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A multi-stakeholder situation assessment of COVID-19 disease preparedness and mitigation measures in a large prison complex in Malawi.

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Abstract

Purpose: Prisons in the sub-Saharan African region face unprecedented challenges during the COVID-19 pandemic. In Malawi, the first prison system case of COVID-19 was notified in July 2020. While, prison settings were included in the 2nd domestic COVID-19 response plan within the Law Enforcement cluster (National COVID-19 preparedness and response plan, July-December 2020), they were initially not included in the K157 billion (USD 210 million) COVID-19 fund.

Design/methodology/approach: A multi-method situation assessment of the COVID-19 response and human rights assurance of prisoners and staff was conducted in a large prison complex in Malawi. Qualitative research underpinned by the Empirical Phenomenological Psychological (EPP) framework consisted of interviews with key informants such as prison health personnel, senior prison staff, penal and judicial policymakers, government and civil society organisations (n = 14) and focus group discussions with consenting male (n = 48) and female prisoners (n = 48), and prison wardens (n = 24). Prison site visits were supported by detailed observations based on the WHO Checklist for COVID-19 in prisons (n = 9). Data were collected and analysed thematically using the EPP stepwise approach and triangulated based on Bronfenbrenner's model conceptualising COVID-19 as a multi-level event disrupting the prison eco-system.

Findings: The results are presented as *MICRO-MESO* level individual and community experiences of incarceration during COVID-19 spanning several themes: *Awareness raising and knowledge of COVID-19 in prisons; Prison congestion and the impossibility of social distancing; Lack of adequate ventilation, hygiene and sanitation* and *Provisions and correct use of personal protective equipment (PPE); MESO-MACRO* level interplay between the prison community of prisoners and staff and judicial policy impacts; *Medical system COVID-19 response, infrastructure and access to healthcare; COVID-19 detection and quarantine measures* and *Prisoner access to the outside world.*

Originality: This unique situation assessment of the Malawian prison system response to mitigate COVID-19 illustrates the dynamics at the micro-level whereby prisoners rely on the State and have restricted agency in protecting themselves from disease. This is due to severe structural inadequacies based on low resource allocation to prisons leading to a compromised ability to prevent and treat disease; an infirm and congested infrastructure and bottlenecks in the judicial system fueling a continued influx of remand detainees leading to high over capacity. Multi-pronged interventions involving key stakeholders, with prison management and line Ministry as coordinators are warranted to optimise COVID-19 interventions and future disease outbreaks in the Malawian prison system.

Key Words

COVID-19, Mandela Rules, Malawi, human rights, prisoners, infectious disease

Background

On March 11th 2020, the COVID-19 (a respiratory illness caused by SARS-CoV-2) outbreak was declared by the World Health Organization (WHO) to constitute a pandemic (WHO, 2020a). Detention settings worldwide as high-risk environments for communicable disease faced incredible challenges during that time in mitigating COVID-19 (UNODC, 2020; WHO, 2020b; Beaudry *et al.,* 2020). On March 25th 2020, the UN High Commissioner for Human Rights called on States to instigate decongestion measures as a critical component of their overall COVID-19 response (OHCHR, 2020; UNODC *et al.*, 2020; Amon, 2020). Presidential pardons, early and emergency release schemes and amnesties were implemented in many countries (Simpson and Butler, 2020; Lines *et al.,* 2020). Prisoners living in congested prisons and those with chronic ill health are especially at risk of severe COVID-19 disease (Beaudry *et al.,* 2020). The United Nations Office on Drugs and Crime (UNODC), WHO, DIGNITY and Penal Reform International technical guidance on tackling COVID-19 and human rights assurances (WHO, 2020b; WHO, 2020c; UNODC, 2020; PRI, 2020; DIGNITY, 2020) were promulgated in 2020.

In Africa, where prison capacity is stretched, it is estimated that one million people are deprived of their liberty with, on average, 42% in pre-trial detention. (World Prison Brief, 2020). The threat of COVID-19 is immense, particularly to the health and safety of those living and working in African prisons (and their families) and is exacerbated by colonial infrastructure, historical poor conditions of detention and low government resourcing of a COVID-19 response in its prison systems (Nkengasong and Mankoula, 2020; Muntingh, 2020; Van Hout, 2020a; Van Hout, 2020b; Van Hout, 2020c; Van Hout, 2020d; Nweze *et al.,* 2020; World Prison Brief, 2020; Lucero-Prisno, 2020; Van Hout and Wessels, 2021).

On May 25th 2020, a group of human rights organisations submitted letters to the Southern Africa Development Community (SADC) and its Member States highlighting the severe deficits in the prison system during COVID-19 (SADC, 2020). Following the first case notification in Egypt, from March 5th 2020 to April 15th 2020, COVID-19 spread across 23 Southern and East African countries (except Lesotho) (Muntingh, 2020). The African Commission on Human and Peoples' Rights (ACHPR) released several documents outlining effective human rights-based responses to COVID-19 including in prisons (ACHPR, 2020a; ACHPR, 2020b). By May 26th 2020 however, prisons in South Africa, Sierra Leone, Algeria, Kenya, Cameroon, Morocco, Ghana, Egypt, Democratic Republic of Congo and Guinea confirmed cases of COVID-19 (Prison Insider, 2020). There is little transparent and publicly available data on COVID-19 positivity rates, deaths and recoveries in African prisons (with the exception of South Africa) and little information provided on the profile of those released during prison decongestion measures (Muntingh, 2020; Nweze *et al.,* 2020). Prison situations were also volatile due to the lack of disease mitigation, continued intake of remand detainees and existing poor conditions of detention, with riots and protests by staff and prisoners reported in many African states (Prison Insider, 2020; Van Hout, 2020c; Van Hout and Wessels, 2021).

We report here from Malawi, where commentaries have underscored the threat of COVID-19 as a public health crisis due to its overburdened health system and political and economic challenges (Patel *et al.,* 2020; Sonenthal *et al.,* 2020). The National COVID-19 Preparedness and Response Plan was launched in March 2020 with a budget of $28 million and the first three COVID-19 cases were notified on 2nd April 2020 in Lilongwe (Ministry of Health, 2020; Patel, 2020; United Nations Malawi COVID-19 Update, 2020; Mzumara, 2021). The Malawi government declared a state of disaster on 20th March (United Nations Malawi COVID-19 Update, 2020); however, this was subsequently blocked in the High Court (News 24, 2020; Muntingh, 2020).

The most recent data, from December 2020, listed the Malawian prison population at 14,500 spread over 30 prisons, with an occupancy level of 260% capacity (World Prison Brief, 2020), including one maximum security prison (Zomba Central), built in 1935 and two large prisons in Lilongwe (Maula) and Blantyre (Chichiri Central) (Gadama *et al.,* 2020). A strong evidence base exists for the spread of communicable diseases in Malawian prisons (HIV, tuberculosis (TB), scabies, Hepatitis C and sexually transmitted infections) (Zachariah *et al.,*2008; Banda *et al.,* 2009; Chirwa *et al.,* 2018). While non-governmental organisations play a significant role in supporting and backfilling government HIV response efforts (Gondwe *et al.,* 2021), conditions remain poor due to outdated colonial infrastructure, understaffing and severe congestion with prisoners sleeping in rows and suffering a lack of sufficient sanitation, ventilation and food insecurity, as well as reports of torture and interpersonal and custodial violence (Malawi Inspectorate of Prisons, 2019; Water Supply and Sanitation Collaborative Council, 2020; Van Hout, 2020c; Gadama *et al.,* 2020; US Department of State, 2020). On July 14th 2020, the first cases (staff/prisoner) of COVID-19 were registered by the Malawi Prison Service at Mzimba Prison where a prison officer tested positive for COVID-19 and in Chichiri Central prison where a prisoner tested positive (Southern African Litigation Centre, 2020). By September 26th 2020, 26 staff and 408 prisoners tested positive and two deaths were reported (Prison Insider, 2020). The first prison COVID-19 death reported by the Malawi Prison Service was in Maula prison in Lilongwe.

Prisons were included in the 2nd domestic COVID-19 response plan within the Law Enforcement cluster (National COVID-19 preparedness and response plan, July-December 2020), but were initially not included in the K157 billion (USD 210 million) COVID-19 fund; with media reports of prison staff strike action with requests for hazard pay and sufficient personal protective equipment (PPE) (Muheya, 2020; Masina, 2020a). Human rights organisations raised concerns in late 2020 regarding inadequate testing capacity, care of the terminally ill and the chronic ill health of many prisoners (especially HIV and TB infection) and the significant risk of catastrophe in prison confines (Pensulo, 2020a). There were increased calls to decongest the prison system (Face of Malawi, 2020) and sentencing adjustments in April 2020 via the '*Justice and Accountability Chilungamo Programme,'* resulting in the release of 1,397 prisoners with 499 receiving a Presidential pardon (Chilundu, 2020; Phiri, 2020; Masina, 2020b:c). There was, however, little transparency in terms of who was released,

with Zomba prisoners omitted in May 2020 despite the prison operating at severe over capacity (Chilora, 2020). Maula prison closed its female wing in July 2020 to open a COVID-19 isolation centre. This closure resulted in the subsequent transfer of 71 women with infants, including remand detainees to rural prisons (Kapalamula, 2020; Pensulo, 2020b; Van Hout, 2020c). Four isolation centres for pretrial detainees were created at Zomba, Maula, Mzimba and Thyolo prisons, three of which used the female section (Zomba, Maula, Mzimba) (Southern African Litigation Centre, 2020). Prison system efforts included the segregation of infected prisoners, ban on visitation and the suspension of out of prison formations to work (Masina, 2020b:c). Media reports emerged of inadequate PPE disinfection and sanitation supplies for staff and prisoners and insufficient medical staff on site, with lockdown measures confining prisoners to cells and access restrictions to the prison disrupting prisoner reliance on family and civil society support in the supply of food, soap, and clothing (Van Hout, 2020c, Guta, 2021). Donations of COVID-19 materials to the prison system were made by the United Nations High Commissioner for Refugees (UNHCR) (Chikoti, 2020). The COVID-19 response was blighted by reports in 2021 of extensive mismanagement of COVID-19 funds (Kateta, 2021). Hence, we conducted a situation assessment of the COVID-19 response and level of human rights assurance of prisoners and staff in a large prison complex in Malawi. Human rights in this sense centre on the right to health including prevention of disease, right to safe working conditions, right to access of legal representation and families and equivalence of healthcare provisions in countering the COVID-19 pandemic in prisons, all of which are mandated in international and regional human rights law, standards, and safeguards.

Method

The project was undertaken as part of a large scale international collaborative human rights project in sub-Saharan Africa. A multi-method situation assessment of stakeholder perspectives of the COVID-19 response and human rights assurance of prisoners and staff was conducted in a large prison complex in Malawi. Its design was cognisant of the technical guidance around human rights assurance during COVID-19 promulgated by the UNODC and Penal Reform International (UNODC, 2020; PRI, 2020).

Ethical and COVID-19 considerations

The project was facilitated and led by the Centre for Human Rights Education Advice Assistance (CHREAA), a civil society organisation that works with prisons in Malawi. Ethical approval was granted by the University Research and Ethics Committee at Liverpool John Moore's University, United Kingdom (20/PHI/031) and the Kamuzu University of Health Sciences (KUHeS) Research and Ethics Committee, Malawi (COMREC) (P.03/21/3281). Permission to conduct the study was provided by the Malawi Prison Service and Blantyre Director of Health and Social Services (DHSS). All participants were provided with written and verbal information on the study. Potential participants were provided with clear information that the study was not linked to medical treatment or any other health or social service and they should self-refer if requiring support for COVID-19 or any other related

illness. Participation in the study was voluntary. All participants received a participation incentive equivalent to USD10.00. Informed consent was provided, with right to withdraw and full anonymity and confidentiality assured. Interviews were conducted in private spaces in the absence of third parties. All participant data was made anonymous through the use of personal identification codes and data collected was stored in accordance with General Data Protection Regulation (GDPR).

All data collection followed COVID-19 prevention measures as outlined in COMREC COVID 19 guidelines dated 1st April, 2020. Specifically, appropriate distance was observed among people during meetings, FGDs or interviews; all participants and staff wore a mask and frequently sanitised hands during training and interviews. Masks and hand sanitizers were provided by CHREAA.

Qualitative and observational data collection

Qualitative data collection guides and observational checklists were based on the WHO COVID-19 in prisons checklist (WHO, 2020c), aimed at evaluating human rights assurance in mitigating COVID-19 in prisons. Questions evaluated the level of *human rights assurance* (principles and practice in prisoner treatment and prison systems) and preparedness for the COVID-19 disease (communications, staff and detainee awareness raising risk mitigation, prevention actions, contingency measures, clinical response). Prison site visits were supported by detailed observations (n = 9) by trained staff who used a checklist to assess the environmental determinants of health, standards of care and operationalisation of disease control measures (testing capacity, disinfection, sanitation, PPE, quarantine cells, decongestion tactics, awareness-raising). Observations were supported by informal questioning of relevant personnel for clarification and reflective memos.

Qualitative data collection consisted of in-depth interviews using a purposive sample of key informants (prison health personnel, senior prison staff, penal and judicial policymakers, government, and civil society organisations who accessed the prison regularly) and focus group discussions (FGDs) with consenting male and female prisoners and prison wardens. In-depth interviews with key informants used a pragmatic approach to explore perspectives and experiences of COVID-19 preparedness in the prison system itself and in the selected large prison complex in Malawi. It further explored prison structures and exposure to biohazards, impact of weak judicial systems (causing high pre-trial detention and congestion), government resource allocation to protect the prison and those who live and work in it and medical responses including COVID-19 testing capacity and disease surveillance across the prison and public health systems. Interviews examined breaches of basic, health, gender and occupational rights, care of chronically ill or vulnerable prisoners, impact of restrictions and the transparency of prison release schemes. Interviews were carried out face-to-face, were audio recorded with permission and lasted between 45 and 60 minutes.

FGDs with prisoners and prison wardens in the selected large prison complex focused on documenting their lived experiences and perspectives on human, occupational, health and gender rights assurance during the COVID-19 pandemic restrictions. They explored ground level perspectives and

experiences of COVID-19 preparedness in the prison, prison infrastructure and the environmental or occupational determinants of health and prison system disease control responses (awareness raising, prevention, detection, quarantine, treatment). Inclusion measures centred on FGD participants (male, female prisoners and wardens) who had been in the prison or worked in the selected large prison complex for three months or longer and were over eighteen years of age. Minors or those who had worked or been living in the selected large prison complex for less than three months were excluded. The FGDs lasted 60 minutes and were gender specific, with 12 participants in each. In total, four FGDs were completed, two male and two female prisoner groups. The FGDs were facilitated by two researchers, were audio recorded with accompanying detailed notes taken. Refreshments were served to all participants at the conclusion of each FGD.

Data collection, management and analysis

Data was collected, processed and analysed between June and August 2021. Audio recordings were transcribed verbatim in the language used for the interview . All notes and transcripts in the local language (Chichewa) were translated into English following standard protocols for quality control. Data collection and analysis was underpinned by the Empirical Phenomenological Psychological (EPP) five-step quality framework (Karllson, 1993). This approach to collecting and analysing data focuses on the subjective experience, in this sense the lived experience of COVID-19 in the prison and adheres to Husserl's (1970) principle of active efforts to *'bracket out'* the researchers' theoretical preunderstanding in the first steps of a text analysis. This *'bracketing'* however does not exclude an empathetic, psychological focus of the experiences of the COVID-19 phenomenon in the prison, as it is lived by the participant and what it means to them. The EPP allows for an incremental understanding of the distinct lived experience of policymakers, prison officials, and prisoners. Analysis of data was iterative, moving between data collection and analysis to test emerging themes or concepts. Care was taken to identify and follow up on outliers. This involved several key steps that focus particularly on the experiential phenomenological aspects of living and working in the prison during the COVID-10 pandemic:

1. Text was read several times to understand the phenomenon, with theoretical reflection withheld;
2. Text was divided into meaningful units (paragraph or a word);
3. Personal language was transformed into researcher language with care taken to avoid 'doing violence' to the lived subjective experience;
4. The text was screened for comprehensive themes, interpreted using researchers' theoretical knowledge and organised into meaningful themes.

A further layer of triangulation across data sources and methods occurred when raising the analysis and interpretation to the abstract level. Combined themes were triangulated based on Bronfenbrenner's (1979) ecological systems framework, which was applied to better understand and conceptualise COVID-19 as an event which disrupts the prison ecosystem and breaches a range of human rights. The

macro, meso and micro level factors interplay and can be leveraged to identify and understand variation in human rights assurances, minimum standards of care, and the disease response. See Figure 1.

Insert *Figure 1. COVID-19 and the prison ecosystem about here*

The results are presented as *MICRO-MESO* level individual and community experiences of incarceration during COVID-19 spanning several themes; *Awareness raising and knowledge of COVID-19 in prisons; Prison congestion and the impossibility of social distancing; Lack of adequate ventilation, hygiene and sanitation* and *Provisions and correct use of PPE; MESO-MACRO* level interplay between the prison community of prisoners and staff and judicial policy impacts; *Medical system COVID-19 response, infrastructure and access to healthcare; COVID-19 detection and quarantine measures* and *Prisoner access to the outside world.*

Results

Participant Profile

In-depth interviews were conducted with a purposive sample of key informant (prison health personnel, senior prison staff, penal and judicial policymakers, government and civil society organisations who accessed the prison regularly) (n = 14). Key informants consisted of prison health workers (n = 4); senior prison staff (n = 5); penal and judicial policy (n = 2) and other key informant representing the Ministry of Health (MoH) and civil society organisations accessing the prison (n = 3). FGDs were facilitated with consenting male (n = 48) and female prisoners (n = 48) and prison wardens (n = 24). All FGDs consisted of 12 participants. Four FGDs were conducted with male and female prisoners and two FGDs with male and female prison wardens at the prison; a total of 48 prisoners and 24 prison wardens participated.

Insert Table 1 Data Collection Events about here

The mean age of male prisoners was 33.4 years. The majority were sentenced (two were on remand) and the length of time in the prison ranged between eight months to ten years. The majority were educated to secondary school level, only two were educated to primary level and two had attended tertiary level of education. The mean age of female prisoners was 33.1 years. A slight majority were sentenced (58%) and the length of time in the prison ranged between four months to eighteen years. The majority were educated to primary school level, only six reported experience of secondary school. The mean age of male prison wardens was 40.3 years, with a duration of prison service ranging from five to thirty-four years. The mean age of female prison wardens was 33.9 years, with a duration of prison service ranging between five to twenty-nine years. The majority of both genders had completed

secondary school education. Nine observation periods were conducted at different dates and times, details of which are presented in Table 2.

Insert Table 2 Observational Data of COVID-19 disease control measures in both male and female prisons about here

MICRO-MESO level individual and community experiences of incarceration during COVID-19

Awareness raising and knowledge of COVID-19 in prisons

Qualitative data indicated that general COVID-19 awareness around symptomatology of the disease, transmission risks and prevention measures among both genders of prisoner was good. They illustrated their knowledge stating:

> ***'I know that it's a very dangerous disease that kills, but it is very simple to prevent it when one follows the health guidelines that were given especially of being clean, washing hands regularly, wearing masks and sanitizing. When one is following COVID 19 guidelines it can be prevented.'*** *(Male prisoner)*
>
> ***'Air…Being in close contact with those who are sick from the COVID disease. The way I touch a phone right? If I have the virus as well as if I touch a table, then someone else touches it, they'll get infected.'*** *(Female prisoner)*

Prisoners received their information from a variety of sources both before entry into the prison (radio, television, churches), the prison clinic on committal, clinical and peer training initiatives, televisions and radios in cells and the activities of international and local non-governmental organisations in the prison. Several prisoners observed:

> ***'Some of us came here when COVID had already started…so we already knew about the COVID regulations i.e. social distance, wash of hands regularly with soap. We also need to observe social distancing.'*** *(Female prisoner)*
>
> ***'I heard about COVID 19 in two or three forms; firstly, we heard from our Peer Educators who were trained by the medics and they have been coming to teach us about COVID.'*** *(Male prisoner)*
>
> ***'…we heard and watched from TVs and radios about COVID 19. Every cell that is big in here has a TV, and sometimes people buy their own and install.'*** *(Male prisoner)*

However, some prisoners indicated they were not formally informed about COVID-19 and relevant public health guidance, but instead learnt about the disease from prison authorities during lockdown, and through the prison grapevine:

> ***'We weren't given enough information about the disease, we just heard rumours from here and there but were not gathered and told. We just heard that there is COVID 19 out there and the prison was closed and we were not able to meet or see our relatives.'*** *(Male prisoner)*

Both prisoners and prison officials reported that communications around COVID-19 health guidance were difficult to implement in the prison. Access to different media and channels of information such as television, radios, newspapers and public address systems, whilst available, were restricted. This was further compounded by the continued turnover of prisoners, resulting in a limited dispersal of information. One prison health professional reiterated that:

> ***'…having access to mediums that help one access information is quite restrictive in prisons. People do not really have access to radios, TVs in prison. If accessible, the resources are very few. However, when we look at the outside communities, we know that they have such access through so many ways such as "loud car news" circulation or different kinds of stakeholder meetings. We do not get to experience the same in the prison community and when we do, it is infrequent as well.'*** *(Key informant Prison health professional)*

Prison congestion and the impossibility of social distancing

Triangulated data illustrated the serious shortage of accommodation and capacity to house the prison population and to work in a safe occupational environment. In-house spaces occupied by both prisoners and prison wardens were described during FGDs as ***'congested'.*** Prison wardens described their own difficulties in adhering to COVID-19 guidelines, particularly around the sharing of office space. Congested offices were not conducive to social distancing. It became apparent during FGDs that up to 19 prison wardens occupy one office preventing their capacity to keep a safe space between individuals and increasing concerns regarding transmission; one warden explained how:

> ***'…we could be a group of 19 people in one office therefore we can't practice social distance. Generally, it's very much congested here which can lead to easy transmission of COVID 19.'*** *(Prison warden)*

Both male and female cells were severely congested, holding numbers beyond their official capacity. Large cells were observed to hold approximately 200 prisoners, smaller ones holding 60. The two cells in the female section were observed to be congested as well, with 30 prisoners including children occupying each cell (seven bunkbeds, with three in a bed, others on the floor). During FGDs, male prisoners demonstrated the physical sleeping arrangements at night (sleeping back-to-back while facing the person in front, or sleeping on their sides, side-by-side, with legs and heads in the opposite directions). Participants described the distance between people in the cells as ***'zero centimetres'*** indicating how compact the cells are at night. Several prisoners reiterated this concern stating:

> ***'…we are overcrowded at where we sit and sleep in prison cells hence they say that we should wear masks and observe social distance but that's not practiced in here.'*** *(Male prisoner)*

'We sleep 0cms, the place is very compacted and has no space. Sometimes we sleep very tightly and seated.' *(Male prisoner)*

'God loves people who are in prison because if people outside could sleep like this a lot of them could have died.' *(Male prisoner)*

This severe congestion at night was both observed and experienced by many with conditions not conducive to public health COVID-19 guidance, which requires safe distancing from others, frequent hand sanitisation and the wearing of face masks. Prisoners recognised how unachievable this advice is despite being ***'told to be washing hands regularly, we should be hygienic but because we are crowded…we sleep very close to each other…so that's why it is difficult to observe those regulations.'*** *(Male prisoner).*

Many prisoners, particularly women, were concerned about the intake of remand detainees and the bridge of disease transmission between community and prison via the mixing with those already serving sentences ***'…sleeping here is a challenge because we are crowded and moreover, we don't know the behaviours of other prisoners who were outside.'*** *(Female prisoner)*

Lack of adequate ventilation, hygiene and sanitation

Triangulated data revealed severe deficits in provision of adequate ventilation, hygiene and sanitation. Many prisoners described ***'poor living conditions'*** in the prison and that survival from COVID-19 was by the ***'mercy of God'.*** Ventilation in cells was described as ***'poor'*** and exacerbated by severe congestion, with the placement of windows high up on the walls. The windows in the cells were described as ***'small'*** or ***'holes up there in the roof'***. One female prisoner noted that although ***'the windows are there but because we are crowded, it doesn't work. The holes that are up there on the roof…were blocked by wires…we just receive air flow from the windows that's all.'*** *(Female prisoner)*. Officials supported this claim saying ***'…most of the prisons facilities have no big windows only small windows that are placed high up in the cells and because of congestion in the cells there is no good ventilation'*** *(Key informant #3)*

Qualitative data further supported the site observations presented in Table 2 and revealed serious malfunction of ablution facilities (taps and toilets), with conditions deemed unhygienic and conducive to the spread of disease. This was echoed by both prisoner and official participants:

'It's true that that there is not much care here in prison because our toilets are not clean, there is no waste management, and our bathrooms are in worst conditions.' *(Male prisoner)*

'We only have one toilet in each cell and some toilets cannot flush anymore, they are broken therefore you have to keep water at night to use it for flushing once you have used the toilet otherwise it becomes a disaster.' *(Key informant #2).*

In the female section, a total of five taps were observed during site visits, with three around the compound, one in the bathroom and kitchen (respectively). However, the bathroom tap was not

functional. In the male section, out of the 26 taps observed, only eight had running water and no soap was available. One male prisoner described the defective logistics of this as ***'each and every cell section has four cells and in one cell about 180, 160 prisoners, they all use one water tap in that section.'*** *(Male prisoner).*

While the prison had received a donation of one bucket per cell at the outset of the COVID-19 pandemic, these were currently broken and inoperable or missing. There were no handwashing buckets on the compounds of the prison. Only two buckets with running water and soap were observed, at the main entrance to the prison and visitors waiting area and were only accessible to prison staff and visitors. This was the case in both female and male wings. Handwashing soap was not available at all handwashing facilities. Prisoners reported receiving a half tablet of *U-fresh* soap, once a week during the first COVID-19 wave, which was put next to handwashing buckets. However, they observed that this provision had ceased a ***'long time ago'.*** No hand sanitisers were observed at the waiting area, prison compound or cells. A female prisoner observed ***'first of all, the challenges we face here in prison are numerous, lack of soap…the basic needs for a human being are not there.'*** *(Female prisoner)*

Provisions and correct use of PPE

Triangulated data revealed a consensus that the provision and supply of PPE was not adequate for prisoners. During FGDs, both female and male prisoners reported that the Malawi prison system does not provide them with face masks. PPE is donated by local and international non-governmental organisations, civil society, local hospitals and faith-based organisations. One female prisoner noted '***well-wishers [mentions an NGO] brought them [PPE] at the beginning. Secondly, we received from the hospital.***' (Female prisoner). However, donations were prominent during the onset of COVID 19, but, later decreased due to the economic situation in Malawi. A prisoner highlighted the discrepancy between the provided health guidance and the ability to apply these personal protective measures:

> ***'The authorities do give us the information but we do not have the necessary tools [PPE] to use according to the information we are given. They just give us words and off they go. So for us here in prison where are we going to get those tools? We end up staying like that(.) coughing on each other, sharing blankets.'*** *(Female prisoner).*

Observational data revealed a minority of prisoners in the prison compound wearing masks, with many female prisoners not appearing to know how to wear the mask correctly (covering the nose). Prisoners stated that they were never taught how to put the masks on and learned from listening to the radio. Most prison wardens and officers were observed wearing no face mask. FGDs revealed that whilst the Malawi prison system provided face masks and soap to staff, provisions were deemed insufficient. Staff were unable to protect themselves from COVID-19 and both prison wardens and prison officers described using personal funds to procure their own PPE. In contrast, prison health professionals at the clinic observed receiving adequate PPE through Blantyre District Health Office.

MESO-MACRO level interplay between the prison community and policy impacts

Medical system COVID-19 response, infrastructure and access to healthcare

There was consensus across key informants that the general policy and health directorate response to the COVID-19 outbreak in the prison system, whilst well intended and driven by the State, was reactive and sub-optimal when applied and lacked a definitive sustainable strategy for future disease outbreaks. One key informant explains:

> ***'…the Ministry of Health had to organize a number of prison visits so that prisoners are attended to. The testing part of the prisoners was done by the Ministry of Health and even the civic awareness was done by the health personnel and some health personnel would come and organize training sessions for the prison officers as well as for prisoners so that they become conversant with the preventative measures against COVID-19.'*** *(Key informant #3)*

Because of the lack of a systematic approach, the COVID 19 response in prisons was characterised by key informants as ***'fumbling'*** and ***'reactive'*** across the three waves. One key informant described the response as ***'superficial'***, as resources were not directed at ***'systems strengthening'*** to respond to COVID 19 in a robust manner. The inadequacy, as observed by other key informants, was not the lack of resources for a COVID 19 prison response, but rather ***'misallocation',*** and ***'mis-prioritising'***:

> ***'I would say it is the speed and the time that the interventions were taken in not a timely way. I think it was a bit superficial in the sense that we did not do much in the terms of systems strengthening. So a lot of support and money came in but it did not help us to actually improve on our local infrastructure and the system in general so that we are better prepared to actually manage a similar kind of outbreak in future. I wish that there was a deliberate effort to make sure that a certain portion of the resources and support was actually put aside to strengthen the system so that we should do better next time. …during the first wave, there was a lot of fumbling in terms of the response. After the cases had actually declined and no one was actually looking into the system again and no one was actually looking into the resources. With the second wave, we were panicking again and in the third wave, now we are panicking again.'*** *(Key informant #2)*

During interviews, some key informants observed that the medical response to COVID-19 across the Malawi prison system was compromised by under resourced clinics, both financially, medically and in terms of human resources. The use of unqualified health personnel and insufficient medicine supply was a recurrent observation. A key informant said:

> ***'….. it's not all prison facilities that have clinics and even if we have clinics, you find that qualified health personnel are not enough. As a result, in some facilities, we find ourselves using un-qualified health personnel. This obviously shows a deficiency. And also when you look at availability of drugs, at times, departmental prisons may not have enough of these or not have enough funds to procure the necessary drugs. In terms of***

drug stock, we may really not compare ourselves to the clinics on the outside.' *(Key informant #1)*

Many observed that the rights of prisoners to equivalence of care to that in the community was not yet achieved:

'… the health care services in the prisons are not as robust and well established like that of public health care system that we have out here. In terms of capacity, infrastructure, human resources, even material resources, drugs, medical supplies are not at par.' *(Key informant #2)*

The reliance on non-governmental and faith-based organizations to backfill the government response was observed across FGDs and interviews with key informants:

'…even those religious organizations, churches, Muslim communities they came with a number of donations, in particular PPEs to support the prisoner population and that again was a very good response to the prison setting.' *(Key Informant #3)*

COVID-19 detection and quarantine measures

FGDs and interviews with key informants revealed that rapid COVID-19 testing, or mass screening is/was not a standard or a norm at the selected large prison complex. COVID-19 testing on request was not operationalised. Mass screening occurred at certain times in response to fears of an outbreak. One male prisoner observed:

'The only time we are tested is when they come to test us all and when there is a rumour that the cases have escalated outside there. We don't have the right to get tested whenever we feel not alright.' *(Male Prisoner)*

Likewise, turn-around for COVID-19 test results was reported to be two weeks with no segregation of prisoners during this time:

'They may test an prisoner today and bring the results two weeks later then they isolate him yet he has been sleeping with us in that crowded cell the whole time which is contrary to what the measures indicates.' *(Male Prisoner)*

There was strong consensus across FGDs and interview data that both prisoners and prison wardens complained and feared that remand detainees are a potential source of infection to the prison and they were neither isolated nor screened for COVID-19. Many were concerned about the threat posed by the ever-moving prison population and said:

'It has become very dangerous for us because the police are still arresting people every day and are bringing them to prison for remand and are putting them in the cell with us without knowing whether they are covid positive or not, we don't know and we are not isolated from them.' *(Male Prisoner)*

Only one key informant was aware of the prison policy specifying that remand detainees be isolated for 14 days, tested for COVID -19 then released to the general prison population. However, it was observed that in practice, this was impossible to implement due to the high influx of remand detainees and inadequate accommodation for isolation purposes. Remand detainees or convicted new prisoners were mixed with existing prison populations in both male and female wings without COVID 19 screening or testing. During the end of one site visit, approximately 15 people were observed coming in on remand. A key informant illustrated the challenges in applying the policy:

> ***'we cannot regulate the reception of newcomers ...it was also difficult for us to observe the 14 days observatory period because the minimum requirement is that a person has to be tested after 14 days and if the results come out negative, the person has to be brought to the general population. That was difficult because in normal circumstance we were supposed to have about 14 cells where the first day the person has to be in the first cell and the next day in the next cell up to the 14th day and that was not practically possible because maybe our holding facility only have about 3 cells then it means that some people for 5 days they were just being joined together and that for us to properly separate the duration of stay was so difficult.'*** *(Key informant #3)*

Different policies were applied to male and female prisoners when a COVID-19 infection was detected. COVID-19 positive female prisoners remained at the selected large prison complex. All who were negative were transferred to other prisons such as Zomba, Mulanje and Chikwawa. A prison warden explained the process ***'those who have been infected with COVID are isolated. They remain here and the rest who have tested negative are transferred to other prisons such as Zomba, Mulanje and Chikwawa.*** *(Prison Warden).* In contrast, during suspected outbreaks COVID-19 positive male prisoners were isolated in a spacious upstairs building within the prison premises. During initial low case numbers, males were isolated in a smaller cell on site in the juvenile section. Repurposed isolation spaces were reported to be congested at certain times. For those testing positive, quarantine measures were deemed good, with sufficient isolation space. This was reported by both prisoners and staff:

> ***'For us who were found positive we were isolated and given a good place for quarantine purposes. We were placed at the new building called "upstairs" and were sleeping very far from each other.'*** *(Male Prisoner)*
>
> ***At the males side, they are isolated somewhere right there. There were seven people who tested positive. Once we got tested and got the results we got transferred the same day.'*** *(Prison Warden)*

Prisoner access to the outside world

The judicial response to the pandemic focussed on decongesting prisons. One key informant explained that:

> ***'…in early 2020 they conducted a number of camp courts in order to release some prisoners and they were granting a lot of bails to most prisoners who were on remand as a way of mitigating congestion in prisons …those institutions which deal with the release of prisoners have done a commendable job because the number of prisoners who were released [Presidential Pardons] in 2020 exceeded 6000 and that was not a mere intervention.'*** *(Key informant #3)*

The impact of prison lockdown during State disaster measures was discussed in FGDs and key informant interviews. There was strong consensus among prisoners, prison officers and key informants that, despite access restrictions, the prisoner's right to access legal representation and medical care during this time was upheld by the Malawi Prison System. Key informants reported that:

> ***'Legal representation is still around…there was no restriction. No prisoners can claim that during this period prison staff stopped my lawyer from coming to me because we ensured that legal representation right must not be infringed upon...anyone who needed a lawyer or legal representation was allowed to come as long as the lawyer observes the COVID-19 preventative measures.'*** *(Key informant #3)*
>
> **'*Yeah to their families there is that restriction but legal representation, visit by…medical practitioner that is allowed.*'** (Key informant #1).

However, the majority of prisoners indicated the senselessness of this policy, in light of the influx of remand detainees into the prison, who were not screened for COVID-19 and were housed in mixed accommodation with the sentenced prison population. Of great concern was that the policy of restricting access to the prison during state disaster measures was cutting a vital supply of necessities such as food, soap, medicines and clothing to prisoners and, in many instances, heightened the risk of basic hunger, severe malnutrition and illness:

> ***'As a country we never had a lockdown but as a department we imposed some restrictions. We stopped relational visits to prisons. We had two reasons for doing that: (i) our prisons had already started registering COVID cases within the prison community and our view was that it was very easy for the people outside to get the virus from the prisons (ii) some prisons where there were no cases it was also going to be easy for them to get COVID-19 from the visitors because we didn't have a proper mechanism to check if the person was positive or negative. This is because a requirement of testing was that after testing we send the samples elsewhere and we get the results and by that process a person could not be waiting for the results so that he/she has to come in prison. So because of that lengthy process we just thought it is best to limit visits from prisons so that we prevent prisons from getting the COVID-19 virus from the community…..'*** *(Key informant #3)*

Discussion

At the time of writing, Malawi had reported 61,517 COVID active cases, 2,278 deaths and 54,668 recoveries (Worldometer COVID-19 Data, 2021). We present here the first attempt to illustrate individual, community and policy level experiences and impacts of COVID-19 during state disaster measures and the State requisite disease mitigation response in the Malawi prison system. This study builds on the growing interest in sub-Saharan African prison responses to COVID-19, including situation assessments and legal realist assessments (Van Hout and Wessels, 2021; Mekonnen *et al.,* 2021; Mhlanga-Gunda *et al.,* 2021). It acknowledges the importance of consulting with a range of stakeholders spanning the prison ecosystem to better understand the interplay of individual, community (prisoner, staff, family) and policy level factors at play. Whilst strengths of this situation assessment lie in the depth of consultation and triangulation of data across stakeholders and data sources, limitations centre on its small scale '*one prison complex'* approach. Findings may not be generalisable to all prisons in Malawi. Despite this, we have attempted to provide a thick description of the factors at play in the prison ecosystem during COVID-19, so that results can be transferable to similar settings or contexts in sub-Saharan Africa.

The Malawi prison system's COVID-19 approach was aligned to international non-binding technical guidance (WHO, 2020b; WHO, 2020c; UNODC, 2020; PRI, 2020, DIGNITY, 2020) and the SADC protocols (2020) and was relatively successful in preventing a catastrophe of contagion within the selected large prison complex itself. Whilst prison settings were included in the second domestic COVID-19 response plan within the Law Enforcement cluster (National COVID-19 preparedness and response plan, July-December 2020), they were initially not included in the K157 billion (USD 210 million) COVID-19 fund. Operationalisation of the response was compounded by an ad hoc reactive approach, lacking direction cognisant of future outbreaks and severely hampered by historical resource and infrastructural deficits (congestion, lack of ventilation, hygiene and sanitation). Similar findings have been reported elsewhere in the sub-Saharan African region, in terms of the COVID-19 prison system response relating to insufficient provision of PPE, cell capacity issues inhibiting social distancing, segregation of remand detainees, medical quarantine and the overall monitoring of COVID-19 incidence (Van Hout, 2020c; Amnesty International, 2020a;b; Muntingh, 2020; Chireh, and Essien, 2020; Van Hout and Wessels, 2021; Katey *et al.,*, 2021; Mukenwa *et al.,* 2021; Nweze *et al.,* 2021). COVID-19 testing was not on demand and results were not timely. Prisoners were not supplied with sufficient face masks, hand sanitiser and soap and staff were equally disadvantaged and neglected in system resourcing. As reported elsewhere (South Africa, Zimbabwe, Sierra Leone) failures in the supply of fresh water and severe congestion, particularly at night where prisoners lie side by side, (Van Hout and Wessels, 2021; Mhlanga-Gunda *et al.,* 2021; Saalim *et al.,* 2021), negated public health communications and physical efforts to protect against COVID-19. As in other African countries (Muntingh, 2020), during State disaster measures, the role of civil society and faith based organisations

continue to backfill government responses in terms of supporting basic needs in the provision of soap, detergent, food, bedding and PPE.

Overall, COVID-19 has amplified the need to address the colonial infrastructure of Malawi prisons, particularly environmental conditions, which continue to constitute a threat to health to those living and working in the prison, their accommodation and working spaces and levels of medical service provisions (staffing, medicines supply). Whilst the Malawi system is to be applauded for instigating prison release schemes and amnesties during state disaster measures, there are concerns around the continued intake of remand detainees and the inability of prison staff to screen them for COVID-19 and segregate them prior to mixing with the general prison population. The bridge of disease transmission between prison and community is of grave concern in many sub-Saharan African countries, including Malawi (Van Hout, 2020a; Van Hout, 2020b). As elsewhere in sub-Saharan Africa, the processes of COVID-19 awareness raising (including correct PPE etiquette), to ensuring social distancing and that all who live and work in the prison have sufficient PPE warrants improvement and enhanced support (Katey *et al.,* 2021; Van Hout and Wessels, 2021; Mhlanga-Gunda *et al.,* 2021). There are also observed human rights breaches and concerns around the transfer of women to remote rural prisons, far removed from family and legal supports when COVID-19 cases are detected in their wing (Van Hout, 2020c).

The Malawi Prison system can leverage the COVID-19 situation and lessons learnt during State disaster measures to build on their considerable progress to date in the mitigation of other communicable diseases (HIV and TB). There has been progress built on commendable efforts to employ active case finding, detect, monitor and mitigate disease among staff and those detained in the Malawian prison system (mainly Chichiri and Zomba prisons), particularly HIV and TB, provide treatment and care, whilst navigating the challenges of insufficient financial and human resources as well as the overcrowded unsanitary conditions of detention and fragmented referral systems (Kachisi *et al.,* 2002; Harries *et al.,* 2004; National Tuberculosis Programme, Ministry of Health, 2007; Chimphambano *et al.,* 2007 ; Makombe *et al.,* 2007; Kanyerere *et al.,* 2012; Tuberculosis Control Programme, Ministry of Health, 2014; Mpawa *et al.,*, 2017; Singano *et al.,* 2020; Gondwe *et al.,* 2021). COVID-19 should be no different.

The study overall yields several recommendations for consideration by the Malawian government, which uphold the human and health rights of staff and prisoners and are in alignment with international non-binding technical guidance (WHO, 2020b; WHO, 2020c; UNODC, 2020; PRI, 2020; DIGNITY, 2020) and the SADC protocols (2020). Firstly, the Ministry of Homeland Security should coordinate the COVID -19 response and bring together key stakeholders such as the MoH, Judiciary, local and international non-governmental and religious organisations to realign COVID -19 mitigation measures within a revised prison strategy, policies and practice to prevent unnecessary duplication. Secondly, the Prison Management, in collaboration with local and international non-governmental and religious organisations must lead an intensive and sustained COVID-19 awareness raising campaign on COVID-19 preventative measures in prison particularly regarding face mask etiquette, frequent

handwashing with soap, not touching mouth and eyes. This approach must go hand-in-hand with availability of PPE for all staff and prisoners. At the operational levels, preventative measures warrant sufficient resourcing by government and should include sufficient coverage of handwashing stations, functional taps and toilets and screening of all on entry to the prison using lateral flow testing. Thirdly, to decongest prisons, the prison management should work together with the judiciary and their line ministry to enact and sustain policies and practice. This will necessitate speedy disposal of minor cases, reducing the flow of committals via alternative sentencing of minor offences and relaxed bail conditions, the release of the elderly, women with children and those with chronic illness and greater support for the camp court system. Prison management must lobby the line ministry, local and international partners to expand prison accommodation to ensure sufficient space and ultimately improve the living conditions of prisoners and occupational health standards for those working in the prison.

Conclusion

The project was undertaken during a time of great threat to health systems and prisons in the sub-Saharan Africa region. Prison health is a neglected political issue in Africa due to the continued prioritisation of prison security amid calls for advocacy for prisoner health and broad-based torture prevention initiatives (O'Grady, 2011; Jefferson and Jalloh, 2019). Research on prison health is also under developed in many countries in the region, as well as prison health surveillance (Mhlanga-Gunda *et al.,,* 2020; Van Hout and Wessels, 2021). This situation assessment builds on human rights based commentaries and similar efforts to consult with stakeholders during COVID-19 in Ethiopia, Zimbabwe and South Africa (Van Hout, 2020a; Van Hout, 2020b; Van Hout, 2020c; Van Hout, 2020d; Amon, 2020; Muntingh, 2020; Chireh, and Essien, 2020; Van Hout and Wessels, 2021; Katey *et al.,*, 2021; Mukenwa *et al.,* 2021; Nweze *et al.,* 2021; Mekonnen *et al.,* 2021; Mhlanga-Gunda *et al.,* 2021). An encouraging note is that Malawi is now implementing a COVID-19 vaccine programme having received doses from COVAX and other sources, with prison wardens and prisoners included as priority groups (Reliefweb, 2021).

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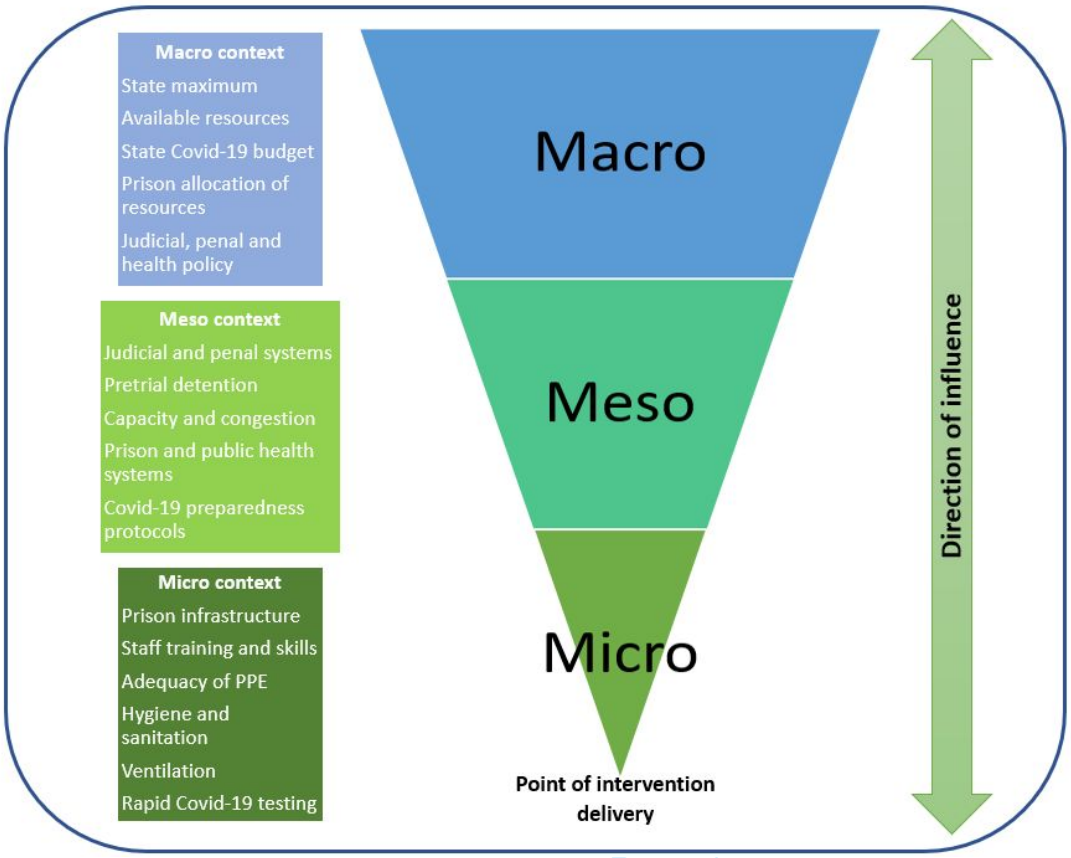
Figure

Figure 1. COVID-19 and the prison ecosystem



Tables

Table 1: Data Collection Events		
Participant Category (*n = number of participants*)	**Data Collection Event Type**	**Number of Events**
Female prisoners (*24*)	Focus Group Discussion	2
Male prisoners (*24*)	Focus Group Discussion	2
Prison wardens (*24*)	Focus Group Discussion	2
Prison health personnel (*4*)	In-Depth Interview	4
Senior prison staff (*5*)	In-Depth Interview	5
Penal and judicial policy makers (*2*)	In-Depth Interview	2
Other stakeholders (MoH, Civil society etc) (*3*)	In-Depth Interview	3
Prison site visits (*NA*)	Observations	9

Table 2. Observational Data of COVID-19 disease control measures in both male and female prisons

Checklist Item	Prison	Comment following Observation
Water taps (CHECK if working)	Male	All areas, including outside cells were checked. A total of 26 taps were found. Out of the 26 observed, when checked, only 8 were functional and had running water. There was no soap for handwashing.
	Female	Five taps were found (three outside, one in the kitchen and one in the bathroom) all were functioning apart from the one in the bathroom.
Other handwashing facilities (CHECK for example buckets, is there water?)	Male	Only two buckets with running water and soap were observed at the main entrance to the prison and visitors waiting area. Handwashing facilities were only accessible to visitors and prison officers. Apart from taps, there were no buckets or soap available in the cells or around the prison compound for prisoners. Prisoners and prison wardens reported that during the first wave of COVID-19, the prison received a donation of one bucket per cell, but since then, some are missing and some broke.
	Female	During the first COVID-19 wave, four handwashing buckets were provided. Two in the warden's offices and one buckets per cell. In total, they were provided with four buckets, however, these were broken and no longer available.
Availability of soap at hand washing facilities (CHECK)	Male	While prisoners reported only receiving half a bar of *U-fresh* soap once a week to put near the buckets they received. There was soap next to the two buckets at the entrance and visitors waiting bay.
	Female	Handwashing soap was not available at all handwashing facilities. Women used to receive half a bar of *U-fresh* soap once a week, but supplies are no longer available.
Presence of hand sanitizer-points. (CHECK presence of hand-sanitizer)	Male	There were two bottles in the visitor and remand office. However, prisoners have never had access to any type of hand sanitizers.
	Female	None were observed, it was reported that these were never received.
Number of people wearing face masks (CHECK they are worn correctly)	Male	Most people did not wear masks around the prison and in the cells. Only a few prisoners were observed within the prison compound wearing masks. Only four out of 12 persons observed came to the FGD wearing a mask. However, they were worn correctly covering nose and mouth. Prisoners reported that wearing face masks was pointless due to their sleeping arrangements in overcrowded cells. Most prison wardens and officers were observed with no face mask on.
	Female	When observed in the prison, and during the FGD all prisoners wore a face mask, but some did not know how to put the mask on correctly (not covering up their nose area). Prisoners stated that they were never taught how to put on the masks, they learned from listening to the radio. Most of the prison wardens were not wearing masks.

Number of people/cell (ASK)	Male	The size of cells was observed, and a question asked around the number of people who sleep in each cell. Overall, there are 24 cells in the male section. It was reported that larger cells contain 200 prisoners, with smaller ones containing 60 . Cell spaces were by far smaller compared to reported number of prisoners accommodated.
	Female	Only two cells were available to house women. There are about 30 people in each cell including children. They also had 7 bunk beds with 3 people sleeping on each bed. Women prisoners described their sleeping space as “congested”.
Presence of isolation center for COVID 19 cases (CHECK/ASK)	Male	It was observed and reported that there was no specific space to isolate male detainees who are COVID-19 positive. Space is re-purposed. COVID-19 positive male prisoners are either transferred to the old juvenile section cells or transferred to a new prison building which has bigger rooms with the capacity for self-isolation and social distancing. However, these repurposed isolation spaces were reported to be congested at certain times. During the end of one observation session, about 15 people were observed coming in on remand. It was further reported that those on remand are mixed with convicted prisoners.
	Female	There is no COVID-19 isolation space for female patients. COVID-19 positive individuals were left at the prison whilst the uninfected women were removed and transferred to other prisons such as Chikwawa, Mulanje, Zomba.

Title: A multi-stakeholder situation assessment of COVID-19 disease preparedness and mitigation measures in a large prison complex in Malawi.

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