Title "*Ubuntu" I am because we are*: COVID-19 and the legal framework for addressing communicable disease in the South African prison system.

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Abstract

Purpose: Severely congested and ill resourced prison systems in Africa face unprecedented challenges amplified by COVID-19. South Africa has recorded the highest COVID-19 positivity rate in Africa and on March 15th 2020 declared a national state of disaster. The first prison system case was notified on April 6th 2020.

Design/methodology/approach: A legal-realist assessment of the South African prison system response to COVID-19 in the 12 months following initial case notification focused on the minimum State obligations to comply with human rights norms, and the extent to which human, health and occupational health rights of prisoners and staff were upheld during disaster measures.

Findings: A legal-realist account was developed, which revealed the indeterminate nature of application of South African COVID-19 government directives, ill resourced COVID-19 mitigation measures, alarming occupational health and prison conditions and inadequate standards of health care in prisons when evaluated against the rule of law during State declaration of disaster.

Originality: This legal-realist assessment is original by virtue of its unique evaluation of the South African prison system approach to tackling COVID-19. It acknowledged State efforts, policy making processes and outcomes, and how these operated within the prison system itself. By moving beyond the deleterious impacts of the COVID-19 pandemic on the already precarious South African prison system, we argue for rights assurance for those who live and work in its prisons, improved infrastructure and greater substantive equality of all deprived of their liberty in South Africa.

Keywords

COVID-19, Mandela Rules, South Africa, human rights, prisoners, infectious disease.

COVID-19 and tackling communicable disease in African Prisons

On March 11th 2020, the World Health Organization (WHO) announced that the outbreak of the Coronavirus disease 2019 (COVID-19), a respiratory illness caused by the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) was a pandemic (WHO, 2020a). Global criminal justice and prison systems faced unprecedented challenges amplified by COVID-19 (UNODC, 2020a; WHO, 2020b). Prisons are high risk environments for communicable disease outbreaks, including COVID-19; with prisoners vulnerable to severe COVID disease due to existing underlying chronic ill-health and with potential for rapid transmission due to high population density and turnover (Beaudry *et al.*, 2020). On March 25th 2020, the United Nations (UN) High Commissioner for Human Rights called on States to instigate prison decongestion measures as a critical component of the COVID-19 response (OHCHR, 2020; UNODC *et al*, 2020; Amon, 2020).Temporary release schemes were implemented in many countries (Simpson and Butler, 2020; Lines *et al*, 2020).

The first COVID-19 case in Africa was reported in Egypt, followed by Algeria spreading to 23 southern and east African countries (except Lesotho) in the period March 5th 2020 to 15th April 2020 (Muntingh, 2020). States varied as to whether they declared a state of disaster or emergency, or anything at all (Muntingh, 2020). Prisons in Africa were especially vulnerable to the spread of air-borne disease during this time, due to a general lack of resourcing in the State COVID-19 response, and with existing poor infrastructure, congestion and inadequate standards of sanitation making it impossible to implement adequate COVID-19 disease mitigation measures (Nkengasong and Mankoula, 2020; Muntingh, 2020; Van Hout, 2020a; Van Hout, 2020b; Nweze *et al.*, 2020; World Prison Brief, 2020). Approximately one million people are incarcerated in African prisons, with on average 42% held in pre-trial detention, with prison systems operating over capacity (highest in Uganda at 318%) (World Prison Brief, 2020). Conditions are conducive to disease with staff and prisoners exposed to similar biohazards by sharing cramped conditions, air, water and ablution facilities (Muntingh, 2020; Telisinghe *et al.*, 2020; Van Hout and Mhlanga-Gunda, 2018; Van Hout; 2020a, Van Hout 2020b; Van Hout *et al.*, 2021; World Prison Brief, 2020).

The COVID-19 threat was not restricted to those deprived of their liberty but extended to prison staff and their families, official staff (health, legal, services) and families visiting prisons (Van Hout, 2020c; Van Hout, 2020d). By May 26th 2020, prisons in Algeria, Sierra Leone, Cameroon, Ghana, Democratic Republic of Congo, Guinea, Egypt, Morocco, Kenya, and South Africa confirmed cases of COVID-19 (Prison Insider, 2020). Protests and riots by both prisoners and prison staff occurred in many African states in response to inadequate COVID-19 screening practices at intake, limited access to clean water, insufficient supplies of personal protective equipment (PPE) and COVID-19 testing kits, inadequate facility disinfection practices and continued committals aggravating existing high pre-trial detention rates and fuelling disease transmission (Prison Insider, 2020). In March and April 2020, the African Commission on Human and Peoples' Rights (ACHPR) issued several declarations outlining effective human rights-based responses to COVID-19 in prisons, which urged all African States to

operationalise decongestion and health and security measures to mitigate disease (ACHPR, 2020a; ACHPR, 2020b). To date, very few African States have provided detail on such release schemes or transparent prison monitoring data on COVID-19 infection rates (Muntingh, 2020; Nweze et al., 2020). Prison health surveillance and prison health research in Africa is also under-developed (Mhlanga-Gunda et al, 2020), compounding COVID-19 response efforts.

We focus here on the South African prison system response to COVID-19. To date, the South African National Institute for Communicable Diseases has recorded that the country has the highest COVID-19 positivity rate in Africa, with a cumulative rate of COVID-19 positivity of over 2.7 million (NICD, 2021). On March 15th 2020, it declared a national state of disaster. The first Department of Correctional Services (DCS) prison system notification of COVID-19 was on April 6th 2020, with over 15,173 prison system cases recorded at the time of writing (August 5th 2021) (DCS, 2021).

The legal realist approach

A legal-realist assessment (Leiter, 2015) was conducted of the South African prison system response to COVID-19 in the 12 months following initial case notification, focusing on the minimum State obligations to comply with human rights norms and the extent to which human, health and occupational health rights of prisoners and staff were upheld. Legal realism as naturalistic theory was deemed most applicable due to its emphasis on the law as derived from real world observations regarding social interests, welfare and public policies (Leiter, 2015). Provisions mandating good practice in prison management and humane treatment of those detained, as indicated by a range of international and regional non-binding instruments relevant to prisons were considered, along with the 2020 non-binding UNODC, WHO and Penal Reform International (PRI) technical guidance documents (WHO, 2020b; WHO, 2020c; UNODC, 2020a; PRI, 2020) promulgated during the COVID epidemic. This approach was cognisant of the ultimate importance of ensuring the correct balance between protective measures during contagion and the risk of inhumane or degrading treatment of those in prison.

Firstly, the various international and African protections and rights assurance mechanisms respecting the right to health of those deprived of their liberty were scrutinised (not limited to prohibition of torture and discrimination but also including those relevant to the mitigation of disease in prisons, environmental conditions of detention and right of access to healthcare, including during emergency). Secondly, we present context with regard to the South African prison system and relevant jurisprudence on the rights of prisoners. Subsequently, extant data from academic and publicly available data bases, global human rights and penal resources, government and non-government websites and investigative reporting were examined to assess the transparency and implementation of gazetted South African government directives, COVID-19 prison lockdown and mitigation measures, standards of care including access to healthcare, occupational health conditions, independent oversight and monitoring of standards, and prisoner access to justice and the outside world.

The developed legal realist account considered whether the South African prison system had a culture of respect for the rule of law regarding human rights assurance for those living and working in its prisons during the COVID-19 health emergency, by evaluating the indeterminate nature of application of COVID-19 government directives, prison restrictions and disease mitigation measures, occupational and environmental health conditions and standards of health care (including disease preventative measures) during the declared state of disaster.

Human Rights, Right to Health and Management of Disease in Prisons

Tackling disease in prisons is a public health and human rights imperative, given the bridge of transmission between prison and community via the flow of court appearances, prisoners and remand detainees, staff and visitors (Van Hout 2020a; Van Hout 2020b). There is no shortage of guidance, binding and non-binding, concerning the rights of prisoners and in particular their right to health and the obligations of states to promote and protect this right. These instruments are also supported by various special procedures and mechanisms. It is also the case that most domestic constitutions also enumerate specific health related rights along with, at minimum, general protections against torture, inhumane and other ill treatment. The latter is also supported by a range of fair trial rights.

States have positive obligations under the international treaties which 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)) (UN, 1966) and the UN Committee on Economic, Social and Cultural Rights (CESCR) *General Comment No*. 14 to uphold the right to health and to protect those living and working in prisons from contagion. *Article* 12 (2) of the ICESR specifically obliges States Parties to take steps necessary regarding disease prevention, treatment and control and assurance of access and provision of all required medical support and care during illness. Additionally, whilst the International Covenant on Civil and Political Rights (ICCPR) (UN, 1966) does not expressly provide for a right to health, it specifically provides the right to humane treatment of prisoners (*Articles* 2,6,7, 10 and 26) (OHCHR, 2012). The Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT) (UN, 1984) creates further binding obligations on States not to ill-treat those deprived of their liberty. It recognises *"an inadequate level of health care can lead rapidly to situations falling within the scope of the term 'inhuman and degrading treatment"* (Council of Europe, 2015). This is especially foreseen in the wake of communicable disease outbreaks such as COVID-19 in prisons.

In addition, there are non-binding UN norms and minimum standards for the treatment of prisoners and medical declarations particular to the rights of prisoners regarding their health and medical ethics in detention settings (UN, 1982; UN, 1988; UN, 1991; Lines, 2008). The Standard Minimum Rules for the Treatment of Prisoners (*"Mandela Rules"*) (UN, 2016) draw attention to the State duty to provide prisoners with access to necessary health-care services in terms of free non-discriminatory care, and access to medical assessment, care and treatment (including continuity of

disease prevention, quarantine and care for communicable diseases) (*Rules 24*, 25, 30, 31, 35). Environmental determinants of health in prison crucial to disease mitigation are provided for in *Rule* 13 which 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"* (UN, 2016). The WHO (WHO, 2003) and World Medical Association (WMA) (WMA, 2011) declarations further mandate the rights of prisoners to humane treatment and appropriate medical care, including against disease. Particularly pertinent to the COVID-19 pandemic, is that the UN Principles of Medical Ethics relevant to prisons (*Principles* 1, 6) contain a non-derogation clause during State declaration of emergency (UN, 1982).

The UN Human Rights Committee states that it is "*incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection"* (Lines, 2008). It's jurisprudence (including where African States are concerned) indicate that the right to adequate living space sufficient to safeguard health constitutes the pre-conditions of health, with environmental health determinants (water, sanitation, overcrowding) recognised as potentially subjecting prisoners to disease. Concluding observations by the UN Human Rights Committee reflect the binding State obligation to "*take action to safeguard the health of prisoners",* with explicit reference to taking positive steps to prevent spread of communicable disease. Extant UN Human Rights jurisprudence includes reference to State failure to instigate adequate measures in tackling disease in prisons (i.e. airborne precautions in tuberculosis-TB mitigation), placing a prisoner's right to health in serious jeopardy in violation of *Articles* 6, 7, 9 and 10 of the ICCPR and indicative of an overall inhuman or degrading condition whilst detained.

At the regional African level, human and health rights of prisoners are encompassed in the African Charter on Human and Peoples' Rights (OAU, 1981) a legally binding treaty designed to promote and protect human rights in the African continent. Whilst the ACHPR notes that the 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 (*Article* 16), the Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa, continues to report that African prisons navigate enormous challenges in adhering to minimum standards of care (ACHPR, 2012). It has two special mechanisms on prisons (Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa, Committee for the Prevention of Torture in Africa) and has adopted a range of non-binding instruments to support criminal justice and penal reform. These include the *Robben Island Guidelines* (ACHPR, 2008) which are aligned to the *Mandela Rules* (UN, 2016).

The African Court on Human and Peoples' Rights complements the ACHPR, with its jurisprudence referring to conditions of detention spanning the rights of prisoners to adequate living conditions (sanitation, hygiene, ventilation) and access to medical care (Muntingh, 2020). Extant applications regarding right to health of prisoners have generally been engaged under the prohibition of cruel, inhumane or degrading treatment and the right to life, based on deplorable conditions of detention (congestion, lack of adequate food, sanitation and ventilation). See Table 1. There have been several

successful applications by prisoners to the ACHPR, with several States found in violation of the Charter's right to health (*Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine de l'Homme, Les Te´moins de Jehovah v. Zaire* in 1996; *International PEN and Others v. Nigeria* in 1998 and *Malawi African Association and others v. Mauritania* in 2000). Where denial of medical intervention is cited, this is additional to a ruling of inhumane or degrading treatment as constituting physical abuse of prisoners (*Krishna Achuthan (On behalf of Aleke Banda), Amnesty International (On behalf of Orton and Vera Chirwa) v.Malawi* in 1994 and *Constitutional Rights Project and Civil Liberties Organisation v. Nigeria* in 1999). At the African Court on Human and People's rights, several applicants refer to deplorable conditions of detention relating to congestion, lack of adequate food, sanitation and ventilation (Burkina Faso, Tanzania) (*Konaté v Burkina Faso* and *Abubakari v Tanzania* in 2016; *Guehi v Tanzania* in 2018). Two explicitly refer to the rights of prisoners to adequate medical care (medication and appropriate nutrition for chronic ill health) when in detention (*Lohé lssa Konaté v Burkina Faso* in 2013 and *Mugesera v Rwanda* in 2017).

Insert Table 1 African Regional Jurisprudence about here

Despite international and regional treaties, and non-binding normative minimum standards of care, States have discretion in defining humane treatment and adequate medical care of prisoners. (Lines, 2008). Relevant normative disease control and human rights provisions in prisons during the COVID-19 pandemic are detailed in the 2020 WHO, UNODC and PRI non-binding technical guidance documents (WHO, 2020b; WHO, 2020c; UNODC, 2020a; PRI, 2020). Essentially States should take all measures to address the risks posed, by limiting contamination, detecting ill prisoners and staff and providing medical treatment to those infected. Restrictions may only be applied on the grounds of medical necessity and in compliance with key human rights principles of legality, proportionality, oversight, time-limitation, and non-discrimination. States should further guarantee monitoring bodies' access to prisons. Disease mitigation and restriction measures must never result in inhumane or degrading treatment of prisoners (i.e. unreasonable solitary confinement, the right to access legal representation and right to communicate with family) and detention conditions should not contribute to the development, worsening or transmission of disease.

The Context

According to most recent government 2019/2020 figures, South Africa has 238 functioning prisons housing 154,449 detainees, including two super maximum prisons (*C-Max in Gauteng; Ebongweni in KwaZulu-Natal*), and nine female prisons (DCS, 2020a). Whilst the prison population is at its lowest level in decades, South African prisons continue to operate at over-capacity (over 40% in 2019) (DCS, 2019; Cameron, 2020a; DCS, 2020a). There is significant critique of the South African bail system, its mandatory minimum sentencing regime and continued high pre-trial detention (de Ruiter and Hardy,

2018; Cameron, 2020a), with calls for increased use of parole and medical parole to relieve overcrowding (Mujuzi, 2011; Maseko, 2017a).

The last inspection of South African prisons by the ACHPR Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa was in 2004 (ACHPR, 2012). The 2005 White Paper on Corrections in South Africa and other various policies, regulations and statutes containing provisions around minimum standards of care, conditions and disease control measures (HIV, TB) are intended to guide the DCS prison protocols (DCS, 2004; DCS, 2011; South African Department of Health, 2013; DCS, 2014). There are, however, historical gaps in government oversight of its prisons, despite the efforts of the Judiciary Inspectorate of Correctional Services (JICS) to assess housing and standards of care of prisoners (Kleijn *et al.,* 2017). Minimum standards of care relating to space, food, bedding, toilet paper, sanitation and access to healthcare even in recent years are not sufficiently implemented (Gordin and Cloete, 2013; Muntingh, 2016; Maseko, 2017b; Nagisa-Keehn and Nevin, 2018; Cameron, 2020a; Muntingh, 2020). The system reflects dated colonial infrastructure, with sexual violence, gangsterism and environmental conditions conducive to the spread of disease (HIV, TB, COVID-19, leptospirosis) (Dissel, 2016; Nevin and Nagisa-Keehn, 2018).

There are a series of relevant landmark cases regarding health rights of those deprived of their liberty in South African prisons (Nagisa-Keehn and Nevin, 2018). The first case abolished capital punishment due to its conflict with the new constitutional commitment to human rights in 1995 (*S v Makwanyane and Another*). In 1997, in two cases, the court held that prisoners have fundamental rights to adequate accommodation, nutrition and medical care. In addition, the court ruled that the DCS bears a greater duty of care to people living with HIV in prison given their unique health vulnerabilities. It reaffirmed that those living with HIV in prison have a right to medical treatment and ordered the DCS to provide anti-retroviral treatment (ART) to those prescribed treatment (*Van Biljon and Others v Minister of Correctional Services and Others* and *B and Others v. Minister of Correctional Services and Others*). These landmark cases whilst laudable did little to change realities on the ground and were followed by three cases (*Stanfield v Minister of Correctional Services* in 2003; *Du Plooy v. Minister of Correctional Services* in 2004 and *Mazibuko v. Minister of Correctional Services* in 2007) regarding medical parole for terminally ill prisoners (including those living with HIV), where denial of same violated the right to detention conditions consistent with human dignity. This, according to Nagisa-Keehn and Nevin (2018), was *"in total conflict with the person's rights to dignity, health care, and to not be punished in a cruel, inhuman, or degrading manner".* The DCS had to revise restrictive practices regarding the release of terminally ill prisoners amid increased advocacy by civil society organisations for medical parole of prisoners living with HIV where ART remained unavailable to them. Since 2015, a prisoner's ill health (i.e. HIV status) and the impact of prison conditions regarding health risk is recognised at the sentencing stage (see *S v Magida*).

In 2006, in the *EN and Others v Government of RSA and Others* case, the court ruled in favour of prisoners at Westville, going beyond the *B and Others* and the *Van Biljon* cases, and held that all

prisoners living with HIV who qualified for ART according to national policy be treated accordingly (a wider group of people than previously). Again, implementation was challenging and it took three years and two further court orders to secure a scaled up ART programme in the prison. This was followed by the infamous *Lee v Minister of Correctional Services* case in 2012, where a pre-trial detainee contracted TB after almost five years on remand in Pollsmoor prison prior to his acquittal, having entered in good health. The court ruled that the DCS had violated its constitutional obligations to provide humane conditions of detention respecting human dignity and the provision of adequate medical treatment, given that the DCS was aware of TB prevalence and risk in the severely congested facility, and the complete lack of TB screening and disease management in the prison. In 2010, the UN Human Rights Committee ruled that South Africa had violated *Articles* 10 (1), and 7 ICCPR in conjunction with *Article* 2 (3) in a prison case, because prison officials had not investigated a prisoner's ill-treatment and sexual abuse in prison and denied him access to medical care (including HIV testing), legal assistance and his family for one month (*McCallum v. South Africa*).

In 2016, *Sonke Gender Justice* and Lawyers for Human Rights challenged the inhumane and congested conditions for pre-trial detainees in Pollsmoor prison, which resulted in a court ruling that the State had violated prisoners' constitutional rights to health and that conditions of detention were inconsistent with human dignity. An historic order was made to reduce occupancy from 252% to 150% over a six-month period (*Sonke Gender Justice v Government of South Africa*). The effect, whilst encouraging for those on remand, was short-lived as occupancy was reduced by simply redistributing to other detention facilities (Nevin and Nagisa-Keehn, 2018). Pollsmoor prison was still in violation of the Overcrowding Court Order in 2018 (JICS, 2018).

In 2020, in the case of *Sonke Gender Justice NPC v President of the Republic of South Africa and Others*, the Constitutional Court examined the independence of the Judiciary Inspectorate of Correctional Services (JICS) and held that the JICS as currently formulated is neither financially, nor operationally independent. The judgment is significant in terms of encouraging a shift toward impartiality and greater independence of the JICS in its ability to investigate conditions of detention and human rights abuses within prisons. See Table 2.

Insert Table 2 Domestic Jurisprudence about here

Timeline of State Directives and Prison Realities

On March 18th 2020, the State published its regulations in issuance with the Disaster Management Act of 2002 (27(2)) (CoGTA, 2020). The Minister of Justice and Correctional Services announced its COVID-19 Disaster Management Response Strategy several days later, with intended movement restrictions and disease control actions largely in line with the Southern African Development Community (SADC) and ACHPR COVID-19 recommended responses (SADC, 2020) See **Figure One.**

Insert Figure 1 The COVID-19 timeline in South African prison systems about here

The DCS conducted operational visits across the country in order to "***get a true picture***" of the on-the-ground battle against COVID-19 (DCS, 2020b). Reports emerged however, describing severe congestion in communal cells exacerbated by continued committals and pre-trail detention, dire prison conditions and inadequate prison disinfection measures in some facilities (Kimberley, 2020a). The Law Society of South Africa observed the general inadequacy of prison disinfection measures and provided legal advice to incarcerated clients, which included requests for cell changes (Evans, 2020). High Court challenges began to include requests to be released from prison due to the threat of COVID-19 and for early prison release of the chronically ill (Ground Up, 2020a; Venter, 2020).

In early April 2020, the first DCS directive focused ***initially*** on restrictions regarding detention of foreign nationals in prisons for immigration purposes, the suspension of day parole and continuation of referral of remand detainees to court and the facilitation of telephonic communication between prisoners and legal representatives (Department of Justice and Correctional Services, 2020a). In addition, an online COVID-19 counter was launched; however both staff and prisoners regularly contested veracity of data (Kras and Fitz, 2020). Incidence of COVID-19 increased with case notification among prisoners and staff at Sun City, St Albans, Worcester, Warm Bokkeveld, Kutama Sinthumule and East London prisons (Prison Insider, 2020). Journalists who entered one large facility (Sun City holding 9500 prisoners with 1000 staff) reported on the absence of screening and quarantine protocols and insufficient provision of sanitizer and staff PPE (Mvumu, 2020).

Families of prison staff at several prisons (Kutama Sinthumule, St Albans, East London) expressed concern around health risks given inadequate occupational health standards (including having to work without sufficient PPE supplies) (Prison Insider, 2020). Prison staff also protested the alarming occupational health conditions, management unwillingness to disinfect the facilities and provide support for temperature checks, their concern for potential exposure to family members, and demanded mass COVID-19 testing in prisons (Zuzile, 2020; Vuso, 2020; Zincume, 2020; Marupeng, 2020). In May (and June), work stoppages occurred at Qalakabusha and Voorberg prisons. The South African Prisoners Organisation for Human Rights instructed its members *"to embark on an indefinite passive resistance"* (Prison Insider, 2020). A joint letter by the Inspecting Judge of Correctional Services and a coalition of civil society organisations advocated for the early release of ill and elderly individuals (Cameron, 2020b). In the following months up to August 2020, incidents of prison unrest and protests were reported including hunger strikes (Mdakane, 2020; Hans, 2020; Koko, 2020), setting fire to clothes and mattresses (Ellis, 2020; Kimberley, 2020b), property damage (Siqathule, 2020), self-isolation and self-protection with self-made weapons (Mitchley, 2020) and violence against prison staff (Singh, 2020).

In early May 2020 the Minister of Justice and Correctional Services stated; *"We are confronted with a **glaring impossibility** of maintaining social distancing in our centres due to overcrowding."* The

President authorized the early release scheme of nearly 19,000 individuals (12% of the prison population) (JICS, 2020). Those qualifying included individuals convicted of minor offences, deemed low risk and within five years of release (but excluding those convicted of violent crimes, gender based violence, child abuse, sexual offences, and murder). The subsequent DCS directive contained further detail on the use of prisons for immigration detention due to border closures (Department of Home Affairs, 2020). Several COVID-19 outbreaks were reported, along with three COVID-19 related deaths. Civil society backfilled the inadequate DCS response by supporting prison disinfection and PPE requirements and mask making enterprises led by prisoners themselves were enacted at Rooigrond Medium B facilities (Heiburg, 2020; DCS, 2020c). Following written demands from prisoners, the first prison inspection was conducted at Sun City. Inspectors observed conditions with severe overcrowding (prisoners sleeping on floors), cell lockdowns with no access to a daily outdoor walk, only leaving for meals and with high rates of TB and other diseases in circulation (Prison Insider, 2020).

In June 2020 the situation escalated further with media reporting on the deplorable lack of disinfection measures and PPE for both staff and prisoners, severely delayed COVID-19 test results, reports of staff withholding positive test information from prisoners and prisoners self-harming (burning themselves, injecting with sanitiser) at Leeuwkop, Baviaanspoort and Zonderwater prisons in order to secure placement in isolation cells (Naik, 2020). In many prisons, COVID-19 infected prisoners were reportedly held in solitary confinement in cells without ventilation or windows and without medical care or visits by medical staff (Prison Insider, 2020). By June 23rd 2020, seven prisoners and six officers had died from COVID-19, with reports of outbreaks at Sada and Qalakabusha prisons (Prison Insider, 2020). Prisoners at Potchefstroom prison set cell blocks on fire demanding *"to be tested or to be released"* (Prison Insider, 2020). Whilst all provinces had to establish isolation facilities, a special quarantine facility was established at Barberton prison (Kras and Fitz, 2020).

By the end of June 2020, national prison congestion reached hazardous levels, with the JICS Ministers Briefing reporting that 35.5 % of the prisoner population was awaiting trial (JICS, 2020). A new DCS directive was published (Department of Justice and Correctional Services, 2020b), which recommended enhanced disease mitigation measures (screening, quarantine, social distancing measures), but with the referral of prisoners to external health facilities confined to medical emergencies only. This directive also suspended community service, provision of amenities from external sources, legal consultations (with exception of telephonic contact) and all visits by the public and external non-essential healthcare providers. Referral of detainees to court and JICS visits for performing statutory oversight were permitted. Despite the release of 7000 individuals by the 18th of July 2020, and the government adding 2650 extra bed spaces to the system, close to 30,000 prisoners in South Africa did not have a bed by the end of July 2020 (Felix, 2020). Releases were countered by increased pre-trial detention and custodial sentencing for breaches of COVID-19 regulations with over 230,000 new arrests during that time (Geer and Guara, 2020) and severe delays in the deportation of foreign nationals (over 500 individuals) (Gasa, 2020).

COVID-19 levels escalated further and resulted in prisoner rioting and staff strike actions (Kras and Fitz, 2020; Khoza, 2020a). Hunger strikes occurred at St Albans, Sun City and Kgosi Mampuru prisons to protest the alleged concealment of the COVID-19 infection rate and inadequate measures to protect individuals and staff (Koko, 2020; Molosankwe and Koko, 2020; Makgatho, 2020; Gililli, 2020). In mid-August 2020, seven prison officers and one prisoner at Westville prison were stabbed with prisoners reporting to journalists that the incident *"was the result of months of tension finally boiling over"* due to excessive use of cell confinement and the unavailability of COVID testing (Prison Insider, 2020). The Police and Prisons Civil Rights Union (POPCRU) advised its members that "*they had the right to refuse to go to work if they felt themselves in danger"* (Prison Insider, 2020). Nursing staff refused to work at St Albans prison, resulting in closure of the prison infirmary (Prison Insider, 2020). Three prison officers died from COVID-19 within a two week timeframe at Modderbee prison (Prison Insider, 2020). Water shortages also impacted severely on sanitation levels and access to clean drinking water at several prisons (Brandvlei, Thohoyandou) (Ground Up, 2020b).

By late August, 43 prisoners and 60 prison staff had died from COVID-19 (Prison Insider, 2020). 118 new COVID-19 cases were reported in one day and five deaths occurred during one week at Kgosi Mampuru prison (holding 7,000 prisoners), with prisoners alleging that social distancing was impossible and accusing prison staff of neglect, human rights abuses and of fuelling the transmission of the virus during prison cell raids (Molosankwe and Koko, 2020; Mahlangu, 2020). The DCS refuted these claims, with a spokesperson detailing the multi-pronged approach to prevention, detection, containment and treatment in South African prisons and the increased human resource capacity to support the prison health response (700 additional nurses were recruited) (Mahlungu, 2020; Rapisarda and Byrne, 2020).

In early September 2020, a new DCS directive for Alert level 2 was issued containing similar detail on safety and general measures to previous directives, but which now included mandatory wearing of face masks, along with the easing of restrictions to facilitate transfer and referrals for medical care or court attendance (Department of Justice and Correctional Services, 2020c). Concerning official breaches in COVID-19 guidelines and restrictions were observed, where administrations recalled prison staff to work whilst in quarantine (Prison Insider, 2020; New Frame, 2020). By late September, Kgosi Mampuru prison reported more than 177 cases, with five prisoner and four staff fatalities (Prison Insider, 2020). The media reported on the lack of prisoner contact with the outside world, with many prison telephones inoperable and no alternative methods of communication provided (Khoza, 2020b). In October 2020, Leeuwkop prison quarantined three prisoners who tested COVID-19 positive. This was followed in early November 2020 (Department of Justice and Correctional Services, 2020d) by a DCS directive for Alert level 1, which was similar to the previous directive and included a new regulation to schedule all prison appointments**.** In late November, an entire communal cell of 35 prisoners at St Albans were placed in quarantine. The media reported on how continued prison lockdowns fuelled prison tension and related violence (Prison Insider, 2020). In early January 2021,

152 prisoners and eight staff tested positive at Helderstroom (Evans, 2021). The latest DCS directive issued on 28 January 2021 (Department of Justice and Correctional Services, 2020e) reiterated previous guidelines and contained a new section on disease mitigation in prisons designated as "*hotspots*".

Assessing Human Rights Assurance in South African prisons during COVID-19

This legal-realist assessment of the South African prison system approach to tackling COVID-19 was conducted using a unique theoretical approach (Leiter, 2015), in evaluating the rule of law and normative standards of care as derived from real world multi-stakeholder and rights holder observations and experiences regarding prison situation, welfare, system operations and policies during that time. It acknowledges State efforts, policy making processes and outcomes and focuses on how these operated within the prison system itself. By moving beyond the deleterious impacts of the COVID-19 pandemic on the already precarious South African prison system, we argue for human rights assurance for those who live and work in its prisons, improved infrastructure and greater substantive equality of all deprived of their liberty in South Africa.

Despite minimum State obligations to comply with human rights norms, the COVID-19 pandemic situation has amplified existing and created new identifiable breaches in the human, health and occupational health rights of those living and working in South African prisons. Whilst the DCS system published a comprehensive range of mitigation measures (aligned to international and the 2020 SADC regional responses) in their Directives, these were not implemented with sufficient resourcing, capacity and uniformity across the country's prison system. The assessed investigative journalist reports and academic literature illustrates the conflicting perspectives on the DCS system response to COVID-19 in South African prisons (prison officials versus detainees) (Rapisarda and Byrne, 2020). Fortunately, reported figures indicate a moderate level of COVID-19 transmission in the prison system itself, indicating some success of restrictions of human traffic into and out of prisons and the dampening of outbreaks within the prison walls.

The right to reasonable accommodation (space, ventilation, sanitation) and right to an environment free from torture and inhumane treatment warranted close examination for potential violations during COVID-19. Prison congestion was a significant impediment to disease mitigation and contributed to severe prison unrest and instability during COVID-19 restrictions. Social distancing was impossible. Communal cells, often at 50% overcapacity, did not provide the bare minimum floor space set by the CAT at four square meters per person in a communal cell (and six square metres for a single cell), which could be declared by courts as cruel or degrading (Steinberg, 2005). The response was hampered by delayed prison release schemes, continued intake and flow of detainees and mixing of pre-trial and incarcerated populations. The promised 19,000 prison releases has not been achieved (at the time of writing, 7000 released) (Dube, 2020) and with little transparency on who was released. Environmental health conditions were inadequate (floor space and cubic content of air) with insufficient disinfection measures (hygiene, sanitation, ablution) (Ngoepe, 2020) (see *Mandela Rules* 13 to18, 25,

35). Shortages in clean drinking water, water for personal hygiene and food and the inability to access outdoor air during 24 hour cell lockdowns were contra the *Mandela Rules* 22(1) and (2), 23(1) and 42. Reports of the application of quarantine in the form of *'de facto'* solitary confinement measures, often in cells without windows, is of further concern and raises vital questions regarding legality, time-limitation and proportionality of the South African DCS system response to COVID-19 infection rates. There are significant ethical/practical concerns regarding the critical distinctions between punitive '*solitary confinement'* and ethical use of '*medical quarantine'* during pandemic conditions in prison (Cloud *et al.,* 2020). The denial of contact with the outside world (not limited to those in solitary confinement and medical quarantine) creates a similar question, where prisoner right to access legal representation and family support for basic provisions were restricted (*Mandela Rules* 61(1)(3)), particularly where contact via technological means (*Mandela Rule* 58(1a)) was not facilitated by the DCS (Postman, 2020). There are further indications of lengthy arbitrary immigration detention due to border closures (Gasa, 2020).

Most concerning from a public health perspective, and notwithstanding the existing multi-morbidities experienced by prisoners and the circulation of TB and HIV, were the violations of normative standards of disease prevention and the non-derogated rights of prisoners to equivalence of care (including testing, quarantine and treatment) (*Mandela Rules* 24(1), 25, 30, 31, UN Principles of Medical Ethics, WHO and WMA declarations) during the COVID-19 public health emergency and State declaration of disaster. DCS system deficits contributed to the insufficient resourcing and weak implementation of COVID-19 disease mitigation measures (testing, quarantine, distribution of PPE and disinfectant) in protecting both prisoners and staff. Prison congestion made it impossible for prisoners and staff to physically distance. COVID-19 responses in prisons were confounded by delayed test results, lack of sharing of information by the authorities regarding COVID-19 positivity in prisons and inadequate basic prison functioning regarding testing and quarantine of new committals. Water and food shortages breached basic human rights to adequate food and safe drinking water. Health responses were further impeded by infirmary closures due to staff stoppages. The denial of access to medical care, including when prisoners were very unwell with COVID-19, are indicative of serious failures on the part of the State.

The occupational health rights of staff were equally ill-supported in the DCS approach despite the risk encountered in their roles and having occupational health rights (*Mandela Rules* 25(2), 35(1)). They were 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).

It is questionable whether a truly effective complaints mechanism for those deprived of their liberty is provided for in South Africa (Van Hout and Wessels, 2021). The suspension of visits by external persons (lawyers, medical professionals), including the South African prison oversight body

(JICS) created barriers to independent oversight, including under the CAT (Muntingh, 2020). Strategic public interest litigation is crucial to stimulate South African prison reforms (Van Hout and Wessels, 2021). Whilst civil society organisations largely contribute to holding the South Africa government to account, there are several possibilities for prisoners (and prison staff) to assert their rights. Routes to justice relate to the rights of prisoners to sufficient water, sanitation, nutrition, safe space and timely and appropriate healthcare and the State obligation to take the requisite steps regarding prevention, treatment and control of disease via domestic, regional and international legislation. At the dome level, future claims against the State are supported by previous successful litigation (as outlined in Table 2), declaring the State in violation of its commitment to uphold the rights of prisoners regarding inhumane prison conditions, prevention of disease and the right to medical care in the case of HIV and TB (Nagisa-Keehn and Nevin, 2018). For instance, the lack of prisoner access to timely COVID-19 testing results and medical care and the use of solitary confinement, were contra the DCS directives themselves. The observed congested and unsafe prison conditions, movement and security restrictions and insufficient actions to prevent disease and provide routine medical care potentially breach Section 35(2)(e) of the South African Constitution. There are possible routes regarding individual complaints under the CCPR-OPT1 *Articles* 2, 10 and 26 with regard to rights of prisoners to humane treatment, non-discriminatory protection of the law and equality before the law of a State and right to an effective remedy for violations. South Africa has ratified the CAT and OPT-CAT and accepted the inquiry procedures under CAT *Article* 20 and individual complaints under CAT *Article* 22. Equally important however, with regard to the rights of incarcerated women and children, is that whilst South Africa has ratified 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) and accepts inquiries under CEDAW-OPT *Articles* 8-9 and CERD *Article* 14, it does not accept individual complaints or inquiry mechanisms under the CRC-OP *Article* 13.

Conclusion

South Africa continues to be ranked as high-risk in the pandemic and still has the highest detected COVID-19 positivity in the African continent (Bulled and Singer, 2020; NICD, 2021). To date, there has been no legal realist assessment of the situation of those living and working in South Africa's prisons during COVID-19 pandemic times. In July 2020, the Minister of Justice and Correctional Services reiterated that South Africa makes it its mission to translate the Mandela Rules into a daily reality for prisoners (UNODC, 2020b).

We have presented a summary of relevant human rights law and expectations both before and during this public health emergency and illustrated how failure to adhere to these standards before the COVID-19 pandemic contributed an inability to adequately respond in a time of crisis. Whilst the State COVID-19 approach was aligned to international and SADC guidelines and was relatively successful in preventing a catastrophe of contagion within South African prison walls, COVID-19 has amplified

the need to address the historical breaches in the human rights of prisoners in South Africa in terms of system failure to meet minimum standards of care.

Hence, this legal realist assessment is intended to provide a forum to elucidate useful lessons for preventing similar challenges to the system in the future. COVID-19 may now act as a leverage to improve overall criminal justice system functioning, prison infrastructure and disease mitigation protocols and, ultimately, the conditions for those who live and work in South African prisons. Firstly, the COVID-19 experience underscores the need for South Africa to address prison congestion by reviewing its bail and mandatory minimum sentencing regime and to further utilise release schemes and alternative sentencing options. Secondly, the prioritisation of security must not eliminate the human rights of those who live and work in prisons, nor must they ignore the public health issues at hand (Nagisa-Keehn and Nevin, 2018). A strategic public health and human rights based approach is warranted to mitigate transmission of disease in prisons and improve health for all affected, including as an occupational health and community issue (Amon, 2020; Kinner *et al.*, 2020; Van Hout, 2020a;b;c;d). Recommendations centre on improving the structured independent oversight of the South African prison system itself, working towards upgrading overall environmental standards of care (sanitation, hygiene, emergency preparedness) in all facilities, developing a system for enhanced technology assisted communication for the incarcerated during future disease outbreaks and ensuring that staff are communicated to and supported in all aspects of occupational health. Humane and ethically sound forms of medical isolation and quarantine should be implemented, which are equivalent to and aligned to standards of care in the community and which uphold the rights of those deprived of their liberty without compromising public health (Cloud *et al.*, 2020). Thirdly, the development of further strategic public interest litigation is warranted, moving beyond that of civil society advocacy and inclusive of individual actions against the State. Lastly, continued health surveillance by the South African public health systems hand in hand with the DCS is warranted to monitor the situation, along with facilitation of access to prisons by academic research teams for future research studies.

Working toward the enhanced protection of a range of human and health rights of prisoners and staff is imperative. We do not know what future zoonotic diseases are around the corner. The time to act is now.

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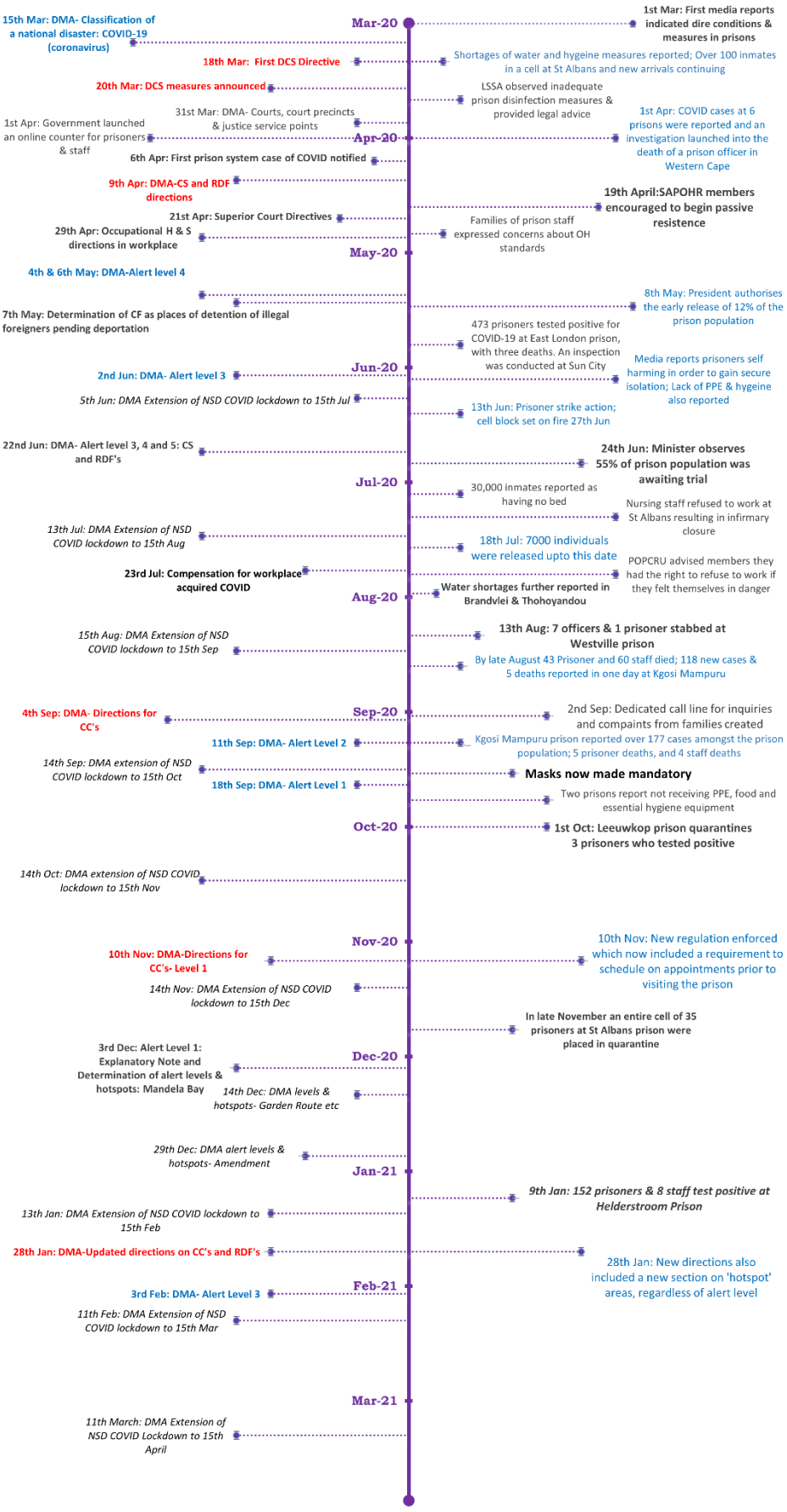
International PEN and Others v. Nigeria (1998)ACHPR Nos.137/94,139/94,154/86,161/97 para 112
Malawi African Association and others v. Mauritania (2000)ACHPR Nos.54/91,61/91,98/93,164/97 a,196/ 97 and 210/98 para 122
Free Legal Assistance Group, Lawyers' Committee for Human Rights, Union Interafricaine 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

Table 1 African Regional Jurisprudence

S v Makwanyane and Another (1995) ZACC3 at 151,1995(3)S.A 391 *Van Biljon and Others v Minister of Correctional Services and Others*(1997)(4)SA441(C) *B and Others v. Minister of Correctional Services and Others* (1997)(4)SA441(C);1997(6)BCLR789(C) *Stanfield v Minister of Correctional Services*(2003)ZAWCHC 46 *Du Plooy v. Minister of Correctional Services* (2004) 3AllSA613(T) *Mazibuko v. Minister of Correctional Services*(2007)Case No:38151/05.JOL18957(T) *S v Magida*(2005)(2)SACR591(SCA)paras 9-10 *EN and Others v Government of RSA and Others*(2006)006(6)SA575(D);2007(1)BCLR 84.SAHC Durban 2006 *Lee v Minister of Correctional Services*(2012)ZACC30 *McCallum v. South Africa*(2010) UN Doc CCPR/C/100/D/1818/2008 (2 November 2010) *Sonke Gender Justice v Government of South Africa* 24087/15(unreported) WC HC *Sonke Gender Justice NPC v President of the Republic of South Africa and Others*(2020)ZACC para 38-40

Table 2 Domestic Jurisprudence


15th Mar: DMA- Classification of a national disaster: COVID-19 (coronavirus)
Mar-20
1st Mar: First media reports indicated dire conditions & measures in prisons
18th Mar: First DCS Directive
Shortages of water and hygeine measures reported; Over 100 inmates in a cell at St Albans and new arrivals continuing
20th Mar: DCS measures announced
LSSA observed inadequate prison disinfection measures & provided legal advice
31st Mar: DMA- Courts, court precincts & justice service points
1st Apr: Government launched an online counter for prisoners & staff
Apr-20
1st Apr: COVID cases at 6 prisons were reported and an investigation launched into the death of a prison officer in Western Cape
6th Apr: First prison system case of COVID notified
9th Apr: DMA-CS and RDF directions
19th April:SAPOHR members encouraged to begin passive resistence
21st Apr: Superior Court Directives
29th Apr: Occupational H & S directions in workplace
Families of prison staff expressed concerns about OH standards
May-20
4th & 6th May: DMA-Alert level 4
8th May: President authorises the early release of 12% of the prison population
7th May: Determination of CF as places of detention of illegal foreigners pending deportation
473 prisoners tested positive for COVID-19 at East London prison, with three deaths. An inspection was conducted at Sun City
Jun-20
2nd Jun: DMA- Alert level 3
Media reports prisoners self harming in order to gain secure isolation; Lack of PPE & hygeine also reported
5th Jun: DMA Extension of NSD COVID lockdown to 15th Jul
13th Jun: Prisoner strike action; cell block set on fire 27th Jun
22nd Jun: DMA- Alert level 3, 4 and 5: CS and RDF's
24th Jun: Minister observes 55% of prison population was awaiting trial
Jul-20
30,000 inmates reported as having no bed
Nursing staff refused to work at St Albans resulting in infirmary closure
13th Jul: DMA Extension of NSD COVID lockdown to 15th Aug
18th Jul: 7000 individuals were released upto this date
POPCRU advised members they had the right to refuse to work if they felt themselves in danger
23rd Jul: Compensation for workplace acquired COVID
Aug-20
Water shortages further reported in Brandvlei & Thohoyandou
13th Aug: 7 officers & 1 prisoner stabbed at Westville prison
15th Aug: DMA Extension of NSD COVID lockdown to 15th Sep
By late August 43 Prisoner and 60 staff died; 118 new cases & 5 deaths reported in one day at Kgosi Mampuru
4th Sep: DMA- Directions for CC's
Sep-20
2nd Sep: Dedicated call line for inquiries and compaints from families created
11th Sep: DMA- Alert Level 2
Kgosi Mampuru prison reported over 177 cases amongst the prison population; 5 prisoner deaths, and 4 staff deaths
14th Sep: DMA extension of NSD COVID lockdown to 15th Oct
Masks now made mandatory
18th Sep: DMA- Alert Level 1
Two prisons report not receiving PPE, food and essential hygiene equipment
Oct-20
1st Oct: Leeuwkop prison quarantines 3 prisoners who tested positive
14th Oct: DMA extension of NSD COVID lockdown to 15th Nov
Nov-20
10th Nov: DMA-Directions for CC's- Level 1
10th Nov: New regulation enforced which now included a requirement to schedule on appointments prior to visiting the prison
14th Nov: DMA Extension of NSD COVID lockdown to 15th Dec
In late November an entire cell of 35 prisoners at St Albans prison were placed in quarantine
3rd Dec: Alert Level 1: Explanatory Note and Determination of alert levels & hotspots: Mandela Bay
Dec-20
14th Dec: DMA levels & hotspots- Garden Route etc
29th Dec: DMA alert levels & hotspots- Amendment
Jan-21
9th Jan: 152 prisoners & 8 staff test positive at Helderstroom Prison
13th Jan: DMA Extension of NSD COVID lockdown to 15th Feb
28th Jan: DMA-Updated directions on CC's and RDF's
28th Jan: New directions also included a new section on 'hotspot' areas, regardless of alert level
Feb-21
3rd Feb: DMA- Alert Level 3
11th Feb: DMA Extension of NSD COVID lockdown to 15th Mar
Mar-21
11th March: DMA Extension of NSD COVID Lockdown to 15th April