

Human Rights and Health among Juvenile Prisoners in Zambia

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ABSTRACT

Globally, over 1 million children in conflict with the law are in detention, yet little research, particularly from Africa, has addressed their experiences of incarceration. Between September 2009 and February 2010, 246 prisoners, 30 prison officers, and 46 key informants from six prisons were interviewed as a part of a mixed-method study examining human rights conditions and HIV and tuberculosis (TB) prevention, treatment, and care in Zambia. Nineteen male and four female “juvenile” (ages eight to 18) prisoners participated in the study and completed a short quantitative survey and a longer, in-depth interview. Despite specific provision under international law that children should be detained only as a last resort, for the shortest appropriate time and be held separately from adults, we found that juvenile detainees in Zambia are routinely incarcerated for extended pre-trial periods, denied basic health care, imprisoned with adults, and face significant risk of contracting HIV and TB. Attention both to juveniles’ health needs, and to the criminal justice system failures that keep children incarcerated in adult facilities for extended periods, is necessary in order to improve health outcomes for children in conflict with the law in Zambia.

INTRODUCTION

In addition to the protections provided to all prisoners, international human rights law and standards guarantee imprisoned children special protections (CRC, 1989; The Beijing Rules, 1985). The Convention on the Rights of the Child protects children from torture or other cruel, inhuman or degrading treatment or punishment, and provides that children deprived of their liberty shall be treated with humanity and respect for the inherent dignity of the person (CRC, 1989). Detention of a child “shall be used only as a measure of last resort and for the shortest appropriate period of time” (CRC, 1989). For those children who are detained, they are to be separated from adults (CRC, 1989).

Worldwide, over 1 million children are detained by law enforcement bodies (UNICEF, 2010). While data on the prevalence of child incarceration are uneven and sometimes unavailable, throughout Africa, the percentage of the prison population comprised of child detainees generally ranges from 0.5% to 2.5%; Namibia, where juveniles represent 5.5% of prisoners, has the highest reported rate (Sloth-Nielsen, 2008). In April

2010, Zambia’s prisons held 414 “juvenile” inmates (a category under Zambian law encompassing inmates aged eight to 18), representing 2.5% of all Zambian inmates. Just over half ($n = 218$, or 53%) of these inmates, were detained awaiting trial (Chileshe, 2010). Zambia has a total of 86 prisons throughout the country, and though one of these facilities is dedicated exclusively to juveniles, juveniles are incarcerated with the adult population at other facilities countrywide.

Between September 2009 and February 2010, 246 prisoners from six Zambian prisons were interviewed as a part of a mixed-method study examining human rights conditions and HIV and tuberculosis (TB) prevention, treatment and care. This study presents the results of interviews conducted with juvenile

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detainees and examines the extent to which international and Zambian law, and national health and prison policies, are respecting the rights of juvenile detainees, with particular emphasis on HIV and TB infection risk, testing, and treatment.

METHODS

In July 2009, the Prisons Care and Counselling Association (PRISCCA) of Zambia sought approval from the Zambian Ministry of Home Affairs and Ministry of Foreign Affairs for a mixed-method study of conditions in Zambian prisons. In September 2009 both Ministries granted permission. A detailed description of the methods of the study is presented elsewhere (PRISCCA et al, 2010a). In addition to key informant interviews with government and non-government (NGO) officials, a law and policy review, and interviews with prison officials, researchers conducted a brief prisoner survey and longer, semi-structured in-depth interview in six Zambian prisons.

All six prisons selected housed juveniles; interviews were completed with juveniles in five, including three urban prisons: Lusaka Central Prison (Lusaka province), Mukobeko Maximum Security Prison (Central province), and Kamfinsa State Prison (Copperbelt province); one rural district prison: Mumbwa Prison (Central province); and one peri-urban prisons: Choma State Prison (Southern province). Prisons were selected based on their diverse location, size, and security level, and because of ongoing participation in an HIV peer-education program conducted by one organization participating in the research (PRISCCA).

In each prison visited, researchers requested from the officer in charge a private location to conduct interviews. Officers identified prisoners who were then provided by researchers with a verbal explanation of the survey (in English or French, and translated into Bemba, Nyanja, or Tonga, if necessary), asked if they were willing to participate, and assured of anonymity. Individuals were assured that they could decline to participate, end the interview at any time, or decline to answer any specific questions without negative consequence. The names of all prisoners who participated in this study have been changed to protect their anonymity and security, and because of the small sample size, exact ages of some of the juveniles interviewed have been omitted.

Interviews took approximately 45 minutes and were conducted in English or French by researchers from one of three organizations (Human Rights Watch, PRISCCA, or the AIDS and Rights Alliance for Southern Africa (ARASA)) or in Bemba, Nyanja, and Tonga, with translation to English provided by members of PRISCCA. Interviewers used a brief verbal questionnaire to gather information on the prisoner's incarceration history, medical care, and experience of HIV/AIDS and TB testing and treatment. Researchers then probed responses and

asked further questions regarding prison conditions, discipline, and HIV/TB risk behavior in open-ended, in-depth interviews. All interviews were conducted outside of the hearing of prison officers and other prisoners, in a private setting.

Interviews with key informants from the government and national and international non-governmental organizations were also conducted, prior to and following prison-based interviews, to identify salient issues and probe specific findings raised in the research. In addition, national legislation and policy governing the administration of the prison and criminal justice systems were reviewed.

RESULTS

Nineteen male and four female juvenile detainees were interviewed; five male and two female juveniles in Lusaka Central Prison (Lusaka province), six male juveniles in Mukobeko Maximum Security Prison (Central province), one male juvenile in Kamfinsa State Prison (Copperbelt province); one male juvenile in Mumbwa Prison (Central province); and six male and two female juveniles in Choma State Prison (Southern province). Ages ranged from 15 to 18, with an average age of 17. Juveniles interviewed had, on average, spent 11 months in the prison in which they were interviewed. Thirty percent ($n = 7$) reported having completed primary education, and 70% ($n = 16$) of juveniles interviewed had reached secondary education level. A majority ($n = 14$) were students before arrest, and all but one were of Zambian nationality.

Extended Confinement

Zambia has no dedicated juvenile justice system, and children in conflict with the law face trial in the adult court system. Juveniles' process through the justice system can be excruciatingly slow. Even though review by a judge or magistrate within 24 hours of arrest is required under Zambian law (Criminal Procedure Code Act, 1996), only one of 23 juvenile inmates interviewed reported having seen a judge or magistrate within 24 hours of arrest, and on average juveniles had waited two months before an initial appearance.

Even after an initial appearance before a judge or magistrate, juvenile inmates reported lengthy periods of incarceration awaiting conclusion of their cases. Eighteen of 19 juveniles interviewed had been continuously detained from arrest and had not received police bond or bail. Current unconvicted juvenile detainees ("remandees") had waited a median of five months in detention, and a maximum of three years and seven months. As one 17-year-old detainee, said:

"I am here on remand; I came in July 2007. I am done with my trial, just waiting for judgment... The trial did-

n't take too long, it is only the judgment that has taken long. It's been a year and four months since my trial ended. I've been back to court four times just for the judgment but it never comes" (PRISCCA et al, 2009a)

Another teenage inmate reported that he had been waiting for his release for 18 months, after a High Court judge found no evidence of the crime charged in his case (PRISCCA et al, 2009d).

International law mandates that persons who are charged with a criminal offense be informed of their right to have access to a lawyer (ICCPR, 1966; Body of Principles, 1988). However, 73% of juvenile prisoners interviewed reported no legal representation whatsoever. Even children appearing before the High Court were rarely represented by counsel. As one teenage detainee reported:

"I had no representation, I stood on my own behalf. It was my first time in a police station or in court. I was just speaking, and I was scared. So I didn't know what I was saying... As young people, it is very threatening to see the inside of the court. Even if you are not guilty, you end up pleading guilty" (PRISCCA et al, 2009e)

Conditions of Confinement

At all six of the prisons we visited, children were universally held in cells with adult inmates. "As a father it pains me" that children do not have their own facilities, an officer in charge admitted (PRISCCA et al, 2009k). One teenage detainee reported being threatened by other inmates (at the instigation of the officers) if he revealed the combined sleeping arrangements:

"We sleep with the adults, but they told us to say we sleep in a juvenile cell. If we don't say we sleep in a separate cell, they will beat us. We are given punishment when we start talking. But we are scared we might die here" (PRISCCA et al, 2009l).

These cells are severely overcrowded, and juveniles reported sleeping three or more to a mattress, with the congestion leading to significant discomfort and the spread of rashes (see, e.g., PRISCCA et al, 2009d).

Food was reported by nearly all prisoners interviewed at all prisons to be insufficient and of poor quality. As one 17-year-old prisoner stated simply, "The food is not adequate, we need more food" (PRISCCA et al, 2009c). Another teenage inmate noted the health consequences of such food insecurity, describing symptoms consistent with thiamine deficiency (vitamin B1) (Ahoua et al, 2007) (the presence of which was confirmed by the director of prison medical services (PRISCCA et al,

2009b)): "The diet is very bad – your feet become swollen, even your legs" (PRISCCA et al, 2009k).

Hygiene and sanitation for juvenile and adult inmates alike are reportedly inadequate, and basic necessities frequently lacking. As one 17-year-old, who was wearing rags, told interviewers, "I have no proper clothes" (PRISCCA et al, 2009h).

Physical abuse, at the hands of prison officers or fellow inmates, was a consistent theme of juveniles' experiences in prison. Describing the abuse at the hands of prison guards, one 17-year-old prisoner noted:

"As for physical abuse, some of the officers are harsh and can slap prisoners or call us names. Yes, I have seen injuries after. Some of the inmates, when they are given work, they resist and say they are tired. They attract physical abuse, slapping. They may bleed from the mouth after, or complain of internal pain" (PRISCCA et al, 2009d).

While not routine punishment for juveniles, occasionally juveniles reported being imprisoned in the "penal block" as punishment. The penal block is a small, windowless cell, measuring two meters by two meters, where inmates are held (for up to 30 days at one prison) as punishment. Inmates are stripped naked and made to stand or sit in water reaching their ankle or mid-calf height, with limited or no food and no toilet facilities – so that inmates are forced to sit or stand in their own excrement. One juvenile inmate described his experience:

"We are taken to the penal block with permission from the officers. More severe crimes, especially theft, attract the penal block. I have had the experience of being taken to the penal block. There is a small room. They pour water. You are isolated, in the room alone with the water. They took me there when I came in as a young person [as punishment for theft]. They took advantage of me to wash others' clothes, but reported me for theft for stealing. I was kept in there for four days and nights in the cell. The water was above my ankles. There was no light, no windows. There was no beating – the isolation, the water are the punishment. It being the first time, I was really afraid. It was pitch black. I didn't know what was coming next, I felt very afraid and insecure" (PRISCCA et al, 2009j).

Juveniles reported having been beaten with a cane (PRISCCA et al, 2009e), beaten with a water container and hosepipe (PRISCCA et al, 2009j), or slapped, punched, and forced to stand on the toilet for hours shouting "yes, sir" (PRISCCA et al, 2009l) by their fellow (adult) inmates, who are frequently granted disciplinary authority over both adult and child detainees (PRISCCA et al, 2010a).

Sexual Violence and HIV

When last measured in 1999, overall HIV prevalence among Zambian prison inmates was 27%; inmates under 20 years of age had an HIV prevalence of 14.5% (Simoooya et al, 2001). In our study, female juvenile inmates did not report specific HIV risk behaviors, while male juvenile inmates reported that they were frequently forced into sexual relationships constituting rape, particularly when held with adult prisoners.

One 17-year-old male detainee described how adult inmates seek to establish relationships with juveniles, and how prison authorities fail to protect them:

“One of the older inmates who was put into our cell to sleep at night started showering my cellmate, a juvenile, with gifts. He promised him money in return for sexual favors. My friend wasn’t happy, and neither did he consent. But the other imposed himself by buying him off with gifts, and saying that there was 100,000 kwacha [USD\$21] waiting for him ‘at the reception.’ When the older inmate finally approached him sexually, my friend was intimidated, but managed to shout and attracted the other attention of the juveniles. Unfortunately we reported it to the officer on duty at night, and he promised to address it the next day, but he didn’t. The cell captain intervened, though, and removed the man, putting him into one of the other cells... Do I feel safe? No, I don’t feel safe” (PRISCCA et al, 2009c).

Male juvenile detainees reported that sex was frequently exchanged by juvenile inmates for food and other basic necessities including soap. One teenage male detainee reported:

“Mainly the juveniles are very vulnerable. As young people coming into prison, we are full of fear. The convicts take advantage of us by providing us with food and security. We enter their dragnet, but by the time we discover this it is too late” (PRISCCA et al, 2009i).

As another teenager said:

“We have had experiences where the older inmates become physical and abuse us, even sexually... I haven’t physically been abused, because I know the system, and avoid enticements. But my more vulnerable friends fall prey. Once you eat the food, they reprimand you, say you have no choice. I have seen it happen” (PRISCCA et al, 2009d).

Concluded a teenaged inmate:

“Forced sexual activity is very common. The way we sleep,

we are in one another’s lap. Three quarters of the sexual activity I have seen and heard are people who want to force others, one quarter is consensual” (PRISCCA et al, 2009j).

The risk of contracting HIV through rape in prisons was well-known to the juveniles with whom researchers spoke. As one teenager reported:

“By the time we are discharged, we will go out of here with disease. Juveniles are either taken advantage of or enticed because of our vulnerability. We are young, we don’t have people to bring us food and clothes. They make sure we consume what they give, then are unable to refuse” (PRISCCA et al, 2009e).

An example of the vulnerability of juveniles’ confinement with adult inmates was illustrated at the time of researchers’ visit to one prison, where three juveniles were held in a cell with three adults – two of whom were in prison on charges of defilement of a minor.

Condoms were universally unavailable. Attitudes of juveniles asked how they would feel about the availability of condoms ranged from permissive –s “you need to ask those who are partaking of this and get their mind. I don’t want to speak on their behalf” (PRISCCA et al, 2009i) – to, more commonly, hostile, because of a reported fear that condom availability would increase incidence of rape. As one teenager said: “I don’t support their presence, because I feel it would encourage the juveniles to give in” (PRISCCA et al, 2009d).

Tuberculosis

Even while largely unknown and unmeasured, tuberculosis transmission is a constant and serious threat in the prisons’ cramped, dark, unventilated cells. Estimated prevalence rates are very high. Whereas TB prevalence was estimated to be less than 0.4% in the general population in Zambia in 2007 (World Health Organization, 2007), a 2000-2001 study in 13 Zambian prisons estimated prevalence of pulmonary TB between 15% and 20% (Habeenzu et al, 2007).

Following international guidance on TB in correctional settings (CDC, 2006), Zambian prison policy dictates that best practice for TB management demands case detection, isolation, supervised treatment and follow-up support, health education, and nutritional supplementation (Zambia Prisons Service, undated). If a prisoner is found to be suffering from an infectious or contagious disease, under Zambian law, the officer in charge is required to take steps to place the prisoner under treatment and prevent the disease from spreading to other prisoners (Prisons Rules, 1996). The Ministry of Health recommends “isolation for all prisoners with TB” (PRISCCA et al, 2010c).

Yet the doctor in charge of medical services for the Zambia Prisons Service admits that isolation is rare, and reported that only in “two or three” prisons is there true isolation (PRISCCA et al, 2010b). In the rest of the prison system, there is no isolation capability. Even where isolation exists, inmates with suspected TB based on their symptoms remain in the general population until diagnosis, risking continued infection of the general population including children.

The conditions of TB isolation facilities – which at one prison were observed to include nearly nonexistent ventilation and light and cramped, dirty quarters for very ill patients, who sleep on foam pads on the floor – are, in fact, life-threatening. The doctor in charge of prison medical services in Zambia describes TB isolation cells as “death traps” (PRISCCA et al, 2009b).

Further, TB isolation facilities are likely a key site of TB infection, particularly for some child detainees. Healthy children incarcerated at one prison were housed in the TB isolation cell; a measure which they reported was designed to protect them from adult inmates. One 17-year-old inmate said: “I am worried I will catch TB. There is no window, just a small opening with wire over it – not much ventilation” (PRISCCA et al, 2009m). Another 17 year-old prisoner reported that there were “23 TB patients in my cell. There are no vents, no air. I’m worried” (PRISCCA et al, 2009f).

As the doctor in charge of prison medical care concluded, “Our officers have tried their best to isolate patients, but they can’t. There is literally no space...You may say it’s not medically acceptable, but what can you do?” (PRISCCA et al, 2010b).

Medical Care

Zambia has 14 health staff to serve 16,666 prisoners (PRISCCA et al, 2009b; PRISCCA et al, 2010b; Chileshe, 2010). According to prison officers and prisoners, access to care in outside medical facilities is controlled by medically unqualified and untrained prison officers, and lack of prison staff for the transfer of sick prisoners, lack of transportation and fuel, and security concerns keep inmates from accessing care, sometimes for weeks after they fall ill.

Like adult prisoners, children detained as juvenile inmates frequently are confronted by restrictions on their ability to access medical care. One 17-year-old detainee was wheezing when researchers spoke with him. He reported:

“I asked for help at the clinic and they said they would take me to the hospital – that was seven months ago. They gave me some medicine but it only makes me sleep, it doesn’t help me breathe” (PRISCCA et al, 2009f).

As another teenager said, “Sometimes it is difficult getting to the clinic, sometimes you may not get to go. We ask the cell

leader – [and even if they agree] the guards might say no” (PRISCCA et al, 2009l). Concluded one 16-year-old: “If you are sick, then you can’t go to the clinic” (PRISCCA et al, 2009g).

Compared to incarcerated adults, adolescents reported disproportionately low levels of HIV and TB testing in prison (PRISCCA et al, 2010a). Over all prisons visited, four percent of juveniles had been tested for TB compared with 25% of adults, and 44% of juveniles had been tested for HIV compared with 59% of adults.

DISCUSSION

Human rights groups, judges, and international observers, have in recent years repeatedly criticized juvenile justice systems in countries across Africa. In 2007, Human Rights Watch documented poor conditions, sexual abuse, and lack of education for children detained in Burundi, a country without a juvenile justice system, alternatives to incarceration for children, or reintegration services to help children released from detention (Human Rights Watch, 2007). Reports from Liberia have described a gap between law and practice in the administration of juvenile justice, and UN Secretary General Ban Ki-moon has called the country’s juvenile justice system “a source of deep concern” (IRIN News, 2007). A 2010 workshop for judges, police officers, social workers, and prison administrators in Cameroon examined the process of juvenile justice in the country and the chasm between practice and Cameroon’s international obligations (Nkematabong, 2010). Similar gaps between national and international legal frameworks on juvenile justice, poor implementation of what positive legislation there is, and over-reliance on detention under poor conditions in adult prisons, have also previously been noted in Nigeria (National Human Rights Commission et al, 2003).

Yet the health consequences of extended juvenile detention – particularly in the context of the HIV and TB co-epidemics in African prisons – have received little explicit attention. Even amid the limited literature on HIV and TB in African prisons, the health needs of the thousands of children in prison in sub-Saharan Africa have received minimal attention (Sloth-Nielsen, 2008; UNODC et al, 2007; Carelse, 1994).

Overcrowding in prisons has an undisputed negative effect on prisoner health (Walmsley, 2005). Indeed, the findings of this study in Zambia underscore the importance of addressing both the criminal justice failures that lead to juveniles being incarcerated for extended periods under deplorable conditions, and the particular ways in which juveniles’ treatment in adult facilities – subject to sexual abuse and at risk of TB transmission – makes them vulnerable to disease. Yet, as noted above, juveniles are even less likely than their adult counterparts to be tested for these diseases and have their health needs addressed.

The difference between adult (and particularly adult male) prisoners' access to TB and HIV testing and that of juveniles may be attributable to a combination of factors: juveniles had, on average, been detained and incarcerated in their current facility for a shorter time than their adult male counterparts; juveniles reported experiencing fewer health problems during incarceration and thus were probably less likely to visit health facilities; and juveniles' age and vulnerability within the prison hierarchy may mean that juveniles were less able to request testing and care.

The gap between juveniles' protections afforded under international law and current practice by African prison and justice systems is vast (International Centre for Prison Studies, 2006). Mounting immediate pressure at the international level is necessary to effect change. Increased and sustained attention by United Nations agencies, particularly the United Nations Children's Fund (UNICEF), to child detainees could help to increase pressure for reform, though regular visits to monitor the conditions of individual detainees, as well as through higher-level advocacy. Greater international donor support for juvenile justice initiatives and facilities could also go far toward supporting efforts to provide juveniles with legal representation or improved facility conditions. Additionally, human rights advocates have suggested the development of expanded mechanisms under the Convention Against Torture focusing on conditions in detention, and in particular the development of a new international instrument—such as a Second Optional Protocol—specifically to focus on health standards and define the rights of prisoners and monitoring under the Convention against Torture (Lines, 2008). The establishment of such mechanisms could be a useful addition to the international mechanisms for exerting pressure on states to improve health in detention, particularly for children. Ultimately, however, the responsibility lies with the Zambian government and other national governments to ensure that national laws and practice protect children in conflict with the law, through establishing a functional juvenile justice system, and separate facilities for children in accordance with international law and standards.

CONCLUSION

Improving juvenile health in detention facilities in Zambia requires both expanded health services and improved conditions of confinement, including separate facilities for juveniles. Furthermore, attention to human rights and juvenile justice issues is essential to improving the health of juvenile inmates in Zambian prisons: eliminating extended pre-trial detention, expanding non-custodial options, and ensuring that children are only detained as a last resort are key to keeping juveniles out of the unhealthy environment of Zambian prisons and protect-

ing the health of children in conflict with the law. Pressure and funding at the international level and action by the Zambian government are immediately warranted to improve the health of children detained in Zambia.

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