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PROVISION OF CLINICAL SERVICES ON THE WELL-BEING OF INMATES IN ZIMBABWE PRISONS AND CORRECTIONAL SERVICES: A CASE OF HARARE CENTRAL PRISON, HARARE PROVINCE, ZIMBABWE

Authors: Simbarashe Kelvin Mutsago (skmutsago@gmail.com) Dr. Michael Mugah Sitawa (michael.sitawa@gmail.com), Mr. Wilkins Ndege Muhingi (wilkndege@gmail.com)

Chief Editor
Web: www.ijsdc.org
Email: info@ijsdc.org

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Abstract: This study aimed to investigate the provision of clinical services on the well-being of inmates with life-threatening illnesses in Harare Central Prison, Zimbabwe. The study objective was to explore the extent to which the provision of clinical services has affected the well-being of inmates with life-threatening illnesses. Inadequate provision of healthcare services in prisons attribute as life-threatening. Therefore, the study aimed at improving the welfare of inmates through advocacy and participation of the prison systems to enhance healthcare services. The study utilised a qualitative approach and a case study design through the reference of a transformative worldview paradigm. The units of observation for this study were the prison officials in charge of healthcare services in the prison, and the units of analysis were inmates who have been diagnosed with life-threatening illnesses. The sample size was 13 interviewees which were obtained through purposive sampling and data saturation. Self-administered in-depth interviews were used to collect data. Thematic analysis was applied for data analysis and study findings were discussed and presented in the form of narrations. From the findings, the researcher found out that the Zimbabwe Prisons and Correctional Services cannot contain life-threatening illnesses. The dignity of such patients is highly recognised and thus such cases are special cases in which compassionate release is well observed. Through lack of funding from the government, the prison faces severe shortages of medicines, vital drugs, insufficient equipment and nutrition for supporting its overall inmate population. The study found out that there is no specific special diet for inmates with life-threatening illnesses but instead they feed on fad diet which slows down the healing process. The study concluded that the inmate population whose care needs palliative attention is vulnerable since they have limited options. Also, overcrowding and poor ventilation is a major concern which has accelerated spreading of communicable diseases. The study recommended unrestricted clinical independence between prison healthcare providers and inmates, introducing fulltime trauma-informed care and self-help groups in prisons that cut across all illnesses and enhancing open door policies which attract more funding from outsiders and relevant partners.

1.1 Introduction

According to a comprehensive global prison literature search of data which was published between 2005 – 2015, it estimated that of the 10.2 million incarcerated universally 3.8% were Human Immunodeficiency Virus positive (HIV), 15.1% had Hepatitis C Virus (HCV) while 4.8% were Hepatitis B Virus positive (HBV) and 2.8% had active Tuberculosis (TB). These results proved that the prevalence in prisons was very high as compared to the general population (Dolan et al., 2016). Principle 9, A/RES/45/111 in the Basic Principles for the Treatment of Prisoners under the United Nations General Assembly, (1990) clearly states that "prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation" (p. 1). Those imprisoned according to Abbing, (2013) have the right to healthcare which is equivalent to that which is offered in the general population.

Mitchell and Williams, (2017) found out that in the United States of America (USA) a high ageing prison population has gradually led to an increasing number of prisoners who possess progressive terminal illnesses. Between 2003-2011 more than 4,000 prisoners died in jails and state prisons died of either cancer and heart diseases as main causes of fatalities. These illnesses were seen to be affecting older patients of ages from 55 and above. Between 1993-2013 the same population rose from 3% to 10%. Furthermore, on a national level, 2,621 compassionate release request was placed within one year in the Federal Bureau of Prisons (FBP). Only 85 (3.24%) were granted for compassionate release.

According to Wiseman, (2016), Australia experienced rapid growth of ageing population in the last 10 years. In New South Wales (NSW), the population of 65 and above had increased by 36% in the general population while its prison population rose to 133%. It was projected that by 2036 the prison population of those 65 and above will be one-third of the total NSW prison population. A majority of the prisons are in poor health and there exist an epidemic of cancer, diabetes and cardiovascular diseases among the older prison population. It was a major concern that this ageing population lacks access to adequate palliative care because there is no standardised national model of palliative care within the Australian prisons. According to CareSearch, (2017), 57% of women in Australian prisons present higher rates of HIV and Hepatitis C and they are also 16 times to suffer from a psychiatric disorder.

In Africa, Van Hout & Mhlanga-Gunda, (2019) in their qualitative study found out that the occurrence of HIV within sub-Saharan African (SSA) prisons was predicted within the ranges between two and 50 times higher compared to the general populations. The overall estimations also found out that incarcerated women and girls are the most HIV affected and vulnerable persons more than the male inmates. The estimated figures in 2016 revealed that HIV rates for young females aged between 15-24 were 44% higher than the male prisoners. According to Telisinghe et al., (2016) research concerning the health state of prisons in the African region is scarce because countries located in the SSA region hardly collect deliberate information on occurrences of common ailments and clinical results of HIV and TB infections among inmates.

In Zambia, Topp et al., (2016) conducted a study whose aim was to reveal the nature of interactions within the prison settings and their influence on inmate access to healthcare within four Zambian prisons. The study conducted 111 interviews which comprised of 79 male inmates

and 32 prison staff. The study findings elucidated on five major themes which were coercion, prison health services and protocol, social networks and relationships, nutrition and cooking arrangements, and finally environmental conditions. Focusing on prison health services and protocol, HIV and TB inmates reported being having access to testing and treatment. In all facilities, the unavailability of security officers to accompany inmates, limited sick inmates to access healthcare services.

Besides, another barrier to accessing healthcare services for inmates in these four prisons was the authority of other senior promoted inmates who served various roles in the distribution of and administration of healthcare services. These roles varied in categories such as lists creation of sick inmates and escorting inmates to the clinic. The acts of some these senior inmates were reported negative and malicious behaviour towards caring for sick inmates. Inmates also reported the quality of general healthcare services as poor because they experienced shortages of medicines, drugs and medicinal equipment. Then, there was difficulty in accessing external healthcare facilities which had a better supply of drugs and medicines.

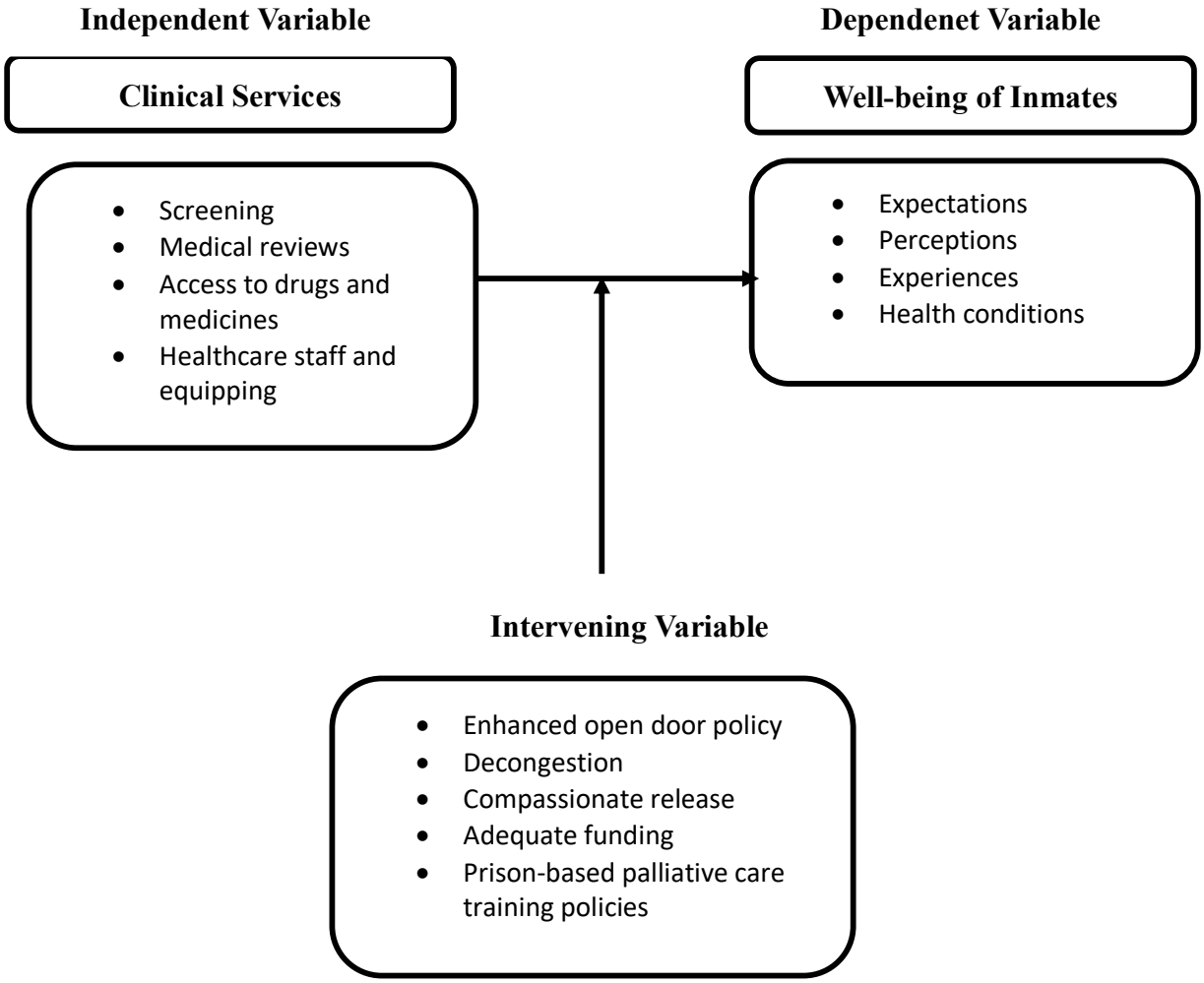
Palliative care was first founded and introduced by Island Hospice in Harare, Zimbabwe in 1979 to implement its services to patients with life-threatening illnesses not limited to cancer, HIV, hypertension, TB, and diabetes (Khumalo & Maasdorp, 2016). Zimbabwe developed its first national palliative care policy in 2014 to strengthen palliative services across the nation (MoHCC, 2014). These policies and services have their interest to serve at the national level in reaching out to every Zimbabwean citizen which also includes the inmate population across the country. In the past decade, Zimbabwe had experienced a huge economic decline that weakened many sectors nationwide. The country had been witnessing high inflation rates, food shortages, fuel shortages, power blackouts, water shortages and inadequate healthcare.

In the policy brief No.2 of 2020 held in Masvingo Province, findings of the discussions found out that the general welfare of prisons in the country had declined (Research and Advocacy Unit, 2020). Taking into account the strides put by ZPCS including their hard work in their overall function to incarcerate, rehabilitate, and reintegrate offenders towards the attempt to look after and care of prisoners' healthcare services, their efforts seemed to fall short of the national expectations. Major impediments arose from the fiscus financial shortages which caused various ministries to receive annual budgets which were far less than requested. Harare Central Prison under ZPCS was no exception. The prison had been witnessing a myriad of challenges which impacted negatively across its roles, tasks and responsibilities to manage their inmate population. The fact did not change that the prison remained the main key in correcting, reforming and rehabilitating prisoners in Zimbabwe under humane conditions. Therefore, this study was seeking to fill in the gap by investigating the welfare of inmates regarding their provision of clinical services in Harare Central Prison.

1.2 Research Objective

1. To explore the extent to which provision of clinical services has affected the well-being of inmates.

1.3 Conceptual Framework



1.4 Theoretical Framework

The Natural Rights Theory

The modern natural rights theory was formulated by John Locke (1632-1704) who was a classic enlightenment political theorist (Montero, 2016). Locke asserted that rights insinuated privileges or freedoms not derived from any political or public authorisation but the creator himself (Nielsen, 2017). Therefore, this theory holds that natural rights are granted by pure nature without the interception of any legal action. Also, Locke as the advocate for this school of thought proclaimed natural rights as privileges that are inalienable inborn and indisputable because they are possessed by men through virtues as given by God. According to Chapman, (2015), The Universal Declaration of Human Rights recognises the natural rights as the grounding foundation for all human rights. The principal truth of human rights is human dignity, the word that commences the preface of the Universal Declaration of Human Rights (Philpott, 2019).

The Natural Rights Theory applied to this study to promote the health rights of prisoners.

Prisoners obtained these rights due to their human nature which is the priority before the law. Thus, entailing their rights to adequate healthcare. For prisoners to exercise self-preservation before God they need to be free from threats to life. Inadequacy or lack of healthcare services is already life-threatening. Those with life-threatening illnesses suffer most when they have constrained access to healthcare services because being imprisoned is already hurting and limiting self-preservation. Besides, natural rights theory was also found to be an appropriate foundation for this study because governments need not abolish the principles of natural rights but to protect the natural rights of individuals. The protection and promotion of individuals' natural rights was the sole justification for the creation of government.

1.5 Review of Empirical Studies

Clinical Services on the Well-being of Inmates

In a nutshell regarding this section, the researcher pursued reviewing related literature of the clinical services rendered to inmates in various prison institutions in different parts of the world. Rich et al., (2017) found out that at a global level prisons had a burden of HIV/AIDS and other communicable diseases compared to the general public. Acknowledging that the development of clinical services such as screening, HIV prevention, and treatment being available in prisons, incarceration played a big role in interrupting with care for those who were on treatment before incarceration. An example was the disruption of antiretroviral therapy (ART) because of undisclosed HIV status, and differing availability of ART in the prison. Also, stigma and discrimination were linked to inmates not wanting to take medications in the presence of other people. Furthermore, the study stressed out the need for political will and financial investment by governments, medical and humanitarian organisations globally so that prisons could equal the standards of healthcare with those in the general community.

Relating to the above, Huh et al., (2018) pointed out that most care for inmates was delivered within the prison facility yet sometimes they needed to be hospitalised for specialised care. The care for hospitalisation of inmates was underlined as a huge cost that involved safeguarding the patient throughout and providing transportation which increased pressure on governments and prisons to cover the expenses. Ness, (2018) discovered that correctional facilities in more than 20 states in the US had their healthcare providers who were privately contracted as prisons battled to cut costs. In California, common cases reported were linked to terminal diagnosis but then reaching out to secondary clinical interventions was difficult due to unexceptional barriers such as security cost and needs which made the whole process complicated.

A study by Handtke, (2015) sought to explore the vulnerabilities of ageing prisoners in Switzerland and involving their health worries in the specific aspect of the provision of end-of-life care. The study utilised a qualitative approach by conducting 35 semi-structured interviews with ageing prisoners in 12 prisons across Switzerland. The questions aimed at exploring the health status before and after incarceration, quality of life, spirituality, healthcare access, and death preparedness. The findings of the study showed that compassionate release for terminally ill and ageing inmates was compromised by punitive settings and legal competing justifications. Clinical provision was hindered by avoidance of dual-loyalty, paternalism between the doctor-patient

relationship and environmental adaptation to the health needs of older prisoners.

Topp, Moonga, Mudenda, et al., (2016) conducted in-depth interviews from 23 female prisoners and 21 prisons officers and healthcare workers across four prisons in Zambia. The study sought to detect and observe the relationship between structural, organisational, and relational factors influencing female prisoners' health and access to healthcare. The study identified three negative effects as barriers to inmates' access to healthcare. These were health resource shortfalls, prioritisation of male prisoners' health needs over females, and persistent and abandoned patterns of both inmate and officer led victimisation. The health of these female prisoners was being determined by the interactions between insufficient internal clinics, deliberate unresponsiveness by female officers to prisoner requests for health-related dilemmas, and also notably differential wealth and access to family support among prisoners.

There was also evidence of other past studies that revealed high rates of communicable diseases among the Zambian prison populations. Interventions such as the National HIV/AIDS Strategic Framework of 2011-2015 was launched as an essential set of prevention strategies for prisoners. However, the researchers discovered that there was no provision of condoms within the male prisons as sexual intercourse between the same sex is a taboo especially in the African context and it also conflicted with the Zambian laws (Topp, Moonga, Luo, et al., 2016).

The Zimbabwe Human Rights NGO Forum which consists of 22 human rights organisations conducted a study in seven of Zimbabwe's prisons. The primary objective of this study was to assess the conditions of the selected prisons to reveal their compliance with international and domestic standards (The Zimbabwe Human Rights NGO Forum, 2018). The research approach taken in this study was both theoretical and empirical. Out of the seven prisons, it was found out that the Harare Central Prison and the Mutare Prison Farm did not have dispensaries for treatment and independent clinics. And then Connemara Open Prison was reported as having two in-house clinics for serving inmates, officers, and their dependents which was rated to have a status of a primary health care centre. Also, the healthcare state of facilities such as Bindura Farm Prison, Tabudirira Satellite Prison, Whahwa Young Offenders Prison, and Mlondolozi Prison were clear examples of failure by the government which was unable to fulfil its obligation to ensure adequate prevention, treatment, and control of diseases.

1.6 Research Design and Methodology

The selected method of inquiry for this research study was anchored upon the transformative philosophical worldview. This study employed a case study research design and also used a qualitative approach in its entirety. The study site was Harare Central Prison located on the east side of the main Harare city centre the capital and largest city of Zimbabwe which is under Harare Province. The target population of this study comprised of 2,200 inmates and then the study population comprised of 13 interviewees. The researcher for this study used the homogenous purposive sampling technique. The researcher conducted a total of 18 interviews but through data saturation, only 13 participants were chosen as the sample size of this study. The sampling technique used for this study and data saturation helped in shaping the sample size of this study.

The two major sources of information used by this study were both primary and secondary data. The primary data was collected through in-depth interviews which were administered by the researcher through face to face interactions with interviewees. The secondary data was collected through document analysis of published related literature such as past thesis, reports, newspaper articles, and dissertation papers. The researcher also obtained permission from the respondents to take notes of the discussions. An interview guide was constructed to facilitate the guidance of the interview procedure. To ensure reliability the researcher used the eyeballing method. The supervisors of this study and peers were used to assess the validity of this study. The researcher employed thematic analysis as a means of analysing data. Discussions of findings were also done in the form of narrations and direct verbatim quotes were also used to further elaborate meanings.

1.7 Presentation and Discussion of Findings

This study found out that the Harare Central Prison was unable to cope with the demands of containing life-threatening illnesses. In this matter, the study found out that the Zimbabwe Prisons and Correctional Services (ZPCS) together with the criminal justice system of Zimbabwe was mandated to the release of inmates on the grounds of specifically exceptional medical circumstances. The release of such inmates also known as the compassionate release was fully observed by both ZPCS and the criminal justice system of Zimbabwe. The study also found out that major impediments arose from the fiscus financial shortages which caused various ministries to receive annual budgets which are far less than requested. ZPCS under the ministry of justice is not an exception. The department was facing many challenges chief among them being inadequate funding from the treasury which ideally impacted negatively in performing its roles in managing the healthcare of inmates. The quote below supported the above explanations.

> *"It is not only at Harare Central Prison where we have the challenge to manage life-threatening illnesses among our inmates. ZPCS as an institution we are not able to watch somebody dying in agony simply because it's a prisoner. As ZPCS we are mandated to release those diagnosed with life-threatening illnesses or on other serious medical grounds. We are struggling to procure medications and providing adequate healthcare services to the entire inmate population. We are not rendered enough funds by the government as to what we propose in our budgets. And because of this, we have experienced a decline in our healthcare sector."*
>
> Source: Key Interviewee One (2020)

The study found out that indicators such as medical reviews, screening were available to patients but there were shortages of drugs and medicines in many cases than it is occasionally. In this regard, the study found out that under normal situations on the first day of incarceration, inmates went through an interview and health assessment for screening tests of TB, diarrhoea, cholera, and typhoid as a routine. However, it was reported that at times it was impossible in cases of mass incarceration resulting in imprisonment without screening. However, this proved very challenging in their mandate of curbing disease occurrence and managing the spread of communicable diseases. The verbatim quote below supported the above explanation.

> *"During the periods of mass incarceration, it becomes very difficult at times to assess inmates for the first time. They end up being admitted to prison without a first-time health assessment. That is the very most important step in managing the control and prevention of diseases spreading amongst our inmates. However, a follow-up is made to trace back the specific individuals (inmates) for screening which at times it is doable and at times impossible due to high numbers. We at times get help from other inmates who alert us amongst themselves if they suspect an illness for one of their own."*
>
> Source: Key Interviewee Two (2020)

Discussions with respondents showed that clinical services played a vital role in serving to prolong the lives of inmates through the diagnosis of diseases in a good time. On the other hand, the administration and access to medications and vital drugs for inmates was the biggest challenge in prison. The prison had been lacking funding to procure adequate medicines and vital drugs for inmates. Regarding this matter a key interviewee conveyed responses as follows:

> *"We have a very poor supply of essential drugs for both mental and chronically ill inmates. We have drug shortages to treat their conditions. They suffer from different types of conditions. These compounding factors have compromised our care for inmates. It puts the health and lives of inmates at risk yet our mandate is to restore health and life. We are forced to improvise strong painkillers by general painkillers. In some cases, for example, the recommended drug will be pethidine but we end up administering panadol or paracetamol. Our equipment is inadequate for example we do not have oxygen tanks so we try to use the available resources."*
>
> Source: Key Interviewee Three (2020)

Also, one of the units of analysis interviewee shared the same sentiments as the above by saying,

> *"Illnesses such as chronic diseases, diabetics, asthma, and phase two HIV drugs we buy for ourselves. Sometimes donors or other well-wishers like churches they intervene. Some inmates no longer have any relations with anyone outside so that they get help. I know of three prisoners who died of HIV, hernia, and sugar diabetes respectively because they could not afford to buy drugs for themselves."*
>
> Source: Interviewee Two (2020)

The study also found out that for this reason as mentioned above, the prison allowed relatives, friends, and family members of inmates who are ill to bring them medication and drugs from outside the prison. In doing so it has eased the burden of both the prison healthcare and that of inmates' health. The prison allowed inmates to access only government-owned hospitals under the referral pathway to seek secondary assistance. According to the Republic of Zimbabwe (2013),

the bill of rights of arrested and detained persons in Zimbabwe under article 50 section (1)(b)(ii) expresses that, "any person who is arrested must be permitted without delay at their own expense to consult in private with a legal practitioner and a medical practitioner of their choice."

The directives on paper appeared to be contradicting with the real situation. Inmates had been experiencing delays to access prescribed medications and referrals due to slow administration systems. This study found out that inmates did not have the liberty or autonomy for medical assistance of their own choice. Those who were on the referral pathway were only allowed to seek secondary medical attention in government facilities. During this period, the country's health system performance was also very low. Additionally, very few amongst the general population could afford to access healthcare while doctors and nurses had been striking for longer periods. This study also witnessed the longest healthcare personnel strike in the country's history which prolonged for over four months in 2019 between July and December. The administrative delays were also evidenced by the verbatim quote below.

> *"I was supposed to have a CT scan and ECG test as recommended by the doctor but it's been three months since the request was delivered to the headquarters and no response has emanated from them. I was diagnosed with ulcers in 2018. It took me about two months before I got medication because the nurse told me there was no medication. I am also a hypertensive patient. On 7 October 2019, I experienced a mild stroke which got me admitted till now. The prison has no drugs so at times I get support from my family. They are unable to come here all the time due to the high cost of living. I also have kids who need to go to school. So, it is a burden to their mother to take care of us all."*
>
> Source: Interviewee One (2020)

Availability of Healthcare Staffing and Equipping

This study found it necessary to establish the healthcare set up as a core pillar in examining the current state of healthcare in the prison and making generalisations to determine accessibility to healthcare by inmates in Harare Central Prison. This section established the availability and expected capacity of categories such as personnel, medical equipment, and the physical infrastructure. Table 4.3 presents the findings on personnel:

Table 4. 1: Personnel

1. Personnel	Available	Expected Capacity	Variance
a) Medical doctors/physicians	1	2	1
b) Clinical officers	0	3	3
c) Pharmacist	0	1	1
d) Laboratory technologist	2	4	2
e) Nurses	20	20	0
f) Dentist	1	1	0
Total	24	31	7
Total %	77.4%	100%	22.5%

Source: *Field Data, 2020*

As shown above, the healthcare personnel's overall operating capacity was 77.4%. The nurses and dentist personnel categories were the only ones that operated at full expected capacity. Altogether this gave the personnel a shortfall and variance of 22.5%. The laboratory technologist was only two instead of four. The prison hospital did not have a standalone physical laboratory. However, the tedious routine was that the laboratory samples were taken to another prison which was Chikurubi Maximum Security Prison for testing and verifying results.

Table 4. 2: Medical Equipment

2. Medical Equipment	Available	Expected Capacity	Variance
a) Ultrasound machines	0	1	1
b) Microscopes	0	1	1
c) Stethoscope	2	2	0
d) Blood pressure cuffs	1	6	5
e) Digital thermometers	1	10	9
f) Nebulizer machines	0	1	1
g) Dental equipment	Insufficient	Expected Standards	Inadequate
h) Medicines and drugs			
i) Wheelchairs	Insufficient	Expected Standards	Inadequate
	4	10	6
j) Oxygen Tanks	0	2	2
Total	8	33	25
Total %	24.2%	100%	75.7%

Source: *Field Data, 2020*

About the medical equipment, the study discovered that the prison's hospital available medical equipment operated at a very low capacity as there was evidence of insufficient supply of medicines and drugs and also short of dental equipment. The overall functionality of the medical equipment section was 24.2% and fall short of the variance of 75.7%. This study also observed the need for procuring infrared thermometers to avoid the spread of diseases than digital contact

thermometers which the prison was using. The point was that digital contact thermometers had been phased out because they were inserted in the armpit to test the patient's temperature.

Table 4. 3: Physical Health Infrastructure

1. Physical Health Infrastructure	Available	Expected Capacity	Variance
a) Dispensary	1	1	0
b) Laboratory	0	1	1
c) Admission wards	2	2	0
d) Sickbeds	19	40	21
e) Ambulances	0	2	2
Total	22	46	24
Total %	47.8	100%	52.1%

Source: *Field Data, 2020*

As shown above, the operating capacity of the prison physical health infrastructure stood at 47.8% with an outstanding variance of 52.1%. The prison healthcare system was compromised because the hospital was a pre-existing prison structure that was modified and turned into a hospital hindering proper and standard hospital operations. Obstacles for proper operations of this structure were but not limited to poor ventilation, small office space, and small sleeping wards. The hospital had two wards and a total of 16 beds. The wards were divided into TB section and the other ward accommodated patients of any other diseases. The prison did not have an ambulance for the transportation of emergency cases but ordinary prison vehicles were used.

1.8 Conclusion

The study found out that the Harare Central Prison was unable to cope with the demands of chronically ill inmates. In this matter, ZPCS together with the criminal justice system of Zimbabwe pardoned inmates who were bedridden through compassionate release. ZPCS was not fully supported financially by the government hence the institution was unable to contain the general inmate population regarding the cost of healthcare, nutrition, and appropriate clothing of inmates. Insufficient funds led to severe shortages of medicines and vital drugs for inmates. However, screening and medical reviews were available for patients and were an ongoing routine. The recovery of sick inmates was prolonged because the drugs which were administered to them were secondary improvisations. The overall operating capacity of the prison in terms of healthcare operations was poor.

1.9 Recommendations

1. ZPCS through the government of Zimbabwe to consider unrestricted clinical independence between prison healthcare providers and inmates as a policy that shapes a foundation of ethically sound healthcare in places of detention. Launching consistent training mechanisms of correctional healthcare professionals regarding the importance of abiding by healthcare ethics which promote clinical independence.

2. To certify the employment of healthcare professionals to rotate in working both in the prison and community healthcare facilities that promote equivalence of care for all and not practise exclusively behind bars. Practising ongoing evaluations that measure the effect of transfer and rotations to evaluate the quality of healthcare that includes doctor-patient relationship.
3. To sanction prison healthcare professionals to directly report health matters to healthcare leadership within prison facilities and abolish commands that require reporting to correctional superiors. ZPCS and the criminal justice system of Zimbabwe to practice mutual understanding of the separation of professional roles and tasks between prison healthcare practitioners and legal professionals so that medical decisions are only made by the responsible prison healthcare authorities without being overruled by non-medical prison staff.

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