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Article

Using COVID-19 to Address Environmental Threats to Health and Leverage for Prison Reform in South Africa, Malawi and Zimbabwe

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Abstract

Health rights of prisoners has long been a neglected political issue in Africa, where over one million people are detained, and almost half of whom are in pre-trial detention. African prisons constitute high-risk environments for communicable disease transmission. During the COVID-19 pandemic, the public health literature on African prison responses focused on preparedness as it related to testing capacity, quarantine practices and personal protective measures to mitigate disease spread. This article combines the right to health as narrowly defined by a prisoner's right to access non-discriminatory equivalent health care, with a broader focus on assessing normative standards of detention. A comparative legal realist assessment of prison operations in South Africa, Malawi and Zimbabwe during COVID-19 state disaster measures is presented, focusing on the environmental determinants of health (ventilation, minimum floor space, water, sanitation, hygiene and nutrition) in prisons. It reveals the inherent tensions in ensuring a balance between respecting the fundamental rights of people living and working in prisons, ensuring adequate environmental health standards and mitigating disease during public health emergencies. Despite insufficient government resourcing and inadequate coverage of COVID-19 responses, few severe outbreaks were reported. This could be due to lack of testing, reporting or other factors (asymptomatic infection, acquired immunity). Prison congestion and unrest however affected prisoners and staff fearful of hazardous living and occupational health conditions. COVID-19 as public health emergency amplifies the need to address systemic deficits in infrastructure, resourcing and efficiency of criminal justice systems. Policy level and pragmatic recommendations for enhanced human rights practice are outlined.

Keywords: Closed setting; degrading treatment; detention; disease; human rights; infection; prohibition of torture; standards

Background

The World Health Organization (WHO) declared COVID-19 (SARS-CoV-2 virus) as a pandemic on 11 March 2020 (WHO 2020a). The African Union Africa Centres for Disease Control and Prevention confirmed the first COVID-19 case in Egypt on 14 February 2020 (Africa News 2020; African Union CDC 2020), and the second in Algeria on 24 February 2020 (WHO-Africa 2020). At the time of writing (8 July 2022), over 12,373,000 reported infections and 256,000 fatalities have been reported in Africa (Reuters 2022). While predictions of the impact of COVID-19 in Africa were initially catastrophic (Badu et al. 2020; Nkengasong and Mankoula 2020), low case numbers and deaths can be partially

explained by the youthful population and limited testing strategies (Usuf and Roca 2021). The absence of systematic surveillance and seroprevalence of mild or asymptomatic SARS-CoV-2 infection and antibody positivity in Africa compounded the risk of under-reporting and underestimation of the true burden of COVID-19 (Chibwana et al. 2020; Cohen et al. 2021; Fryatt et al. 2021; Mandolo et al. 2021). There is however no doubt that health inequality and inequity in Africa were exacerbated during the pandemic, due in part to the high population density, low socio-economic status, and the chronic ill-health, social discrimination and social exclusion of particular marginalized social groups (Lucero-Prisno, Adebisi and Lin 2020; OECD 2021; UN 2020).

This article concerns the situation of prisoners in Africa during the COVID-19 pandemic. Historically, their health rights have been a neglected political issue due to continued state prioritization of prison security, and the neglect of maintenance of basic infrastructure and minimum standards of care (space, air, water, food, medical assistance) in many African states (ACoHPR 2012; O'Grady 2011; Todrys and Amon 2012). There is still reluctance to reform prisons and resource the upgrading of post-colonial facilities, despite the immense threat to public health presented by poorly managed prison systems during COVID-19 (Muntingh 2020; Van Hout 2020a; 2020b). Academic prison health research, and routine health and disease surveillance in prisons also remains underdeveloped in many African states further compounding the lack of attention to the situation of those deprived of their liberty (Ako et al. 2020; Mhlanga-Gunda et al. 2020a).

Fifty-three African states account for 1.1 million prisoners (outside of the unknown figures from Somalia and Eritrea), where on average 42 per cent are held in pre-trial detention (World Prison Brief Africa 2022). Prisons in Africa have long been identified as high-risk environments for communicable disease outbreaks (Telisinghe et al. 2016; Todrys et al. 2011; Rubinstein et al. 2016). Prison communities consisting of staff, pre-trial detainees and sentenced prisoners are particularly vulnerable to rapid COVID-19 disease transmission (Van Hout 2020a; 2020b). Co-morbidity and chronic ill-health of prisoners, high turnover and density of the prison population, severe congestion in cells and inadequate standards of nutrition, ventilation, and water, sanitation and hygiene (WASH) compound the threat that COVID-19 poses in Africa (Amnesty International 2020; Amon 2020; Muntingh 2020).

The African Commission on Human and Peoples' Rights (ACoHPR) issued several declarations in March and April 2020 cognisant of the COVID-19 threat to African prison systems. All African states were recommended to develop and operationalize decongestion schemes (early release/parole, amnesties, presidential pardons, alternative community sentencing), and initiate health and security measures to mitigate COVID-19 (ACoHPR 2020a; 2020b). Actions were aligned to the UN High Commissioner for Human Rights (OCHCR) global call on states to instigate prison decongestion measures as a critical component of the COVID-19 response on 25 March 2020 (OHCHR 2020). Global prison decongestion measures during COVID-19 were additionally supported by the UN Subcommittee on Prevention of Torture (SPT) (UN SPT 2020). Alternatives to custodial sentencing in particular were broadly advocated by the African Centre for the Constructive Resolution of Disputes (ACCORD) (ACCORD 2020). By 26 May 2020, prisons in Algeria, Cameroon, Sierra Leone, Ghana, Guinea, Egypt, Democratic Republic of Congo, Morocco, South Africa and Kenya reported detection of COVID-19 cases among staff and/or prisoners (Prison Insider, 2020). Many African states did not make their prison system COVID-19 detection data publicly available, and there is little transparency to date on the operationalization of prisoner release schemes (actual numbers and types of prisoners released) across the continent (DLA Piper 2020; Muntingh 2020; Van Hout et al. 2022a: 2022b).

The limited capacity to adequately respond to the threat of COVID-19 in African prisons was highlighted in open letters by human rights organizations to the Southern Africa Development Community (SADC) (SADC 2020). Efforts to implement effective COVID-19 prison responses in Africa were generally compromised by lack of adequate government

resourcing of a health budget in prison system operations (generally held by the Ministry of Justice as opposed to the Ministry of Health), weak judicial systems hindered by modalities of policing and existing colonial-era laws (for example vagrancy laws), and dated physical infrastructures of prisons (Amon 2020; Muntingh 2020; Nweze et al. 2020). There has been widespread media and official reporting of human rights violations, riots, protests and strikes by prisoners and prison staff in Angola, South Africa, Ethiopia, Liberia, Democratic Republic of Congo, Guinea, Zimbabwe, Uganda, Malawi and Sierra Leone. Unrest during COVID-19 emergency measures was generally due to hazardous occupational and living conditions, continued intake and mixing of pre-trial detainees with sentenced prisoners, water supply crisis, cell congestion and lockdowns, insufficient nutrition, and general lack of COVID-19 personal protective equipment (PPE) for staff and prisoners (Prison Insider 2020; Saalim et al. 2021). Visitation restrictions by external visitors (lawyers, medical professionals, family) and independent monitoring bodies including in African states party to the Optional Protocol to the Convention against Torture (OP-CAT) (UN 2003) during disaster/emergency measures further compounded unrest (Muntingh 2020; Van Hout and Wessels 2021a).

Using legal realism with an environmental health lens to assess African prison system responses to Covid-19

During the COVID-19 pandemic, the public health literature on African prison responses focused on preparedness as it related to testing capacity, quarantine practices and personal protective measures to mitigate disease spread. Multi-stakeholder situation assessments of prison health responses (including those led by the author, a public health specialist) in these countries are reported elsewhere (Jumbe et al. 2022; Mhlanga-Gunda et al. 2022; Van Hout and Wessels 2021a). This article combines the right to health as narrowly defined by a prisoner's right to access non-discriminatory equivalent health care, with a broader focus on assessing normative standards of detention. This article presents a comparative legal realist assessment of prison situation and operations in three African states of varying economic development, namely South Africa classed as upper middle income country, Zimbabwe as lower middle income, and Malawi as least developed (OECD 2022).

The Sustainable Development Agenda 2030 (UN 2015) underscores how a healthy environment is vital to 'ensure healthy lives and promote well-being for all at all ages' (SDG 3). This article assesses the right to health as narrowly defined by a prisoner's right to accessible, non-discriminatory and equivalent health care, in combination with a broader focus on assessing normative standards of care pertaining to the environmental determinants of health in prison (ventilation, minimum floor space, water, sanitation, hygiene and nutrition) during COVID-19 state disaster measures. It adopts a prison community approach, inclusive of those living and working in prisons.

Legal realism as naturalistic approach to law (Leiter 2015; Shaffer 2015; Wenander 2021) was chosen to underpin this assessment, where the emphasis was on the law as it actually exists in the practical sense and derived from real world observations within prison environments regarding prison contextual and environmental factors, health and welfare of prison communities, public health/prison policies in each country and the law itself. Illustrating the real world space of incarceration during COVID-19 restrictions in each of the selected countries (South Africa, Zimbabwe and Malawi) was intended to exemplify the law in action and related challenges in upholding the human rights of prison communities, while implementing a public health disease control response during health emergency and state declaration of disaster. The socio-legal approach yields a pragmatic and comparative focus of the social and lived experience of COVID-19 in prisons, and how the law and the law's purposes form an integral part of that experience from the perspectives of the prison community, legal representatives and families of prisoners and staff. Ultimately assessing

the law in action in the selected countries, each with distinct prison system operations and challenges using a legal realist environmental health lens sought to generate information used to inform pragmatic considerations for domestic system operations and policy reforms, and to guide future human rights based policy and practice within the African criminal justice and penal continuum.

The structure is as follows. A section on right to health, normative standards of care and the prison environment as provided for in terms of international and African regional human rights treaties, the non-binding UN normative standards of care in prisons, relevant African Court jurisprudence, and contemporary COVID-19 technical guidance issued by UN agencies is presented. These were not limited to prohibition of torture and discrimination of prisoners but encompassed all deemed relevant to environmental conditions of detention and disease control during public health emergencies. A brief contextual section provides a table and extant detail on each country in terms of prison profiles, COVID-19 promulgations, treaty ratification status and relevant case law. The generated legal realist account on South Africa, Malawi and Zimbabwe is subsequently presented, and based on academic publications, human rights, criminal justice and penal resources, government and non-government reports, and investigative reporting by the media in timeframes following first case notification in each country's prison system (April 2020 for South Africa, and July 2020 for Malawi and Zimbabwe).

Collectively they were carefully examined and compared to assess the level to which the rule of law was respected during the COVID-19 disaster measures, and how this interplayed with the environmental determinants of health pertinent to mitigation of COVID-19 and other communicable diseases and development of chronic ill-health in prisons. Themes subsequently centre on standards of WASH, humane treatment of prisoners, space to quarantine and to physically distance as per public health guidance, safe working conditions, supply of PPE, provision and quality of nutrition, and access to the outside world for prison monitoring inspections, legal and family supports. The developed realist account is illustrative of the formal tensions between pragmatism and formalism in legal and policy based measures to mitigate COVID-19 in African detention spaces. It illuminates the indeterminate nature of law and the instrumental nature of the law in serving social ends (Leiter 2015; Shaffer 2015; Wenander 2021). It is further cognisant of the inherent complexities in ensuring the appropriate balance between environmental and occupational health standards, disease mitigation during public health emergency, and the risk of inhumane or degrading treatment of those living in prison during state disaster measures. It compares and contrasts each countries' operationalization of COVID-19 standard operating procedures and respect for the rule of law, standards of health and environmental conditions in prisons, and impact of COVID-19 on prison dynamics and environments.

Human rights and right to health in detention environments

States have positive obligations under a range of international treaties to uphold the human and health rights of prison communities, including the mitigation of and treatment of disease (Lines 2008; Rubenstein et al. 2016). These include the World Health Organization (WHO) Constitution Article 2 (UN 1947), Universal Declaration of Human Rights Article 25 (UN 1948), International Covenant on Economic, Social and Cultural Rights (ICESR) Article 12(1)(2)) (UN 1966a) and the UN Committee on Economic, Social and Cultural Rights (CESCR) General Comment No. 14 (UN CESCR 2000). CESRC General Comment 14 provides that states are (at the very least) required to meet a threshold of a core minimum of social and economic rights, including the right to health, and that prisoners are entitled to the same core minimum health rights as other citizens. Article 12(1) of the ICESR is particularly relevant to standards of detention and the impact of environmental determinants of health in prisons and disease. It obliges states to take necessary measures for 'the

prevention, treatment and control of epidemic, endemic, occupational and other diseases' and 'the creation of conditions, which would assure to all medical service and medical attention in the event of sickness'. Article 12 (2) specifically outlines the necessary steps encompassing disease detection, prevention, treatment and control; and the human rights assurances regarding prisoner access to all required medical support and care during illness.

The International Covenant on Civil and Political Rights (ICCPR) (UN 1966b) further builds on the ICESR by specifically providing for the right to life and right to humane treatment of prisoners, thereby indirectly including the aspects of environmental determinants of health within standards of detention and care (Articles 2, 6, 7, 10 and 26) (OHCHR 2012). The Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (UN 1984) and OP-CAT (UN 2003) create further binding obligations on states not to ill-treat those deprived of their liberty. The rights of women and children in detention settings are further included in the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) (UN 1979) and the Convention on the Rights of the Child (CRC) (UN 1989).

A range of non-binding UN norms and minimum standards for the treatment of prisoners (UN 1982; 1988; 1991) and WHO and medical declarations (WHO 2003; World Medical Association 2011) are relevant to prisoner rights to humane treatment and basic care, protection against conditions conducive to transmission of disease and access to healthcare. The UN Standard Minimum Rules for the Treatment of Prisoners (Mandela Rules) (UN 2016) are most well-known and cover states' responsibility for the health of prisoners. The Mandela Rules are further supported by the non-discrimination provisions contained in the 2010 United Nations Rules for the treatment of women offenders (Bangkok Rules) (UN 2010). Mandela Rule 1 is perhaps most applicable to this realist assessment and states that 'All prisoners shall be treated with the respect due to their inherent dignity and value as human beings and no prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification'. Rule 13 states: 'All accommodation shall meet all requirements of health, due regard being paid to climatic conditions and particularly to cubic content of air, minimum floor space, lighting, heating and ventilation'. With regard to the environmental health aspects of prison settings, the Mandela Rules outline the state obligation to provide prisoners with sufficient standards of care including those crucial to disease mitigation. These include recognition of infrastructure deficits, biohazards and related vulnerabilities to ill-health; and uphold that regular prison health inspections should occur pertaining to the adequacy of WASH, food and the physical conditions of the prison (Rules 24, 25, 27, 30, 31, 32, 35).

The UN Human Rights Committee (UN HRC) concluding observations reflect state obligations to 'take action to safeguard the health of prisoners', and further provides that it is 'incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection' with explicit reference to proactive measures for communicable disease control. The right to adequate living space sufficient to safeguard health constitutes the pre-conditions of health, with the environmental health determinants (overcrowding, WASH, ventilation, food security) recognized by the UN HRC as potentially subjecting prisoners to disease, ill-health and exacerbating the risk of contagion. Jurisprudence at the UN HRC level additionally refers to state failure to instigate adequate disease mitigation measures in prisons (for example airborne precautions in tuberculosis (TB) control), and how negligence of the state system places a prisoner's right to health in serious jeopardy (violating ICCPR Articles 6, 7, 9 and 10) and reflects inhuman or degrading conditions in detention. The UN HRC (2018) in its General Comment No 36 has stated that 'States parties may not rely on lack of financial resources or other logistical problems to reduce this responsibility'. Of crucial importance during state declaration of an epidemiological emergency (as in COVID-19) is that the UN Principles of Medical Ethics relevant to prisons (UN

1982) contain a non-derogation clause during state declaration of emergency (Principles 1, 6).

In Africa, the promotion and protection of the human rights of prisoners are provided for in the legally binding treaty, the African Charter on Human and Peoples' Rights (ACHPR) (OAU 1981). Article 16 recognizes that state obligation regarding the right to health is heightened when an individual is in state custody, with their integrity and well-being wholly dependent on the state; and Article 5 equally provides for the right to dignity and freedom from cruel, inhumane or degrading treatment. The Robben Island Guidelines (ACoHPR 2008) and the Kampala declaration on prison conditions in Africa further protect the rights of prisoners by stating; 'prisoners should have living conditions that are compatible with human dignity, … retain all rights that are not expressly taken away by the fact that they are in detention and the detrimental effects of prisons should be minimised so that prisoners do not lose their self-respect and sense of personal responsibility'. While states have discretion in defining adequate levels of humane treatment of prisoners, domestic constitutions also provide for fair trail rights, and general protections against torture, inhumane and other ill treatment, and specific health related rights (Lines 2008).

Despite these rights obligations, the Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa has reported on the intense difficulties for African states to provide minimum standards of care in its prisons (ACoHPR 2012). The Committee for the Prevention of Torture in Africa is concerned with the state of prisons in Africa. Scoping reviews and human rights assessments of African prisons document little improvement in the conditions of detention in the past 20 years and underscore the additional vulnerabilities of certain groups of prisoners (women, children, juveniles, the mentally ill and mentally incapacitated, and the disabled) in the system (Agomoh et al. 2008; Van Hout and Mhlanga-Gunda 2018; 2019a; 2019b; Van Hout and Wessels 2021c). In terms of African Court on Human and Peoples' Rights jurisprudence, several African states (Nigeria, Malawi, Mauritania, Zaire, Burkina Faso, Tanzania, Rwanda) have been found in violation of the Charter's right to health as it relates to conditions of detention pertinent to a prisoners right to life, and prohibition of cruel, inhumane or degrading treatment concerning neglect, abuse and prison environments as conducive to spread of diseases (human immunodeficiency virus (HIV) and TB) and chronic ill-health (lack of safe and sufficient space, food, sanitation, hygiene and ventilation). See Table 1 for relevant cases.

Table 1. African court jurisprudence relevant to prison standards and the rights of prisoners

Constitutional Rights Project and Civil Liberties Organisation v. Nigeria (1999) ACHPR Comm Nos 143/95, 150/96 para 5
Krishna Achuthan (On behalf of Aleke Banda), Amnesty International (On behalf of Orton and Vera Chirwa) v.Malawi (1994) ACHPR Comm Nos 64/92, 68/92, 78/92 para 7.
International PEN and Others v. Nigeria (1998) ACHPR Nos 137/94, 139/94, 154/86, 161/97 para 112
Malawi African Association and Others v. Mauritania (2000) ACHPR Nos 54/91, 61/91, 98/93, 164/97 a, 196/ 97 and 210/98 para 122
Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine de l'Homme, Les Te´moins de Jehovah v. Zaire (1996) ACHPR Comm Nos 25/89, 47/90, 56/ 91, 100/93 para 47
Konaté v Burkina Faso (reparations) (2016) 1AfCLR346
Abubakari v Tanzania (merits) (2016) 1AfCLR599
Guehi v Tanzania (merits and reparations) (2018) 2AfCLR477;
Lohé lssa Konaté v Burkina Faso (provisional measures) (2013) 1AfCLR310
Mugesera v Rwanda (provisional measures) (2017) 2AfCLR 149

COVID-19 normative guidance

Finally and specific to COVID-19 and disease control, UN agencies and leading human rights organizations have promulgated technical guidance on COVID-19 responses and human rights assurances in prisons (WHO 2020b; 2020c; UNODC 2020a; 2020b; Penal Reform International (PRI) 2020). These statements mandate that conditions of detention should not contribute to the development, worsening or transmission of COVID-19 and other diseases in circulation, and that COVID-19 mitigation measures may not result in inhumane or degrading treatment of prisoners. All disease control measures should be implemented in prisons to counter the risks of transmission and health harms of all in the prison community. Such measures must never result in inhumane or degrading treatment of prisoners (for example unreasonable solitary confinement, the loss of rights to access legal representation and to communicate with family). Restrictions may only be implemented on grounds of medical necessity and in compliance with the human rights principles of legality, proportionality, oversight, time-limitation, and non-discrimination. Independent prison monitoring bodies' must be guaranteed access to prisons by the state. The ACoHPR press releases were largely in alignment with these guiding principles (ACoHPR 2020a; 2020b).

Country prison contexts: South Africa, Malawi and Zimbabwe

Context with regard to COVID-19 data, prison system demographics and state promulgations during COVID-19 disaster measures, and the relevant domestic jurisprudence base pertaining to violation of prisoner rights regarding standards of detention and exposure to communicable disease in South Africa, Malawi and Zimbabwe are presented in Tables 2–4.

In South Africa, despite the prison population being at its lowest level in decades, prisons continue to operate over capacity (140 per cent in 2019; 120 per cent in March 2021) (DCS 2019; 2020a; World Prison Brief South Africa 2022). The South African bail system, its mandatory minimum sentencing regime and substantial pre-trial detention rates contribute to prison congestion (Cameron 2020a; de Ruiter and Hardy 2018; Gordin and Cloete 2013). There have been calls for increased use of parole and medical parole to relieve overcrowding (Maseko 2017; Mujuzi 2011). Minimum standards of care relating to space, WASH, bedding, toilet paper, food and access to healthcare even in recent years are not sufficiently implemented (Muntingh 2016; Nagisa-Keehn and Nevin 2018; Van Hout and Wessels 2021b). Dated colonial infrastructure and poor environmental conditions conducive to the spread of disease (HIV, TB, leptospirosis and others) challenge the South African authorities (Dissel 2016; Nevin and Nagisa-Keehn 2018). The White Paper on Corrections in South Africa (DCS 2004) and other various policies, regulations and statutes containing provisions around minimum standards of care, conditions and disease control measures inform prison system protocols (DCS 2011;2014; South African Department of Health 2013). The most recent inspection by the ACoHPR Special Rapporteur on Prisons was in 2004 (ACoHPR 2012).

In Malawi, the Prison Inspectorate reported between 2018 and 2019 that the system had reached 260 per cent capacity, and documented dire conditions of detention (Malawi Prison Inspectorate 2019). The Malawi Law Commission (2018) has documented failures of the prison system to adhere to provisions contained in the Prisons Act, and described prison overcrowding as 'leading to unacceptable and dehumanizing levels of congestion'. In 2020 overcapacity was 207 per cent (World Prison Brief Malawi 2022). Prison conditions remain poor due to outdated colonial infrastructure, understaffing and severe congestion,[1] with prisoners suffering a range of human rights violations (Chilemba 2016; Gauld 2021).

1 '…packing inmates in an overcrowded cell with poor ventilation with little or no room to sit or lie down with dignity, but to be arranged like sardines violates basic human dignity and amounts to inhuman and degrading treatment' (*Gable Masangano vs The Attorney General, Minister of Home Affairs and Chief Commissioner of Prisons* (2009) MLR 171).

Table 2. South Africa

COVID-19[1]: domestic and prison system reported data	Prison profile	State directives and policies	Treaty ratification	Relevant landmark judgements regarding the rights of prisoners to humane treatment, adequate accommodation, nutrition, medical care and protection from disease
Country wide				
South Africa Upper Middle Income Country (per capita GNI $4 096-$12 695 in 2020)				
3,996,904 COVID-19 cases; 101,868 deaths; 31.9% vaccinated; *Prison System* 6 April 2020: First notification. 5 August 2021: 15,052 cases; 9342 officials/5710 prisoners; 13882 recoveries; 311 deaths: 221 officials/90 prisoners). 68,500 prisoners and 12,000 officials vaccinated.[2]	238 prisons; 140,948 prisoners 127.2% occupancylevel[3]	15 March 2020: declared a **national state of disaster.** State and Department of Correctional Services promulgation in issuance with the Disaster Management Act of 2002 (27(2)). (18 March 2020; 9 April 2020; 22 June 2020; 4 September 2020; 10 November 2020; and 28 January 2021)[4].	ICCPR; CCPR OP2; CAT; CAT OP; ICESCR; CRC; CEDAW **Accepts:** Individual complaints under the CCPR-OPT1 (Articles 2, 10 and 26), CEDAW-OP, CAT Article 22. **Accepts:** Inquiry procedures under CAT Article 20 CEDAW-OP Articles 8–9. **Does not accept:** individual complaints/ inquiry mechanisms under CRC-OP Article 13.	*S v Makwanyane and Another* (1995) ZACC3 at 151 (1995) (3)S.A 391.[5] *Van Biljon and Others v Minister of Correctional Services and Others* (1997) (4)SA441(C) and *B and Others v. Minister of Correctional Services and Others* (1997) (6) BCLR789(C).[6] *Moses vs Minister of Safety & Security* (2000) (3) SA 106 (C)[7] *Stanfield v Minister of Correctional Services* (2003) ZAWCHC 46, *Du Plooy v. Minister of Correctional Services* (2004) 3AllSA613(T) and *Mazibuko v. Minister of Correctional Services*(2007) Case No: 38151/05. JOL18957(T)[8] *EN and Others v Government of RSA and Others* (2006) 006(6)SA575(D); (2007) (1)BCLR 84.SAHC Durban (2006)[9] *Huang & Others v The Head of Grootvlie Prison and Another* (2008) JOL 21089 (0)[10] *Lee v Minister of Correctional Services* (2012) ZACC30[11] *McCallum v. South Africa* (2010) UN Doc CCPR/ C/100/D/1818/2008 (2 November 2010)[12] *S v Magida* (2005) (2)SACR591(SCA)[13] *Sonke Gender Justice v Government of South Africa* 24087/15(unreported) WC HC[14] *Sonke Gender Justice NPC v President of the Republic of South Africa and Others* (2020) ZACC para 38–40[15]

Table 2. Continued

COVID-19[1]: domestic and prison system reported data	Prison profile	State directives and policies	Treaty ratification	Relevant landmark judgements regarding the rights of prisoners to humane treatment, adequate accommodation, nutrition, medical care and protection from disease

[1] See Johns Hopkins University of Medicine. 2022. South Africa—COVID-19 Overview—Johns Hopkins (https://coronavirus.jhu.edu/region/south-africa) (Referenced 8 July 2022).
[2] See McCann, N (2021).
[3] World Prison Brief: South Africa (2022) (Referenced 31 March 2021).
[4] See Department of Co-operative Governance and Traditional Affairs CoGTA (2020); Department of Justice and Correctional Services (2020a, b, c, d, e).
[5] Abolishment of capital punishment.
[6] Prisoners have fundamental rights to adequate accommodation, nutrition and medical care. The DCS bears a greater duty of care to people living with HIV in prison.
[7] State duty to take reasonable steps to safeguard a detained person's interests and protect against assault.
[8] Denial of medical parole for terminally ill prisoners (including those living with HIV) violates the right to access of health care and right to detention conditions consistent with human dignity.
[9] Prisoners living with HIV who qualified for ART according to national policy be treated accordingly (a wider group of people than previously).
[10] Prisoners are entitled to have special dietary requirements based on their religion accommodated under the Constitution.
[11] Constitutional obligations to provide humane conditions of detention respecting human dignity and the provision of adequate medical treatment were violated (severe congestion, and complete lack of TB screening and disease management).
[12] The UN Human Rights Committee ruled that South Africa had violated Articles 10(1), and 7 ICCPR in conjunction with Article 2(3) due to prison official neglect and denial of access to medical care.
[13] Prisoner's ill health, health vulnerability and impact of prison conditions regarding health risk must be recognized at the sentencing stage.
[14] Prisoners' constitutional rights to health were violated due to inhumane and severely congested detention conditions which were inconsistent with human dignity.
[15] The Judiciary Inspectorate of Correctional Services (JICS) was deemed neither financially, nor operationally independent when investigating conditions of detention and human rights abuses.

Table 3. Malawi

COVID-19: domestic and prison system reported data[1]	Prison profile	State directives and policies	Treaty ratification	Relevant landmark judgements regarding the rights of prisoners to humane treatment, adequate accommodation, nutrition, medical care and protection from disease.
Country wide Malawi Least Developed Country (LDC)				
86,658 COVID-19 cases; 2,646 COVID-19 deaths; 8.31% vaccinated *Prison System* 14 July 2020: First notification. There is no detail publicly available regarding COVID-19 positivity rates or vaccination coverage in prison.	30 prisons 14,500; prisoners 207.1% occupancy level[2]	30 March 2020: declared a **national state of disaster.** There was a series of standing orders for the Malawi Prisons Service on the Prevention and Management of COVID-19, in pursuance of Section 13 of the Prison Act 1956.	ICESCR; ICCPR; CAT; CRC; CEDAW It has not ratified the CAT-Optional Protocol. **Accepts:** individual complaints procedures under ICCPR-OP1 and CEDAW-OP; and **accepts:** the inquiry procedure for CAT, *Article* 20. **Does not accept:** individual complaints procedures under ISCESCR -OP the Optional Protocol to the ICESCR or under the CAT, Article 22.	*Gable Masangano vs* The *Attorney General, Minister of Home Affairs and Chief. Commissioner of Prisons* (2009) MLR 171[3]

[1] See Johns Hopkins University of Medicine. 2022. Malawi - COVID-19 Overview - Johns Hopkins (https://coronavirus.jhu.edu/region/malawi) (Referenced 8 July 2022).
[2] World Prison Brief: Malawi (2022). (Reference 31 December 2020).
[3] Prison overcrowding, lack of sanitation, hygiene and ventilation in prisons violated the Malawi Constitution and international and regional African human rights norms.

Table 4. Zimbabwe

COVID-19: domestic and prison system reported data[1]	Prison profile	State directives and policies	Treaty ratification	Relevant landmark judgements regarding the rights of prisoners to humane treatment, adequate accommodation, nutrition, medical care and protection from disease.
Country wide Zimbabwe Lower Middle Income Country and Territories (per capita GNI $1 046-$4 095 in 2020)				
255,805 COVID-19 cases; 5560 deaths; 30.78% vaccinated; *Prison System* 21 July 2020: First notification. There is no detail publicly available regarding COVID-19 positivity rates or vaccination coverage in prison.	46 prisons; 20, 407 prisoners; 120% occupancy level[2]	30 March 2020: declared a **national state of disaster.** 30 March 2020: The Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe) (COVID-19) Notice, followed by seventeen COVID-19 related statutory instruments[3]	ICCPR; ICESCR; CEDAW; CRC Has **not** ratified the CAT or the CAT-Optional Protocol. **Does not accept:** individual complaints procedures or inquiry procedures under these treaties.	*Muzanenhamo v Officer in Charge CID (Law & Order) & Ors* (CCZ 287 of 2012) (2013) ZWCC 3 (13 November 2013)[4] *Fikilini v Attorney-General* (1990) (1) ZLR 105, 113 A-H (SC); *Re Mlambo* (1991) (2) ZLR 339 (S) at 344B-C; *Re Masendeke* (1992) (2) ZLR 5 (S); *S v Mukwakwa* (1997) (2) ZLR 298 (H); and *S v Kusangaya* (1998) (2) ZLR 10 (H)[5] *Kanengoni v Minister of Justice, Legal & Parliamentary Affairs & 2 Ors* (HH 156 of 2018, HC 544 of 2015) (2018) ZWHHC 156[6]

[1] See Johns Hopkins University of Medicine. 2022. Zimbabwe - COVID-19 Overview - Johns Hopkins (https://coronavirus.jhu.edu/region/zimbabwe) (Referenced 8 July 2022).
[2] World Prison Brief: Zimbabwe (2022). (Reference 31 March 2021).
[3] See Lawyers for Lawyers (2020). Several regulations enabled by Section 68 (1) of the Public Health Act were enacted, which included the Statutory Instrument 77 of 2020 titled Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) Order; the 2020 Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (No. 2) (Amendment) Order, 2020 (No. 7) and the Public Health (COVID-19 Prevention, Containment and Treatment) (Amendment) Regulations, 2020 (No. 8).
[4] Deplorable treatment of prisoners in terms of denial of medical treatment (ART), stripping of prisoner and placing in solitary confinement, with denial of access to blankets and unhygienic ablution facilities.
[5] See Zimbabwe Human Rights Forum. 2018. Lengthy pre-trial detention in Zimbabwe violates the standards set out in the Constitution (for example sections 50(2)(b) and 50(6)) and section 32(2) of the Criminal Procedure and Evidence Act (Chapter 9:07), and a range of international and regional human rights instruments.
[6] There is a duty on the part of the state to respect, protect, promote and fulfil the rights and freedoms set out in the Constitution. That includes access of prisoners to proper medical care to prevent unwarranted deaths.

A substantial lack of sanitation, ventilation and food security, and high rates of exposure to custodial violence is documented (Gadama et al. 2020; Malawi Inspectorate of Prisons 2019; 2021; USSD 2020a). Chronic ill-health of prisoners and the spread of communicable diseases (HIV, TB, scabies, Hepatitis C and sexually transmitted infections) in Malawian prisons is reported to be directly caused by environmental conditions (Banda et al. 2009; Chirwa et al. 2018; Gondwe et al. 2021; Zachariah et al. 2008). In 2020, in a report submitted to the UN CAT, it was documented that 414 people had died in Malawi prisons between January 2014 and September 2018, with no cause of death provided (UN Malawi 2020). Non-governmental organizations play a significant role in supporting and backfilling government HIV and basic needs response efforts in prisons (Gondwe et al. 2021).

In Zimbabwe, a similar lack of government resourcing and systemic poor standards of detention are reported, where prisons were documented to be 120 per over-capacity in March 2021 (World Prison Brief Zimbabwe 2022). Grave conditions of detention centre on a severe lack of safe space and adequate ventilation, water shortages and power outages and a lack of sufficient supply of food, medicines, clothing and bedding (Mhlanga-Gunda et al. 2020b; Mukwenha et al. 2021; USSD 2020b; Zimbabwe Human Rights Forum 2018). Dependence on family and NGO/faith based organizations to bring clean water, food and medicines to prisons in Zimbabwe is well documented (Prison Insider 2020). The (only) ACoHPR Special Rapporteur report on prisons in Zimbabwe reported in 1997 on poor conditions and significant overcrowding at the time (ACoHPR, 1997).

The interplay of COVID-19 mitigation measures and environment determinants of health in South Africa, Malawi and Zimbabwean prisons

The three prison systems operated at varying degrees of government resourcing of the COVID-19 response, prison capacity and congestion, and ability to adhere to the UN minimum standards of care during state disaster measures. Promulgation of COVID-19 strategic action plans were comprehensive and aligned to international and African guidance. Few severe COVID-19 outbreaks were reported. This may have been due to lack of testing, reporting or other factors (asymptomatic infection, acquired immunity).

Despite best efforts, the operationalization and coverage of COVID-19 action plans in prisons were compromised by lack of government prioritization of prison health in domestic health budgeting and reliance on prison systems largely funded by the Ministries of Justice to support their own prison health response, insufficient resourcing and extensive mismanagement of COVID-19 funds in the three countries. This led in many instances to systemic deficits in basic standards of care of prisoners during COVID-19, poor coverage of disease mitigation measures, inability to provide sufficient PPE, testing and medical isolation capacity, and ad hoc reactive approaches to (potential) COVID-19 clusters (Jumbe et al. 2022; Kateta 2021; Mhlanga-Gunda et al. 2022; Van Hout and Wessels 2021a). The legacies of post-colonial criminal justice systems and dated infrastructures in South Africa, Malawi and Zimbabwe were aggravated by COVID-19 disaster measures. Environmental determinants of health crucial to the mitigation of disease within prisons were compromised to varying degrees in each country during state disaster measures, particularly as they related to hygiene, sanitation, access to fresh air, nutrition provisions for prisoners and sufficient safe space.

Prison congestion and decongestion measures

The continued flow of human traffic into and out of prisons in South Africa, Malawi and Zimbabwe exacerbated all efforts to mitigate disease via disinfection, sanitation and PPE measures. Arrests and detention for breaches of COVID-19 restrictions, continued committals despite state prison release schemes, the mixing of pre-trial and sentenced prisoners,

lengthy pre-trial and pre-deportation detention periods was documented in all three countries (Van Hout and Wessels 2021a; Van Hout et al. 2022a; Van Hout et al. 2022b). Standards of environmental health in so doing were compromised despite the best efforts of prison officials and prison medical staff. Of crucial importance in all three countries was how prison congestion (particularly during mealtimes and at night during cell lockdowns) exacerbated attempts by officials to achieve basic standards of disinfection and disease control (for example air flow, ablution, sanitization, PPE). Screening and systems to medically isolate new committals were insufficiently implemented due to haphazard screening, delays in COVID-19 test reporting and the lack of accommodation capacity to ensure medical quarantine of new committals, and those who were sick (Jumbe et al. 2022; Mhlanga-Gunda et al. 2022; Van Hout and Wessels 2021a).

In South Africa a letter in April 2020 by the Inspecting Judge of Correctional Services with civil society urged government to consider and implement the early release of ill and elderly individuals (Cameron 2020b). The early release scheme to cover nearly 19,000 individuals (12 per cent of the prison population) was authorized in early May 2020, and included individuals convicted of minor offences, deemed low risk and those within five years of release (but excluding those convicted of violent crimes, gender based violence, child abuse, sexual offences, and murder) (JICS 2020). It was however countered by continued committals with over 230,000 new arrests during COVID-19 restrictions, and the use of South African prison facilities as pre-deportation centres (incurring lengthy arbitrary immigration detention) during border closures (Gasa 2020; Geer and Guara 2020). Hazardous levels of prison congestion were documented in June 2020, with the Minister of Justice and Correctional Services stating: 'We are confronted with a glaring impossibility of maintaining social distancing in our centres due to overcrowding'. Letters from prisoners resulted in a prison inspection at the Sun City prison, where inspectors documented deplorable environmental health conditions fuelled by severe overcrowding in cells with prisoners sleeping on floors (Prison Insider 2020). The Judiciary Inspectorate of Correctional Services (JICS) Ministers Briefing in June documented that 35.5 per cent of the total prison population was awaiting trial (JICS 2020). A series of High Court challenges referred to prison release requests of the chronically ill and those fearful of contracting COVID-19 (Ground Up 2020; Venter 2020). Despite the South African government adding 2,650 additional beds to the DCS, and the release of 7,000 prisoners, by the end of July almost 30,000 prisoners still did not have a bed space (Felix 2020). The promise of 19,000 prison releases was not achieved and there was little transparency on exactly who was released at the time (Dube 2020; Van Hout and Wessels 2021a).

Zimbabwe also proposed to enact a series of prison decongestion schemes (Marawanyika 2021; Moyo and Goldbaum 2021) with the General Notice 688 of 2020 providing detail on the qualifying categories of prisoners (Zimbabwean Government Gazette Extraordinary 2020). These generally excluded those convicted of serious or violent crime (murder, treason, rape or any sexual offence, carjacking, robbery, stock theft and public violence) (World Prison Brief: Zimbabwe 2022). Prison decongestion schemes implemented under President Mnangagwa's COVID-19 amnesty reduced the prison population from March to June 2020 by 4,208 prisoners (Mavhinga 2020). Similar to South Africa and Malawi, there was no transparency as to who was released (USSD 2020b). Provisions regarding pre-trial detention and the right to a trial within a reasonable time or unconditional release were further overlooked during COVID-19 as the state disaster measure was regarded as a vis major (USSD 2020b).

In Malawi, in March 2020 the Irish Rule of Law International (IRLI) and Reprieve released a press statement which underscored the grave situation of prisoners, especially the elderly and those with chronic ill health, and urged government to uphold the emergency COVID-19 decongestion measures (IRLI 2020). In April 2020, sentencing adjustments via the Chilungamo Programme resulted in the release of 1,397 prisoners with 499 receiving a

presidential pardon (Chilundu 2020; Masina 2020a; 2020b). Prisons however continued to be severely overcrowded (CHREAA, SALC, IRLI 2021; USSD 2020a). As with South Africa and Zimbabwe, there was little transparency in terms of who was released, and from what prisons: for example prisoners in Zomba prison were omitted from the release scheme in May 2020 despite this large prison operating at severe overcapacity (Chilora 2020). While large numbers qualified for release (for example six months deducted from those serving minor offences, the elderly and women with children), there was a lack of formal communication and transparency around the criteria employed by the Pardon Committee. Severe overcrowding and cell capacity issues continued across the Malawi prison system, particularly in the large prisons (for example Zomba, Chichiri, Maula) due to continued intake of remand detainees and with reports of prisoners sleeping in kneeling positions or side by side on the ground (CHREAA, SALC, IRLI 2021; Gauld 2021; IRLI 2020; USSD 2020a).

Prison insecurity and contact with the outside world

Prison instability and insecurity of prisoners and staff was observed in all three countries during state disaster measures. Isolation measures were compromised by accommodation capacity issues in all countries, despite efforts to enact isolation wings and quarantine sections. COVID-19 restrictions had a heavy impact on the prison environment and prisoner ability to access outside health information, and forms of legal and family assistance.

South Africa experienced significant prison unrest (riots, arson, violence, hunger strikes, striking of staff) due to cramped conditions, excessive use of cell confinement (in many instances 24 hours without access to outside air) and inadequate disease protection measures in many facilities (Kgosi Mampuru, Sun City, Lusikisiki, Leeuwkop, Pietermaritzburg, Baviaanspoort, St Albans Westville, Qalakabusha and Worcester prisons) (Khoza 2020a; Naik 2020; Van Hout and Wessels 2021a). Prisoner contact with the outside world was disrupted due to inoperable prison telephones with no alternative methods of communication provided by the DCS (Khoza 2020b). Monitoring inspections were also prohibited (Muntingh 2020). There were reports of official application of solitary confinement as a medical quarantine measure, often in cells without heating or windows (Van Hout and Wessels 2021a).

Prison insecurity was also observed in Zimbabwe, where recently released prisoners including political activists and journalists who had experienced malicious criminal prosecutions, described a range of human rights violations (arbitrary solitary confinement, denial of the right to a fair trial, access to justice and adequate standards of detention) (Chingano 2020; USSD 2020b; Van Hout et al. 2022a; 2022b). Deliberate exposure to COVID-19 disease by denial of segregation of those with symptoms was also reported in the case of political activists and journalists (Chinowaita 2020; USSD 2020b). The denial of access to legal representation during prison visitation restrictions and the lack of facilitation of contact using technology was reported (Lawyers for Lawyers 2020; Zimbabwe Peace Project 2021). The complete denial of outside contact additionally prevented prisoners from accessing public information (including COVID-19 public health guidance) and much needed family support (including provision of masks, food, clean water, medicines) (for example as reported in Chikurubi prison) (Mhlanga-Gunda et al. 2022). Despite permissions for the Zimbabwe Human Rights Commission (ZHRC) to conduct monitoring visits to its 46 prisons when conditions allowed, it is unclear as to whether such inspections occurred during state disaster measures (USSD 2020b).

In Malawi COVID-19 restriction measures in prisons centred on visitation restrictions, segregation of COVID-19 positive prisoners in isolation centres, and suspension of out of prison formations to work (Masina 2020a). For example four isolation centres for pre-trial detainees were created at Zomba, Maula, Mzimba and Thyolo prisons, three of which used their female sections (Zomba, Maula, Mzimba) (Southern African Litigation Centre 2020). The closure of the Maula prison female wing in July 2020 in order to open a COVID-19

isolation centre resulted in the large scale transfer of 71 women with infants, including remand detainees to rural prisons far away from family and legal support (Pensulo 2020; Southern African Litigation Centre 2020; Van Hout 2020c). Visitation restrictions were documented as severely disadvantaging prisoners who are dependent on family and civil society supports of food, soap and clothing (Guta 2021; Jumbe et al. 2022; Van Hout 2020c).

WASH and exposure to communicable disease

In all three countries, COVID-19 disaster measures worsened systemic deficits in the standards of care, and environmental conditions of detention were reported to be grossly inadequate. There were reports of regular failures of ablution facilities incurring faeces and other bio hazard contamination, lack of heating, ventilation and access to fresh air, lack of sufficient supplies of clean water for drinking, cooking and cleaning purposes, power outages and inadequate disinfection capability (lack of soap, disinfectant, detergents) in many South African, Malawian and Zimbabwean prisons (Jumbe et al. 2022; Mhlanga-Gunda et al. 2022; Van Hout and Wessels 2021a). In all three countries, UN agencies and civil society attempted to backfill the insufficient prison system response by providing PPE (especially masks), disinfection products, hand sanitizer, masks and cleaning detergents (Chikoti 2020; DCS 2020b; Muntingh 2020).

The ability of prisoners and staff to physically distance and protect themselves from COVID-19 were reported to be impossible in all three countries. Prisoners in Zimbabwe and Malawi were reported to be lying side by side in communal cells sleeping 10–30cm apart, often described as arranged like sardines or held in kneeling positions (CHREAA, SALC, IRLI 2021; Mhlanga-Gunda et al. 2022; USSD 2020a; 2020b). Malawi and Zimbabwe reported on the lack of adequate nutrition, medicines and other vital needs fuelling chronic ill health within their prison systems, which included the stealing of food by staff from prisoners (CHREAA, SALC, IRLI 2021; Jumbe et al. 2022; Mhlanga-Gunda et al. 2022). There was a grave lack of adequate nutrition documented in Malawi (UN 2020). In 2021 a report documented fatalities caused directly by severe malnutrition during COVID-19 (CHREAA, SALC, IRLI 2021).

While prisoners were most at risk of COVID-19, staff were equally exposed. Their occupational health situation was threatened by the poor infrastructure, the existing co-morbidities (TB, HIV, hepatitis C), malnutrition and poor health of many prisoners, and the lack of adequate COVID-19 mitigation measures in facilities where they worked. In all countries to varying degrees prison staff reported on the failures of the prison system itself to protect them from disease (including fatalities), despite worker strike actions demanding PPE and hazard pay (Marupeng 2020; Mhlanga-Gunda et al. 2022; Muheya 2020; Masina 2020c; Van Hout and Wessels 2021a). Breaches in COVID-19 guidelines and restrictions were reported in South Africa, where prison staff were recalled to work while isolating (New Frame 2020). South African prison staff were also not included in the government Directive on Compensation for Workplace-Acquired COVID-19 (Department of Employment and Labour 2020a) or the Consolidated Directive on Occupational Health and Safety Measures in Certain Workplaces (Department of Employment and Labour 2020b).

The realities of environmental standards of detention beyond Covid-19 State disaster measures

The UN High Commissioner for Human Rights, Michelle Bachelet has stated that 'Measures taken amid a health crisis should not undermine the fundamental rights of detained people, including their rights to adequate food and water. Safeguards against ill-treatment of people in custody, including access to a lawyer and to doctors, should also be fully respected'. The UN agencies joint statement on COVID-19 in prisons and other closed

settings acknowledges the disruptive effect of COVID-19 restrictions on prisoners, and states that 'restrictions that may be imposed must be necessary, evidence-informed, proportionate (i.e. the least restrictive option) and non-arbitrary' (UNODC, WHO, UNAIDS, OHCHR 2020). Equally important is that failure of the state to protect the health of prisoners can constitute inhumane treatment, discrimination and can incur fatalities, and is prohibited regardless of state disaster measures (Porchet 2021). Consideration of the state obligation to take the requisite steps regarding prevention, treatment and control of disease in prisons using a right to health and an environmental health approach is key. The right to reasonable accommodation and right to an environment free from torture and inhumane treatment warranted close examination for potential violations during COVID-19. Tackling environmental health deficits in prison systems forms a crucial component of any disease mitigation response. The Mandela Rules 13, 15, 16 and 21 provide sufficient detail regarding the minimum standards for environmental health with sanitary facilities consistent with the prison environment, its geography and climate, cubic content of air, minimum floor space, lighting, heating and ventilation. Hence, this generated legal realist account illustrates the unprecedented challenges navigated by the criminal justice and penal systems in South Africa, Malawi and Zimbabwe during the COVID-19 pandemic. COVID-19 has not only amplified the existing deficits to varying degrees in each respective criminal justice system, but it has highlighted the future imperatives to address the inadequate infrastructure of prisons in South Africa, Malawi and Zimbabwe.

There are a series of observed commonalities pertaining to the lack of government prioritization of prisons in the domestic health budgeting during COVID-19, the inadequate resourcing of prison systems and sub-standard levels of environmental determinants of health across prison systems in South Africa, Zimbabwe and Malawi during COVID-19 prison operations. The general lack of financial and human resourcing both historically and during state disaster measures affected the ability and capacity of the prison system to adhere to the normative standards of detention, prison official obligation to mitigate disease and the non-derogated rights of prisoners to equivalence of care (including testing, quarantine, medical supplies, and treatment) (as per the Mandela Rules 24(1), 25, 30, 31, UN Principles of Medical Ethics, WHO and WMA declarations). Operational challenges pertinent to ensuring adequate environmental health conditions were evident. They included old and dilapidated infrastructure (particularly in Malawi and Zimbabwe); high prison population density and throughput (particularly high in Malawi); inadequate cell capacity to support isolation measures (Malawi, South Africa, Zimbabwe), insufficient supplies of PPE for prisoners and staff (Malawi, South Africa, Zimbabwe); and varying degrees of fragile or non-functional WASH aspects in all respective countries (for example electricity loadshedding and drought conditions in Zimbabwe and South Africa affecting access to clean water). Prisons in Malawi continued to suffer inadequate nutrition provisions to prisoners. Occupational health rights of staff, including healthcare staff were neglected (particularly in Zimbabwe and South Africa) and ill-considered the risks posed to them in working in unsafe congested working conditions, and the routes to transmission into and out of the prison (see Mandela Rules 25(2), 35(1)). Of note is that prison staff were not included in COVID-19 occupational compensation schemes and staff breaches of COVID-19 regulations were documented in South Africa (Van Hout and Wessels 2021a).

Congestion is a central factor which underpins the potential for human rights violations in these prisons during COVID-19. Mixing of pre-trial detainees and those sentenced constitutes a grave risk for disease transmission and has a severe impact on environmental health conditions inside prisons. The realist assessment further supports prior literature which underscores the high (and unacceptable) pre-trial detention rates in South Africa, Malawi and Zimbabwe which were high prior to COVID-19. Despite apparent decongestion schemes, continued prison throughput and overcrowding was exacerbated by border closures (particularly South Africa), detention of political activists (Zimbabwe) and

disrupted judicial operations in all three countries (ACCORD 2020; World Prison Brief Africa 2022). Pre-trial detention may only be permissible if undertaken in accordance with procedures established by law in a place of detention that has been authorized (Robben Island Guidelines, para 23) and may not be arbitrary (UDHR, Article 9; ICCPR, Article 9(1), ACHPR Article 6). These provisions were generally overlooked in all three countries during COVID-19. Physical distancing as part of the public health guidance was therefore impossible. Due to the severe congestion, many prisons in South Africa, and especially in Zimbabwe and Malawi did not provide the bare minimum floor space set by the CAT at four square meters per person in a communal cell, which could be declared by courts as cruel or degrading (Steinberg 2005). Reports of prisoners sleeping 10–30cm apart in Malawi and Zimbabwe, 23- and 24-hour cell lockdowns (including with sick prisoners) and solitary confinement practices (particularly South Africa) was documented in all three countries (Van Hout and Wessels 2021a; Van Hout et al. 2022a: 2022b). Little information was released around efficacy of prison release schemes.

The negative impact of prison restrictions on access to family support (food, medicines, clean water) and legal assistance (incurring lengthy detention periods without aid) was documented in all three countries. Visitation restrictions and denial of contact with the outside world (not limited to those in solitary confinement and medical quarantine), where prisoner rights to access legal representation and family support for basic provisions are restricted is contra the Mandela Rules 61(1)(3)). This was particularly the case where contact via technological means (Mandela Rule 58(1a)) was not facilitated by the prison officials in South Africa, Malawi and Zimbabwe. In Malawi, the rights of women were not upheld, where the transfer of women (with children) out of Maula prison to remote rural prisons violated their right to access legal representation and resulted in complete lack of access to their family supports (Pensulo 2020; Van Hout 2020c). This contravenes the Bangkok Rules 4 and 28. It is concerning to see that prison visitation restrictions suspended access to prisons by lawyers and independent monitoring bodies (particularly in South Africa, including under the CAT) (Muntingh 2020). Although visits from the UN SPT may temporarily be denied by local authorities under exceptional circumstances, authorities are not permitted to refuse or restrict visits by national preventive mechanisms who retain full discretion in organizing monitoring visits (Porchet 2021). In Zimbabwe it was unclear as to whether visits by the ZHRC were even facilitated. Malawi in contrast continued to facilitate and publish prison inspectorate reports from 2020 and 2021 (Malawi Inspectorate of Prisons 2021).

In short, a broad range of comparable and potential rights violations spanning human, health and occupational rights were observed in South Africa, Malawi and Zimbabwe during COVID-19 state disaster measures (against the Mandela Rules 13 to 18, 21, 22(1) (2), 23(1), 24(1), 25, 30, 31, 35 and 42, WHO and WMA declarations). It remains to be seen if effective complaints mechanisms are in place in each country, if prison monitoring systems and national preventive mechanisms under OP-CAT (in the case of South Africa) are operating sufficiently or indeed if closer examinations by the respective Human Rights Commissions (SAHRC, ZHRC, MHRC) are facilitated. Complaints and strategic public litigation either by individuals or by the civil society organizations which represent their interests are crucial to leverage for future legislative and prison reforms and lobby for greater resourcing of infrastructure and operations. This amongst constructive dialogue, public reporting and other advocacy efforts will constitute a first step toward tackling harmful systemic practices and the environmental injustices largely experienced by prisoners, and additionally affecting the working conditions of staff. There are already intense advocacy efforts by human rights organizations for prisoner health and broad based torture prevention initiatives encompassing right to health and adequate accommodation (Jefferson and Jalloh 2019).

Regarding the insufficient supply of COVID-19 disease control measures and the impact on environmental standards in prisons, states could be held liable for their failure to provide adequate provisions to protect against disease. Other routes to justice centre on the

crux of the prison environment in preventing or indeed fuelling the spread of disease, and span the rights of prisoners to sufficient cubic content of air and floor space, sufficient water for ablution/sanitation/hygiene/disinfection purposes, access to clean and regular supply of water for drinking and cooking, adequate nutrition to maintain health, access to PPE and medical care, and access to their family, and legal representation. Many prisons in South Africa, Malawi and Zimbabwe potentially breach the country constitutional law regarding the right to adequate accommodation, personal hygiene and appropriate medical treatment as justiciable fundamental rights and freedoms for those deprived of their liberty right to life and the prohibition of torture, cruel, inhuman or degrading treatment (for example Sections 29 (1)(2)(3) and 35(2)(e) of South African Constitution; Sections 50 (5) (d), 76 and 85 of the Zimbabwe Constitution and Sections 12(1)(d)(e), 19, 42(2)(1)(b), 45(1) and 169 of the Malawian Constitution).There are potential questions regarding prison system implementation of humane and ethically sound medical isolation (as opposed to arbitrary solitary confinement) (Cloud et al. 2020). South Africa in particular has a fairly developed base of jurisprudence regarding prisoner right to health, protection from exposure to disease (HIV, TB) and requirements around the independence of the prison inspectorate (see all cases listed in Table 2, Van Hout and Wessels 2021a). In Malawi, even though the least developed country, the Constitutional Court's ruling in the ground-breaking case of *Gable Masangano v. Attorney General* documented the deplorable and congested prison conditions, found that conditions were conducive to disease and constituted degrading treatment, and dismissed the state position that prisoners' right to adequate nutrition and health were non-justiciable and that 'the judicial process is not equipped to deal' with questions of resource allocation of the state (see Table 3, Chilemba 2016). Zimbabwe has several cases which refer to the use of solitary confinement and denial of basic provisions (see Table 4), including the *Kanengoni v Minister of Justice* case which refers to the duty of the state to provide prisoners access to proper medical care to prevent unwarranted deaths.

With regard to international human rights law, one could surmise that the three countries (to varying degrees of severity) are not meeting their obligations under the ICSECR. Meaningful realization of the right to health within the parameters of reasonable accommodation of prisoners needs to be promoted and implemented through the ICESCR, and the combined efforts and actions of the criminal justice system, humanitarian organizations and civil society (Gauld 2021). South Africa has ratified the most treaties (ICCPR, CCPR-OP2, ICESCR, CAT, OP-CAT, CEDAW, CRC) and hence offers the broadest avenues by accepting individual complaints (CCPR-OP under Articles 2, 10 and 26, for example, regarding rights of prisoners to humane treatment, non-discriminatory protection of the law and equality before the law of a state and the right to an effective remedy for violations); CEDAW-OP, CAT Article 22) and inquiry procedures (under CAT Article 20, CEDAW OP Article 8–9). Of note regarding the rights of children in detention during COVID-19, South Africa does not accept individual complaints or inquiry mechanisms under the CRC-OP Article 13. Malawi has ratified ICESCR, ICCPR, CAT, CEDAW and CRC, but not the OP-CAT, and accepts both individual complaints procedures under the CCPR-OPT and CEDAW-OP, and inquiry procedures for CAT under Article 20. It does not accept individual complaints procedures under the ISCESCR-OP the Optional Protocol to the ICESCR or under the CAT, Article 22. Zimbabwe offers the least protections and recourse; while ratifying the ICCPR, ICESCR, CEDAW and CRC, it has not ratified the CAT or the OP-CAT, and does not accept individual complaints procedures or inquiry procedures under these treaties.

Ways forward post COVID-19: lessons learnt and recommendations for prison reform

The UN Assistant Secretary-General for Human Rights has stated that COVID-19 demonstrates the 'urgent need for institutional reforms and societal transformation where human

rights must be front and centre' (Brandze Kehris 2020). This assessment challenges the boundaries of reasonable interpretation (Amorim 2020) in state application on restrictions in prisons during COVID-19 disaster measures and illustrates the importance of evaluating the extent to which human rights values are guiding social action and practice in South Africa, Malawi and Zimbabwe. It is intended to contribute to growing the COVID-19 spotlight on human rights violations, harmful systemic practices and deplorable conditions in many prisons located in Africa, and support commitment and efforts to reform and improve conditions for those deprived of their liberty.

The social exclusion and marginalization of prisoners in Africa still continues to create difficulties in the translation of their fundamental rights into human rights based public and social policies, and exacerbates the lack of public and political interest in the right to health of prisoners (Le Marcis 2020). An anthropological understanding of human rights (Messer 1993; Wilson 2007; Martínez and Buerger 2019) pertinent to respective African countries within the broader analysis of power, politics and social inequality is therefore crucial to better understand and respond to each country's unique and distinctive prison systems, challenges and prison dynamics. Factors to consider are the overall continued neglect of health in many African prisons (including in the selected countries) due to prioritization of security and punishment, the pursuit of rights of people deprived of their liberty through legal channels, local actors (for example civil society organizations) appeals for international involvement, opportunity for greater adopting of human rights concepts into local vernaculars/prison system operations and the likelihood of evidence having a probative value.

The pandemic has highlighted the requirement to encourage the updating of Public Health and Prison Acts (particularly in Malawi) where necessary to move beyond the colonial focus on security and punishment and achieve a greater incorporation of the human rights of those deprived of their liberty and cognisant of modern (zoonotic) diseases in future public health emergencies. The lack of sufficient consideration of prison health in domestic health budgeting is evidence of the continued neglect of health in African prisons, generally due to the responsibility of prison health operations falling under the remit of the Ministry of Justice, and not Health. In essence the point is that government resourcing of the COVID-19 response in each selected country was ad hoc and reactive, and centralized on the medical approach, and was compromised/hindered in its effectiveness by the existing (poor) infrastructure, sub-standard environmental health conditions and weak operation of criminal justice systems. It is however encouraging to see that vaccination roll out with prisoners and prison staff identified as priority groups has commenced in these three selected countries, and is indicative of the growing appreciation of the continuum of public and prison health (Department of Justice and Correctional Development 2021; Mupopery 2021; Reliefweb 2021).

Addressing overcrowding is crucial. South Africa, Malawi and Zimbabwe continued to operate with unacceptable pre-trial detention rates and over capacity during COVID-19. The recognition of the international standards for minimum floor space are key. Prison congestion rates in the three countries can be better addressed via enhanced criminal justice functioning inclusive of a review of bail operations, minimum sentences and non-custodial measures, pardoning/decriminalization of poverty related offences, adherence to set pre-trial custody limits, and placement of people with mental health conditions in suitable facilities. Camp courts (such as those operated by CHREAA and IRLI in Malawi) and open prisons (as in Zimbabwe) offer an innovative route to relief capacity issues (Rupapa 2021).

In conclusion, taken together in each country and for the continent as a whole the COVID-19 experience can be leveraged to support prison and justice system improvements, structural improvements and capacity building across the sector to ensure that the right to health of people deprived of their liberty and the occupational health standards for staff are upheld. Civil society lobbying, independent and Human Rights Commission inspections,

national preventive mechanisms under OP-CAT and litigation by civil society or individuals of course are all options. Oversight mechanisms are crucial and the support of the establishment of national preventive mechanisms in countries where it does not yet exist is to be prioritized. Critical steps in ensuring prison system accountability, effective response and fundamental rights protections centre on transparency of disease surveillance and reporting, the accuracy of reported data, and ensuring visibility of the health of people living in prisons (Knight et al. 2022). Environmental health inspections and the routine monitoring of disease along with the detection, treatment and continuum of care of prisoners and released individuals within the parameters of public and prison health surveillance is an imperative. Addressing the environmental determinants of health in prisons within such a holistic approach will directly improve prison conditions and the health of the prison community, respect their human, health and occupational rights, and form a crucial component of any future pandemic response. Access of academic research teams into prisons is also to be encouraged in order to encourage prisoner and prison staff consultations and allow the voice of prison communities to be heard (Mhlanga-Gunda et al. 2020a).

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Conflict of interest

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