

Gender Inequality, Health Rights, and HIV/AIDS among Women Prisoners in Zimbabwe

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Abstract

Zimbabwe has successfully reduced its HIV prevalence rate and AIDS-related deaths in recent years, but women, particularly those who are in prison, remain at high risk. Poor prison conditions, discrimination, stigma, and the neglect of the sexual and reproductive health of women prisoners living with HIV result in poor health outcomes for women prisoners. Inadequate and inappropriate health provision in prison is a breach of their human rights and a public health problem. This paper analyzes the political commitment of Zimbabwe to address the underlying determinants of health by incorporating into its health laws and policies measures that promote the health rights of women prisoners living with HIV.

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Introduction

Recent years have seen a notable increase in women prisoners in Sub-Saharan Africa.¹ Prison conditions in this part of the world are conducive to the spread of infectious diseases such as HIV, tuberculosis, and COVID-19. Zimbabwean prisons are characterized by overcrowding, dated infrastructure, insufficient and intermittent access to sanitation and hygiene, and inadequate nutrition, among other problems.² Regional assessments and in-depth studies have indicated that despite women prisoners being a minority in a male-dominated prison environment, their health rights and those of their children who are incarcerated with them are poorly provided for, if not neglected altogether. Access to pediatric and gender-specific health care continues to be a challenge.³

According to a 2018 briefing paper, “the disparity between what is known and unknown about HIV in Zimbabwean prisons is alarming.”⁴ This is also true of other infectious diseases, such as tuberculosis, which have a longer history of prevalence in prisons and are closely associated with susceptibility to HIV infection.⁵ Women prisoners are at risk of HIV/AIDS since they generally come from communities that suffer poverty, discrimination, marginalization, and social prejudice.⁶ The connection between susceptibility to certain diseases such as HIV/AIDS and the denial of basic rights (such as the rights to equality and nondiscrimination) and other underlying determinants of health creates an imperative for governments to give effect to international human rights norms that help remove barriers to health. This paper analyzes the political commitment of Zimbabwe to address the underlying determinants of health by incorporating into its health laws and policies measures that promote the health rights of women prisoners living with HIV. It centers on the “political epidemiology” of HIV/AIDS in Zimbabwe—specifically the efforts of the Zimbabwean government to comply with international norms that address the social determinants of health of women prisoners.⁷

Zimbabwe is a low-income country, riven with civil unrest and hyperinflation, and home to more than one-third of the world’s population living

with HIV. Yet, thanks to innovative measures and community-based HIV prevention measures, it has achieved considerable success in reducing the prevalence of HIV/AIDS among its population. A significant intervention was the National AIDS Trust Fund (AIDS Levy), set up to fund HIV prevention and treatment.⁸ Between 1997 and 2013, the country achieved a dramatic reduction in HIV/AIDS prevalence, from 29% to 15%.⁹ Changes in sexual behavior among young adults and the roll-out of antiretroviral therapies have also helped. However, the benefits have not been evenly felt. Like other sub-Saharan countries, Zimbabwe has demonstrated gender-skewed infection rates, with women and adolescent girls most at risk of new infections and more vulnerable to HIV infection than males.¹⁰ Women prisoners in particular are especially at risk. Indeed, a 2014 World Health Organization (WHO) report predicted that half of all new adult HIV infections would be concentrated among key populations—men who have sex with men, sex workers, intravenous drug users, transgender people, and prisoners.¹¹

Globally, the number of people imprisoned and detained, including women, has grown significantly, and prison occupancy in most countries exceeds 100%. Until recently, women prisoners worldwide were housed in prisons built for men with few facilities that catered to their needs.¹² In Zimbabwe, as of April 2019, the 46 main prisons—with a capacity for 17,000 people—were accommodating 19,382 prisoners.¹³ Women make up 1.8% of the country’s prison population.¹⁴ There are three women-only prisons (Chikurubi, Shurugwi, and Mlondolozzi); the other prisons have a separate section for women.

The prevalence of HIV/AIDS, tuberculosis, and hepatitis C is generally much higher in prisons than in the general population.¹⁵ HIV prevalence in prisons in Zimbabwe is estimated to be double that of the general population, and higher among women prisoners.¹⁶ The infection rate among male prisoners is 26.8%, compared to 39% among female inmates. According to the Zimbabwe Human Rights Commission, there are serious inadequacies in Zimbabwean prisons, including the poor con-

dition of prison cells, inadequate access to health care, inadequate food supplies, poor diet, poor sanitation, and poor hygiene.¹⁷ Crowded conditions are especially dangerous to women, as they increase their exposure to violence, sexual abuse, and pregnancy and childbirth while in prison.

The “political epidemiology” of HIV/AIDS¹⁸

At a landmark colloquium in 1993, Jonathan Mann (who became the first director of the WHO Global Programme on AIDS), observed that “the critical relationship between societal discrimination and vulnerability to HIV, as well as other health problems, is the central insight gained from over a decade of global work.”¹⁹ According to Mann, it was the violation of fundamental rights that increased susceptibility to this disease. Rights to equality, freedom from discrimination, and basic subsistence were as indispensable to positive health outcomes as access to medical services and medicines. Mann is credited with the fact that “the promotion of human rights became a foundation of the global response to AIDS.”²⁰

In 1994, UNAIDS brought together 10 co-sponsors (UNICEF, UNDP, UNFPA, UNESCO, the World Bank, ILO, UNODC, WFP, UNHCR, and UN Women) to coordinate the global response to the disease, thus highlighting the economic, social, and political determinants of HIV.²¹ Minimizing the risk of HIV/AIDS requires far-reaching political measures to address the social and economic determinants of health, prompting scholars to describe this as the political epidemiology of HIV/AIDS.²² Political epidemiology tracks the way that health is affected by laws, policies, and their implementation and how these might be reformed to produce better health results.²³

Poverty is the single-most significant factor in HIV infection in the developing world, with women representing a greater share of those living in poverty.²⁴ The phrase “feminization of poverty” was coined to highlight this fact. While this is not a new concept, in the HIV/AIDS context it draws attention to the increasing numbers of women suc-

cumbing to poverty, increasing their risk of HIV/AIDS and incarceration. Insufficient “access to resources, lack of political rights, and limited social options” creates fundamental inequalities and vulnerability to poverty and HIV/AIDS.²⁵ Women lack the power to challenge the embedded discrimination of social institutions, from the family to the state.²⁶ In Zimbabwe, the disproportionate numbers of women infected with HIV has given rise to the “feminization of HIV/AIDS.” The factors creating this situation have been identified as “inadequate support infrastructure to women living with HIV, poverty, unfair gender role allocation, segregation and differentiation and the state of patriarchy.”²⁷ These issues cannot be resolved simply by targeting support to women; rather, they require addressing the rights to equality and nondiscrimination, which would result in substantive equality in health. This means that law and policies that address public health and HIV/AIDS need to be inclusive of the needs of women, including women prisoners, a constituency with little political influence to demand improvements to their health conditions. Unfortunately, prisoners are often “demonised by the public,” meaning that there is little public or political interest in protecting prisoners’ right to health.²⁸

Furthermore, health policies in general do not sufficiently cater to women’s sexual and reproductive health (SRH). In prisons, a lack of gender sensitivity leads to the different needs of women with regard to SRH—such as caring for infants and exposure to abuse and violence—being ignored.²⁹ Health care for women in prisons should comply with international human rights and recommendations on health care provision. States’ failure in this respect is a serious breach of women’s human rights and life-threatening for women living with HIV.

The right to health, HIV/AIDS, and women’s health

The WHO Constitution defines health positively as the “highest attainable standard of health for all.”³⁰ A legal obligation to protect a right to health was created in 1966 by the International Covenant

on Economic, Social and Cultural Rights.³¹ However, the implementation of social, economic, and cultural rights was weakened by the covenant's qualification that state parties must undertake to implement these rights only "to the maximum of [their] available resources, with a view to *achieving progressively* the full realization of the rights recognized in the present Covenant."³² The Committee on Economic, Social and Cultural Rights subsequently addressed the right to health and the health rights of women in General Comment 14, issued in 2000, which requires states to monitor the progressive realization of economic, social, and cultural rights and to implement a "core minimum" of each of these rights.³³ The general comment shifted the responsibility for satisfying the "minimum" of core socioeconomic rights to the state. This implies that if the state ignores a certain right, it is that the state rather than the claimant that bears the burden of proof.³⁴

General Comment 14 introduced a "gendered dimension of the right to health" by taking into account differences between men and women with respect to biology, socioeconomic conditions, and situatedness in the home and in society.³⁵ This is significant because scholars have pointed out that "there are critical gaps on normative standards regarding the human rights of women living with HIV in relation to SRH."³⁶ These gaps and other specific health requirements of women were identified and further highlighted by two crucial conferences held in the 1990s. The 1994 International Conference on Population and Development (ICPD) in Cairo and the 1995 Fourth World Conference on Women in Beijing created two programs that brought together human rights language, the underlying determinants of health, and women's reproductive health.³⁷ The ICPD Programme of Action emphasized the interdependence and indivisibility of civil and political rights and economic, social and cultural rights and successfully broadened women's reproductive health to include the "rights to bodily integrity and security of person, to non-discrimination and equality between women and men, as well as socio- and economic rights."³⁸ The Beijing

Platform for Action highlighted the impact of gender inequality, poor health services, nutrition, gender-based violence, sexually transmitted diseases (including HIV), poverty, and powerlessness on women's susceptibility to disease.³⁹ Importantly, one of twelve critical areas prioritized by the Beijing Platform for Action was the "feminization of poverty."⁴⁰

General Comment 14 requires states to have a national health policy that includes "a detailed plan for realizing the right to health" that ensures "equal access for all persons, including prisoners and detainees..., to preventive, curative and palliative health services."⁴¹ For women, this includes interventions to promote SRH, counseling services for diseases such as HIV/AIDS, interventions to improve child and maternal health, family planning, pre- and postnatal care, emergency obstetric services, and access to information. In the context of SHR, the health rights of women living with HIV should be informed by the principles of nondiscrimination, accessibility, informed decision-making, and accountability.⁴²

In Africa, the African Commission on Human and Peoples' Rights has also taken steps to promote the health rights of women and to target the disproportionate effect of HIV/AIDS on women. Its 2001 resolution on HIV/AIDS, "Threat against Human Rights and Humanity," made HIV/AIDS a human rights issue by linking the spread of the disease to discrimination and requiring governments to protect the rights of those living with HIV.⁴³ Furthermore, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Maputo Protocol) encourages states to enact legislation to remove practices that have a negative impact on women's rights.⁴⁴ Under this protocol, women's sexual and reproductive health rights include the right to self-protection and the right to information about one's health status and that of one's partner, especially if the partner has a sexually transmitted infection such as HIV.⁴⁵ Additionally, health services should be accessible and include education and information programs.⁴⁶ In two subsequent general comments, the commission

calls on states to implement, in the legislative and policy framework, provisions specific to the HIV/AIDS status of women and women's SRH rights.⁴⁷ In a more recent report, issued in 2018, the commission again highlights concerns about the HIV/AIDS epidemic in Africa, such as limited access to services for vulnerable people, including women.⁴⁸ The report identifies women and prisoners as being among the groups needing specific protection and access to HIV/AIDS treatment and health services.

Health rights under Zimbabwe's legislative and policy framework

Zimbabwean law does not include a health entitlement that can be relied on by the general population (including women prisoners); however, the social determinants of health are recognized in the Zimbabwean Constitution and in the country's health strategies and plans.

The Constitution includes a Bill of Rights with several justiciable socioeconomic rights.⁴⁹ Among these is the right to basic health care services, including reproductive health care services, for all, including people living with chronic illness and anyone needing emergency medical treatment.⁵⁰ The Constitution also gives effect to General Comment 14's aim to protect a "core minimum" of economic and social rights, such as the right to food and water; however, the state's obligation extends to reasonable legislative and other measures within the limits of available resources, to achieve the progressive realization of the rights in this section. In the national objectives of the Constitution, which are not legally binding, the qualification is repeated—that the state's measures to prevent disease will be "within the limits of the resources available to it."⁵¹ This formulation dilutes both the right and the state's obligation. It also weakens the public health commitment in the 2016–2020 National Health Strategy to align the Constitution of Zimbabwe, the government policy blueprint, and the Zimbabwe Agenda for Sustainable Socio-Economic Transformation with international commitments not to divorce the living conditions of people from their health risks and status.⁵²

The Constitution also restricts access to

treatment to citizens and permanent residents, theoretically leaving foreign women prisoners living with HIV no access to programs for the prevention of mother-to-child transmission or HIV/AIDS and related opportunistic infections.⁵³ This policy is not in line with international standards—and a similar policy in Botswana did not withstand a legal challenge before a domestic high court. In a 2014 judgment, two Zimbabwe nationals incarcerated in Botswana won the right to receive highly active antiretroviral therapy, which is more effective than conventional treatments in treating HIV-related opportunistic infections.⁵⁴ The claimants were initially left out of the treatment program on account of their foreign status. The court held that the right to life enshrined in the International Covenant on Civil and Political Rights encompasses the right to health in the International Covenant on Economic, Social and Cultural Rights.⁵⁵ The "judgement emphasised the universality, indivisibility, interdependence and interrelated nature of all human rights."⁵⁶ The court included in its reasoning public interest considerations:

It can never be in the public interest nor can it ever be reasonably justified in a democratic society like ours that the provision of life-saving medication like highly active antiretroviral therapy is withheld with the ultimate result that the group of people so deprived becomes more infectious to others or die in our hands.⁵⁷

The state is responsible for the health of prisoners. If SRH services should be made available to foreign prisoners (for example, Zimbabwean nationals) in Botswana jails, it would be difficult to argue that withholding this treatment from foreign women prisoners in other African jails, including Zimbabwe's, would not be a violation of the right to life.

The 2018 Public Health Act of Zimbabwe seeks to align public health laws with the Constitution.⁵⁸ The preamble of the act states that its aims are "to provide for public health" and "for the conditions for improvement of the health and quality of life and the health care for all people in Zimbabwe"; respect for human rights; the adherence to rights and responsibilities; the promotion of justice, eq-

uity, and gender equity; and “the best interests of vulnerable groups.”⁵⁹ However, the act does not incorporate a rights-based framework consistent with the Constitution to protect health rights, to ensure health equality by addressing the specific health needs of women, or to include international law obligations for women with HIV/AIDS. It also does not address the rights of vulnerable groups such as prisoners.

The Zimbabwean government has addressed HIV/AIDS through several national strategic plans. The second Zimbabwe National HIV and AIDS Strategic Plan (ZNASP II), for 2015–2018, included women prisoners among the groups most vulnerable to HIV/AIDS. The plan dealt with the elimination of mother-to-child transmission and made reference to the prevention of mother-to-child transmission for women in prisons.⁶⁰ The current plan, ZNASP III, for 2015–2020, adopts a rights-based approach. It focuses on key populations (such as prisoners, people with disabilities, youth, women, children, and others who may be socially excluded) to ensure the reduction of new infections.⁶¹ ZNASP III is committed to the elimination of mother-to-child transmission to reduce maternal and child mortality rates.⁶² It “recognizes the human rights and non-discrimination of PLHIV” and notes that HIV/AIDS services must be gender sensitive across all key priority areas.⁶³ This includes the provision of comprehensive care, treatment, support, and follow-up for women living with HIV, their infants, and their family (including male partners). ZNASP III also recognizes that prisoners are a key population group vulnerable to infection and allows for informal lobby groups for prevention activities to address HIV/AIDS prevention and education in prisons.⁶⁴ However, a serious omission in ZNASP III is its failure to address the health needs of women prisoners living with HIV. Even when prisoners as a group are specifically addressed, the SRH of women prisoners are ignored.

Unlike ZNASP II and III, the 2016–2020 National Health Strategy does not address the issue of HIV/AIDS in prisons. Although women are mentioned in the strategy, the neglect of prisoners generally and women prisoners specifically shows

the failure of the strategy to adopt an intersectional approach.

Nondiscrimination provisions in international and regional law

Nondiscrimination and equality provisions in international and regional treaties provide the basis for state parties to eliminate health-related discrimination against women living with HIV and, by extension, women prisoners living with HIV.

Formal equality between men and women enshrined in international human rights law does not result in substantial equality in health, since the latter necessitates differential and appropriate health provisions that take into account women’s SRH.⁶⁵ The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) addresses some of the legislative measures needed to ensure substantive health equality for women.⁶⁶ CEDAW’s article 12, on the right to health, includes SRH; family planning services; services relating to pregnancy, confinement, and the postnatal period; and adequate nutrition during pregnancy and lactation.

CEDAW includes elements of both civil and political and economic, social, and cultural rights for women. By and large, the treaty retains the distinction between the two. Civil and political rights are immediately effective, while economic, social, and cultural rights are to be progressively realized within the “maximum available resources.”⁶⁷ This weakens states’ obligations to prioritize gender-appropriate health measures for women. However, two further recommendations by the Committee on the Elimination of Discrimination against Women clarify the duties of states with regard to the health of women living with HIV. General Recommendation 15 requires state parties reporting on health rights to explain the actions taken to stop discrimination against women living with HIV and to provide for their health needs. States’ reports should include measures taken to address both biological and socioeconomic issues affecting women’s health, including menstruation, reproductive function and menopause, risk of exposure to sexually

transmitted infections, the subordinate position of women in the home and workplace, women's nutrition and health, gender-based violence, early pregnancy, and genital mutilation.⁶⁸

Meanwhile, General Recommendation 24 affirms that access to health care, including SRH, is a basic right of women, and it includes the issues of HIV/AIDS and other sexually transmitted infections within the scope of the right to sexual health.⁶⁹ Significantly, the recommendation requires that a "gender perspective" be mainstreamed into all policies and programs affecting women's health and emphasizes the needs of women who are vulnerable and disadvantaged.⁷⁰

The Maputo Protocol also takes a robust approach to health equality to address the high HIV prevalence among African women. Article 1 states that "any form of distinction, exclusion, or restriction or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women in all spheres of life."⁷¹ Moreover, the African Commission has published two general comments providing a much-needed level of specificity for states' obligations regarding women's health. General Comments 1 and 2 oblige states to address the roots of discrimination, social inequality, and gender stereotypes; to examine the role and reach of educational and information programs to make women aware of their health rights; and to address health issues specific to SRH.⁷²

Nondiscrimination and equality under Zimbabwe's legislative and policy framework

The Constitution of Zimbabwe includes an equality right for women similar to those enshrined in the International Covenant on Civil and Political Rights and the African Charter.⁷³ It prohibits laws, customs, traditions, and cultural practices that infringe on the rights of women.⁷⁴ As mentioned earlier, the Constitution mentions SRH only for citizens and permanent residents of Zimbabwe. However, no secondary legislation has been enacted to implement the provisions of the Constitution, the Maputo Protocol, or the African Commission's general comments, creating serious difficulties for

women prisoners, who are in a weaker position to demand health services adequate to their needs.

Health rights in prison and the health needs of women prisoners living with HIV

Treating HIV/AIDS in prisons has proved promising, but the rollout of antiretroviral therapies for persons living with HIV faces barriers in prison settings.⁷⁵ Prisons are not well resourced to provide complete treatments for anti-tubercular therapy or antiretroviral therapy for inmates with HIV-associated tuberculosis.⁷⁶ Gaps in the treatment regime for HIV can lead to resistance to first-line medications, making treatment more difficult and expensive in the long term.⁷⁷ Also, antiretroviral therapies are unlikely to produce expected health outcomes if the health of prisoners is compromised by "poor nutrition, substandard prison conditions and violence," as is the case in Zimbabwe.⁷⁸

Frequently, inmates do not know their HIV status, and their health issues remain undiagnosed. Therefore, prison health screening upon entry is indispensable for effective treatment. However, inmates, even if aware of their HIV status, are often unwilling to disclose it for fear of discrimination by other inmates and prison authorities.⁷⁹ Even though prisons might be the only point of access to health services for many detainees, prisons are often not trusted to carry out non-coercive testing programs, get consent for testing, respect confidentiality, or keep proper records. This is not to underestimate the difficulties inherent in the ethics of treatment. For example, informed consent assumes that the detainee has a comprehension capacity to understand the social and medical implications of testing positive for HIV, but the capacity for comprehension among incarcerated populations generally, is often diminished "due to low literacy, mental illness, substance abuse and other factors."⁸⁰

Few international standards seeking to protect the human rights of prisoners are binding, but they do set minimum requirements.⁸¹ Key among these instruments are the United Nations Standard Minimum Rules for the Treatment of Prisoners, which address the accessibility of health care; pa-

tients' rights and medical ethics; proper medical services from qualified staff; and the duty of the prison authorities to undertake inspections that ensure nutrition, hygiene and cleanliness.⁸² Other instruments include the *WHO Guidelines on HIV Infection and AIDS in Prisons* and the *International Guidelines on HIV/AIDS and Human Rights*, which were developed to stop the spread of infectious diseases in prisons.⁸³ In 2010, the United Nations issued a supplement to the aforementioned Standard Minimum Rules, entitled the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women (Bangkok Rules), detailing the health needs of women prisoners and women living with HIV.⁸⁴ These rules prescribe differential health provision for women pertaining specifically to SRH.⁸⁵ In addition, the health screening of women prisoners should include (voluntarily) the patient's reproductive history; drug dependency; and any previous sexual abuse or violence she may have suffered.⁸⁶ To stop the abuse of women prisoners, the rules prescribe proper, independent investigative processes and redress.⁸⁷ They also address HIV/AIDS, the prevention of mother-to-child transmission, and preventative measures for sexually transmitted infections. Aware of the stigma that HIV carries—which might prevent detainees from seeking treatment—the rules require that training for prison staff include gender and human rights.⁸⁸

Finally, at the regional level, the Southern African Development Community has developed the *Minimum Standards for HIV and AIDS, TB, Hepatitis B and C, and Sexually Transmitted Infections Prevention, Treatment, Care and Support in Prisons in the SADC Region*, which require a political commitment to ensure that prisoners' health is comparable to that of the general population and to implement national AIDS programs in prisons.⁸⁹ These standards include references to the abuse of women in prisons and the need to investigate and address claims of abuse.⁹⁰

Health rights in prison and the health needs of women prisoners living with HIV in Zimbabwe
Zimbabwe provides for the health of prisoners in

the Prisons Act 2018 and the Ancillary Prisons Regulations 2011.⁹¹ The treatment and health of prisoners is mainly in the hands of a medical officer appointed at the discretion of the minister for prisons and correctional services, whose role is to oversee the health of prisoners and report on the treatment of prisoners that might require consideration on medical or health grounds.⁹² The Prisons Act does not prioritize the health of prisoners or the conditions in prison that have an impact on health. No mention is made of the health requirements of women prisoners. Indeed, international and regional guidelines on prisoners' health and rights do not seem to have found their way into Zimbabwean legislation. The regulation dealing with HIV/AIDS is the National Aids Council of Zimbabwe Act, which established the National AIDS Council to administer and coordinate the national response to combat HIV/AIDS.⁹³ There is nothing else in Zimbabwean legislation that deals with HIV/AIDS and related aspects in prisons.

The absence of legislation that might cover the health of prisoners and SHR for women prisoners means that there is weak protection for women prisoners affected by HIV/AIDS. However, women prisoners might have an alternative legal avenue in the Zimbabwe Human Rights Commission, as this body is tasked with overseeing the promotion, protection, and fulfilment of human rights. Through its Monitoring and Inspections Unit, the commission has the authority to inspect the conditions of prisoners and all detainees, including refugees, and make recommendations concerning human rights standards in places of detention.⁹⁴ The commission benchmarks its observations against constitutional provisions on the right of detained persons to be treated humanely; the Prisons Act; and international law provisions (such as the prohibition of torture and degrading treatment or punishment, and the right to food and water). As an independent body, the Zimbabwe Human Rights Commission can shine a light on the health conditions and needs of women prisoners living with HIV. Unfortunately, the commission's powers, when the rights of detainees are violated, is restricted to making recommendations; therefore, its authority to protect

the health rights of women prisoners living with HIV is not very strong.

Conclusion

The global effort to reduce HIV/AIDS has been successful: the world has seen a 35% decline in HIV-related deaths and a 38% decrease in new HIV infections since its peak in 1998.⁹⁵ The recognition that HIV is more lethal to poor and marginalized communities has encouraged the United Nations and regional bodies to develop standards and practical guidance on how to respond to the health needs of women prisoners living with HIV. From the 1990s onward, health entitlements for women have included SHR, gender inequality, and access to specialized services in health.⁹⁶

Unfortunately, as evidenced by our analysis of Zimbabwe's legal framework,

these developments have not resulted in a significant shift in the country's laws to prioritize the health rights of women and the protection of women prisoners living with HIV. Zimbabwe has made an effort to adopt a "human rights, evidence and results-based approach" in its national HIV/AIDS response. This national strategy recognizes that the "fulfilment of human rights can only be achieved if there are adequate and relevant policies and legislation that enhance universal access to HIV/AIDS, and health services, gender equality and sensitivity of response, reduction of stigma and discrimination in all settings." Further, it aligns with national, regional, and international policy frameworks on the attainment of universal health care.⁹⁷ However, this strategy has not translated into provisions that are legally enforceable.

The enactment of the Public Health Act in 2018 provided an opportunity for the government to align the law with the 2013 Constitution, which enshrines a right to health. The act gives effect to the Constitution to protect, improve, and maintain the health of the population, including by preventing the spread of infectious diseases.⁹⁸ However, the act fails to provide stronger rights-based language related to health rights, particularly clauses relating to the prevention and containment of HIV among

women in prisons. Given the obvious and unique challenge of high numbers of people living with HIV in the country, it would have been desirable to have specific and robust provisions to address this pandemic. In addition, it is difficult for the Ministry of Health and Child Care to give effect to disease prevention provisions of the act at the administrative and operational level given the thin budget allocations in this regard.

In general, the health strategies adopted by Zimbabwe purport to take a human rights-based approach to HIV/AIDS and gender inequality, which is fundamental to preventing new infections. However, this approach needs broadening out to include prisons if it is to directly address women prisoners living with HIV.⁹⁹ So far, only one of the country's national strategies specifically mentions prisoners as a vulnerable group. Also, it is necessary to track the prevalence and incidence of HIV/AIDS in prisons, especially among women prisoners, so that the reach and effectiveness of national health strategies can be evaluated for its impact on this marginalized population. These gaps in Zimbabwe's health laws and policies regarding the SRH of women has an adverse impact on the health of women prisoners living with HIV.

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