-101
 - 11 In 2016 there was a name change from Zambia Prisons Service to Zambia Correctional Service to reflect a commitment to transform prisons from punitive institutions to correctional establishments. This case study uses the name of the service relevant at the time.

3.1 The HIV crisis changes ZPS culture, late 1990s

The AIDS crisis was becoming very evident in the prisons in the late 1990s, with inmate deaths occurring daily. ZPS was aware of the scale and urgency of the problem – it estimated that between 1995 and 2000, 2 397 inmates and 263 prison staff died from AIDS-related illnesses, including TB.¹² ZPS was also aware that it was unable to manage the challenges on its own and was therefore increasingly willing to accept support from outside the organisation. This acknowledgement of the need for external support in the context of the consequences of AIDS epidemic was a vital step towards changing the insular social environment of the ZPS, where the focus was on maintaining security and controlling inmates. Issues of public health were new to ZPS and it created resistance at all levels, from the Ministry of Home Affairs, to inside the ZPS, all the way down to the individual prisons.

Nevertheless, the AIDS crisis became a decisive factor in a culture-shift towards taking on the responsibility for improving health and moving the Prison Service to a focus on human rights, a transformation underlined by its 2016 name-change to Correctional Services.

Around the same time, in the late 1990s, In But Free (IBF) emerged, a small but competent prison-focused NGO led by a Zimbabwean medical doctor and a Zambian community-health specialist. Both were employed at Copperbelt University of Zambia, while they were establishing and running the NGO. In But Free provided a unique platform for advocating for prisoner health from a public health standpoint with the weight that comes with strong ties to a research institution.

In this context, ZPS allowed IBF to carry out a UNAIDS-funded study in three prisons. This study showed a high prevalence of HIV infection¹³ as well as high levels of risky behaviour, that included sex between men. At 27%, the HIV prevalence was far higher than the national average and comparable to the rates found in Zambian cities. IBF used the study results to advocate for ZPS to open the prisons to outside support. With sustained pressure, IBF persuaded ZPS to allow it to implement HIV services and in time, ZPS began to view IBF as a health partner.

In 2003, a consultative process led by IBF, funded by USAID and heavily supported by ZPS, resulted in the development of a draft HIV–AIDS–TB policy for prisons. Although the process of adopting the draft was stalled by internal politics between the Ministry of Home Affairs and the ZPS, the opening up of prisons to an external service provider in the context of the AIDS crisis created a precedent for an important development in the prisons health systems – the establishment of the Prisons AIDS Advisory Committee (PAAC).

3.2 The establishment of Prisons AIDS Advisory Committee, 2005

The aim of the Prisons AIDS Advisory Committee (PAAC) was to bring together different partners to discuss, coordinate and strategise on prison health, particularly regarding HIV.

In 2005, UNAIDS in Zambia was heavily involved in advocating for health-care provision for key populations as part of the process leading up to the Fifth National Development Plan (2006–2010). UNAIDS in particular, recognised the vulnerability of prisoners, the lack of a coordinated response and the challenge of limited government commitment to key populations.

The Prison Care and Counselling Association (PRISCCA), a small NGO led by a charismatic ex-prisoner, approached UNAIDS in 2005 asking for support in promoting the HIV agenda in prisons. The UNAIDS Country Coordinator at the time was sensitive to the plight of prisoners, and after a few meetings with PRISCCA, assigned a UNAIDS programme officer to support prison work. The programme officer held bilateral meetings with the few organisations working on health in prisons at the time and it was concluded that the role of UNAIDS would be to facilitate and mobilise civil society.

In 2005, Zambian civil society was uncoordinated and had no common voice. Civil society organisations working in prisons were still relatively weak and unable to challenge government decisions. The organisa-

12 Todrys KW et al. Imprisoned and imperiled: access to HIV and TB prevention and treatment, and denial of human rights, in Zambian prisons. *Journal of the International AIDS society* 2011, 14:8

13 Simooya O et al, 2001: Ibid

tions initially involved in the PAAC were prison-specific NGOs – IBF and PRISCCA – and several organisations that were not prison-specific: Care International, Zambian AIDS Research and Advocacy Network (ZARAN), SHARe, and the Human Rights Bureau (which no longer exists). IBF focused on health – mainly HIV and TB – and also implemented HIV peer-education programmes and other services in prisons. It established a long-term commitment and trusting relationship with the ZPS. The only interest from a bilateral donor at the time was from representatives of the Danish Embassy and a Danish legal expert based in the Zambian Ministry of Justice.

From the time the PAAC was established, the Ministry of Home Affairs (MoHA) viewed civil society with suspicion and was reluctant to allow them much influence. However, high-level ZPS staff were acutely aware that they could not deal with the consequences of AIDS in prisons and wanted more openness to external involvement. The insular prison culture was a considerable barrier – the UNAIDS programme officer was accused of being an American spy on her first visit to HQ – but with perseverance and commitment on the part of UNAIDS and civil society members, this attitude changed over the next few years.

The PAAC meetings only took place because UNAIDS took a lead in convening all the partners. An extraordinary commitment was shown by the participating NGOs, who would show up for the meetings despite frequent cancellations. ZPS attended and participated in all the meetings. However, there was a strict hierarchy dividing the ministry and ZPS, whose staff could do little but offer advice and attend meetings to demonstrate their commitment, which proved to be vital in the coming years.

Initially, two important actions were decided upon by the PAAC:

- PAAC would support the development of a prisons HIV and AIDS policy and a costed strategy based on a policy workshop consisting of government representatives, CSOs, UN and international partners.
- PAAC would support coordination activities, mainly in the fight against HIV and AIDS, and TB.

PAAC created the opportunity for ZPS to share information and coordinate efforts and offered a platform for civil society and others to voice their concerns. It was also an opportunity to keep the government accountable to its promises. Even so, the first years were difficult and the participating organisations were constantly concerned about being shut down or excluded from the decision-making process; any advocacy had to be done very sensitively. It was PRISCCA that took the most risks in this regard; for their pains they were on occasion deregistered by government. Nonetheless, it seems PRISCCA managed to get the right balance between advocacy and diplomacy, because the criticism they voiced was heard.

3.3 The development of a prisons HIV and AIDS policy (2005-2008)

From 2005 onwards, UNAIDS supported the PAAC with policy development. A consultative 18-month process was initiated to develop a new HIV–AIDS–TB prisons policy for both staff and inmates. At its conclusion, a policy workshop was held with participants from international partners, civil society and government to discuss the content of the policy. Civil society representation at the policy workshop included the NGOs that were initially involved with PAAC. Participants also included multilaterals such as UNAIDS, WHO, UNDP and UNFPA as well as representatives from the Danish Embassy.

Ownership of this process was important for ZPS whose staff attended all the meetings, even though they had to travel two to three hours each way between prisons headquarters in Kabwe and Lusaka. Although little decision-making power was delegated to ZPS at the time, meeting attendance and staff commitment proved important nevertheless.

The policy objective for UNAIDS, IBF and PRISCCA was to ensure that prisoners gained access to the same health services and rights as the rest of the population, including condoms. Providing condoms proved to be contentious because of the sensitivity of an implied admission of male-to-male sex in prisons, and opposition to tacit support of homosexuality, which was illegal.

Much debate centred on access to condoms: civil society, international partners and the UN were united in an informal alliance for condom distribution, whereas MoHA was exceedingly reluctant, and ZPS was divided on the matter. Both stated that implementing condom distribution was impossible due to the illegality of male-to-male sex, but civil society representatives, in conjunction with the UN, were able to push the agenda of equal rights of prisoners to prevention, treatment, care and support.

The most important result in relation to condoms was that the agreed policy stated that the same preventive,

treatment and support services available to the general population should be available to prisoners. This principle of equivalence of care is internationally practised in relation to prison health.

In relation to condoms, the principle meant that because condoms are permitted in general society, should there be a change in the law on sodomy, it would be possible to distribute condoms. In 2008, the prisons policy was finally adopted by cabinet. Since then it has received much international acclaim.

3.4 The establishment of a health directorate in Zambia Prisons Service (2008)

In the early 2000s, ZPS relied on the Ministry of Health to provide health services. Within government structures ZPS and PAAC successfully advocated for ZPS to provide health services themselves.

In 2008, a medical directorate headed by a medical doctor was appointed and ZPS slowly built up its capacity to provide health services.

The director played a key role in placing HIV at the centre of the ZPS agenda. He was very open and frank about the issues relating to HIV transmission inside prisons, from male-to-male sex to issues relating to poor service delivery. A powerful example are his contributions to the hard-hitting report 'Unjust and Unhealthy. HIV, TB, and Abuse in Zambian Prisons'¹⁴ which ARASA, PRISCCA and Human Rights Watch published in April 2010. The report was based on facility tours, on access to six representative prisons and on confidential interviews with 246 prisoners, eight former prisoners, 30 prison officers-in-charge and officers. It catalogued criminal justice failures, overcrowding and poor care and how they exacerbate the spread of TB and HIV. The medical director's comments were striking for their openness, depth of criticism and vision; at one point the director describes the absurdly disparate ratio of medical staff to inmates under their care as 'out of this world'.

3.5 Scaling up services with new partners, 2010-

The medical directorate has been of critical importance in paving the way for better coordination and strengthening capacity for health services, particularly for HIV, within prisons. Its openness about health challenges and the lack of internal capacity, and acknowledgement of the need to receive help, has enabled service providers to work extensively in prisons with significant external funding. For example, following an intervention by the medical director in 2010, the Centre for Infectious Disease Research in Zambia (CIDRZ), a health research and service provider, implemented a programme to address TB and HIV in three prisons.¹⁵ From 2013, CIDRZ also delivered the EU-funded Zambia Prisons Health Systems Strengthening Project (ZaPHSS).¹⁶ Another major intervention introduced in 2010 was the PEPFAR-funded SHARE II project which worked in 28 prisons and reached 11 500 inmates with services over five years.

The directorate has demonstrated important results. The capacity to provide health services has been strengthened, including the training of HIV and AIDS coordinators in all prisons in the country, where they are mandated to report on HIV- and AIDS-related issues to head office. Important progress has been made, but what is also significant in the regional context of correctional services, there is openness about the major gaps that remain due to a series of governance, financing and capacity-related health system weaknesses that undermine access to and quality of healthcare in Zambian prison facilities.

14 ARASA, PRISCCA and Human Rights Watch: 'Unjust and Unhealthy. HIV, TB, and Abuse in Zambian Prisons'. New York, Human Rights Watch, April 2010.

15 'Inmates lead the fight against TB in Zambia's prisons' http://www.stoptb.org/news/stories/2011/ns11_038.asp

16 Topp SM, Sharma A, Moonga CN et al. Evaluation of a health system strengthening initiative in the Zambian prison system *BMJ Global Health* Jan 2018, 3 (1) e000614.

4. HOW CHANGE HAPPENED

This section summarises the critical actors and factors in transforming Zambian prison health and HIV services.

4.1 Critical Actors

Actor Category	Actor	Role
National government	<ul style="list-style-type: none"> Ministry of Home Affairs Ministry of Health Zambia Prison Services Zambia Law Development Commission 	Policy development, policy implementation and management, supply of basic health services and funding, convening external civil society service providers
CSOs focussed on people in prison	<ul style="list-style-type: none"> In But Free PRISCCA Prisoners' Future Foundation Ubumi Prisons Initiative 	Advocacy and policy development, service provision
Other civil society organisations	<ul style="list-style-type: none"> Access to Justice CELIM CHRESO CIDRZ SHARe /USAID Discover Health VSO 	Advocacy and policy development, service delivery, infrastructure development and skills development
Research institutions	<ul style="list-style-type: none"> CIDRZ In But Free ZARAN 	Providing strategic information: Knowledge production (HIV prevalence study 1999 and 2010), other studies
International Actors	<ul style="list-style-type: none"> UNAIDS (UN lead organization 2005-2007) UNODC (UN lead organization 2008 – current) USAID, CDC Human Rights Watch 	Research, advocacy, capacity building, health systems strengthening, CSO mobilisation and support, and funding
Individuals/champions for change	Present in both the ZPS and civil society	Advocacy and persistent support despite risk of stigma or other repercussions

4.2 Contributing factors

In identifying the critical factors that contributed to the achievements, a distinction is made between those that created an enabling environment for change and the tactics used to bring about change in this context. Inevitably there is some overlap between them.

Creating an enabling environment

Evidence available: Awareness of prison deaths catalysed the response, but research evidence was also critical. IBF, with support from UNAIDS and later UNODC funding, provided critical information on HIV-prevalence for advocacy purposes. Because of this the problem of HIV could not be denied by public authorities and motivated officials were thus able to use the evidence to lobby internally for change.

Evidence-based practice within government: ZPS accepted the IBF HIV study results in 1999 and 2010. Also, it collaborated with Human Rights Watch to enable it to research and publish a hard-hitting report based on a representative sample of prisons and a significant number of confidential interviews with inmates and staff.

Research institutions expected to engage on findings: IBF, operating under the auspices of Copperbelt University, took the opportunity to carry out surveys to inform the case for better service provision.

Catalytic events: Awareness of exceptionally high numbers of AIDS-related deaths in prisons triggered ZPS to agree to the IBF survey in 1999 and accept the need for external help with health provision. The AIDS crisis became a decisive factor in changing the culture in ZPS towards taking responsibility for improving health and moving the service in general towards an increasing focus on human rights and transforming from a punitive to correctional approach. It was a *zeitgeist moment*.

Influential champions: Government officials and NGO staff alike brought the vision for change – the courage to speak out and highlight sensitive issues, an openness to engage and collaborate, and the commitment and persistence to continue to push for improvements over many years, despite slow progress.

Global policies and guidelines for adoption: UNAIDS, WHO and UNODC produced several guidelines and policies for prison health. These have been used as reference documents and to promote the prisoner health agenda. Human rights standards such as the UN Standard Minimum Rules for the Treatment of Prisoners (now known as the Mandela Rules) were used to develop the HIV policy, including the principle of equivalence. These agencies highlighted the contribution of prisons to public health concerns, particularly in relation to HIV and TB, which promoted availability of significant external funding for prison HIV interventions from 2010.

External funding available: The prison health budget was minimal – just USD 42 000 in 2010 – so CSO service provision was entirely dependent on external funding. PEPFAR and the European Commission provided critical grants from 2010.

A prison service that was open to change: Early on, the ZPS recognised the need to act on HIV in prisons, even though there was little support from the MoHA. This provided space for external partners to provide services. ZPS has undergone a major development in general in the field of promoting human rights and health. This has not been due to civil society alone, but through government and particularly ZPS wishing to become a modern correctional service, with a greater focus on prisoner reform and well-being than on punishment.

Civil society organisations present and with the capacity to respond: International actors, particularly UNAIDS, provided support to nascent civil society organisations dedicated to prison reform. They became stronger, gained recognition and acceptance from ZPS and drawing from their insights were thus able to work collaboratively to make distinctive contributions to improving services.

Tactics used to bring about change

UN agencies played a key facilitating role by bridging the gap between civil society and government, which is much more inclined to take the UN seriously than civil society. In this way, UN-supported civil society, in its early stages of engagement with government, provided coordination and challenged MoHA in the development of the prisons HIV policy.

Collaboration across institutions: Civil society, the UN and Zambian government institutions – in particular ZPS – played an active role in establishing the PAAC as a platform for advocacy, service delivery and coordination.

Persistence and sustained commitment: Government culture seldom changes overnight and most parties understood this. The PAAC and individual partners pushed consistently and persistently for many years. NGOs took a long-term perspective and built trust even if it meant frustrations and critical delays with essential service provision. This led to a more coordinated effort and government slowly developed the levels of trust it needed to expose itself to outsiders.

Wise and committed leadership applied politically astute approaches: Government officials and NGO staff brought a vision for change, the courage to speak out and highlight sensitive issues, an openness to engage and collaborate, and a commitment to persist. The medical director was a critical player who spoke openly, sought external funding and service providers, and challenged the status quo on condom provision. He contributed to the HRW survey and report in 2009/10 which exposed the health crises and the underlying cause in ZPS. This was exceptional behaviour in a region where other prison authorities had been in denial about prison conditions and the reality of male-to-male sex for many years.

PRISCCA showed courage and wisdom in pushing back, risking deregistration. It found the right balance between aggressive critique and respecting government culture, working conditions and other limitations.

ZPS learnt to use civil society at times to speak out and deliver unwelcome messages to other dimensions of

government, which protocol prevented it from saying directly.

Service delivery: The involvement of NGOs has benefitted the prisons in the way that they have been allowed access to implement a variety of projects. The ability and funding to implement changes has been vital for government's interest in opening up to outside help. Access via service provision provided information for advocacy.

Public health approach: ZPS opened prisons up to external health-service provision: expanding services to new sites, improving quality and changing the mindsets of health-care workers to provide friendly and non-judgmental services in the context of sensitive issues such as HIV. Working through public health considerations (rather than a rights-based approach) enabled it to overcome the resistance that stemmed from social conservatism and disdain at both public and personal levels to acknowledging and working with the situations of prisoners (including sex between male prisoners).

Local management in individual prisons: This analysis did not have the space to include lessons learnt at the level of the individual prison. It is important, however, to state that commitment from ZPS headquarters is not sufficient in terms of improving conditions. Individual leadership in prisons is vital to successful implementation. Although the partnerships between headquarters and civil society are important, including local management in development processes is also necessary.

4.3 The role of civil society

Civil society has benefitted the prisons by being allowed to implement a variety of projects. Its ability and funding to provide critical health services has consolidated government's initially hesitant openness to outside help. Access for research via service provision has provided civil society with information for advocacy. Civil society has learnt to push for change within prisons consistently and persistently within the space available, striking the balance between aggressive critique or 'pointing out gaps', and respecting the culture, pace, working conditions and limitations in government institutions.

NGOs took a long-term perspective by building trust, even if it meant frustrations and critical delays with essential provision of services. This led to a more coordinated effort and government slowly gained the necessary trust to open up further to outsiders. The approach of government – especially ZPS – was critical in terms of opening up to civil society as partners, embracing change and using civil society to exert pressure where it was better placed to do this.

5. CONCLUSION

Recently published papers^{17,18} confirm that addressing HIV and wider health needs in Zambian prisons remains a significant challenge in a context of increasingly severe overcrowding, and a series of governance, financing and capacity-related health system weaknesses. However, without the significant external interventions described in this case study the situation would have been considerably worse, and it is hard to see that these interventions would have occurred without the enabling transformations in attitudes, policies and structures, availability of information, and management, established between 1999 and 2010. The AIDS crisis opened ZPS up to tentatively accepting external help, and with UN facilitation and civil society cautiously engaging, this developed into a healthy collaboration.

17 Topp SM, Moonga CN, Luo N, et al, 2016(a): *ibid*

18 Topp SM, Moonga CN, Luo N, et al, 2017(b): *ibid*

Annexure 1: Concluding note on methodology - interviewees

The case study draws on document review and a number of interviews.

Interviewees included¹⁹:

Carolyn Bolton, Director, CIDRZ

Lloyd Chilundika, Deputy Commissioner, Zambia Correctional Services

Anne Egelund, former UNAIDS Programme Officer (2005-07), Managing Director Ubumi Prisons Initiative

Lena Kresojevic, Head of Zambia Country Office, Ubumi Prisons Initiative

George Magwende, Director of Health Services, Zambia Correctional Services

Simon Mutonyi, USAID Discover Health

Sharon Nyambe, UNODC focal point in Zambia

Nawa Sanjobo, Director, In But Free

Harold Witola, Director Medical Services, National AIDS Council

¹⁹ Positions at time of interview

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