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A legal-realist assessment of human rights, right to health and standards of healthcare in the Malawian prison system during COVID-19 state disaster measures.

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Abstract

Purpose: The first case of COVID-19 in the Malawi prison system was reported in July 2020. Human rights organisations raised concerns about the possibility of significant COVID-19 outbreaks and deaths in the prison system, due to the poor infrastructure, lack of health care and adequate COVID-19 mitigation measures, existing co-morbidities (tuberculosis, HIV, hepatitis C), malnutrition and poor health of many prisoners.

Design/methodology/approach: We conducted a legal-realist assessment of the Malawian prison system response to COVID-19 during state disaster measures, with a specific focus on the right to health and standards of health care as mandated in international, African and domestic law.

Findings: The Malawi prison system was relatively successful in preventing serious COVID-19 outbreaks in its prisons, despite the lack of resources and the *ad hoc* reactive approach adopted. Whilst the Malawi national COVID plan was aligned to international and regional protocols, the combination of infrastructural deficits (clinical staff, medical provisions) and poor conditions of detention (congestion, lack of ventilation, hygiene and sanitation) were conducive to poor health and the spread of communicable disease. The state of disaster declared by the Malawi government and visitation restrictions at prisons worsened prison conditions for those working and living there.

Originality: In sub-Saharan Africa, there is limited capacity of prisons to adequately respond to COVID-19. This is the first legal-realist assessment of the Malawian prison system approach to tackling COVID-19, and it contributes to a growing evidence of human rights-based investigations into COVID-19 responses in African prisons (Ethiopia, South Africa, Zimbabwe).

Key Words

Malawi, COVID-19, infectious disease; human rights, minimum standards of detention

Background

On March 11th 2020, the World Health Organization (WHO) declared that COVID-19 constituted a pandemic (WHO, 2020a). Prisons are high risk environments for communicable disease and experienced a range of challenges during the pandemic (Kinner et al. 2020; Barnert et al. 2020). Prisoners with chronic ill health and those living in congested prisons were especially at risk of severe COVID-19 disease (Beaudry et al. 2020). Efforts to decongest prisons via presidential pardons, amnesties and emergency/early release schemes have formed the basis of the COVID-19 response in prisons and other closed settings (OHCHR, 2020; UNODC et al. 2020; Simpson and Butler, 2020; Lines et al. 2020; Amon, 2020). A range of technical guidance on COVID-19 mitigation measures and human rights assurances in prisons were promulgated by the United Nations Office on Drugs and Crime (UNODC), WHO and Penal Reform International (WHO, 2020b; WHO, 2020c; UNODC, 2020; PRI, 2020). Collectively these documents advised that States should take all prevention, detection and treatment measures to address the risks and threat to health presented by COVID-19, by limiting contamination, detecting ill prisoners and staff and providing medical treatment to those infected. They further mandated that detention conditions should not contribute to the development, worsening or transmission of disease, and COVID-19 measures may not result in inhumane or degrading treatment of prisoners; any restrictions may only be implemented on grounds of medical necessity and in compliance with the human rights principles of legality, proportionality, oversight, time-limitation, and non-discrimination; and prison monitoring bodies' must be guaranteed access to prisons.

COVID-19 posed an enormous threat to the health and lives of those living and working in African prisons (Amon, 2020; Bulled and Singer, 2020; Kras and Fitz; 2020; Rapisarda et al. 2020; Nkengasong and Mankoula, 2020; Muntingh, 2020; Van Hout, 2020a; Van Hout, 2020b; Van Hout, 2020c; Van Hout, 2020d; Badu et al. 2020; Chireh, and Kwaku Essien, 2020; Nweze et al. 2020; Amnesty International, 2020; Lucero-Prisno, 2020; Van Hout and Wessels, 2021; Katey et al. 2021). Over one million people are incarcerated in Africa, where prisons are characterised by high rates of pre-trial detention (on average 42%) and severe prison congestion (World Prison Brief: Africa, 2020). By the end of May 2020, prison systems in Sierra Leone, Algeria, South Africa, Kenya, Cameroon, Ghana, Morocco, Democratic Republic of Congo, Egypt, and Guinea confirmed cases of COVID-19 among staff and prisoners (Prison Insider: Africa, 2020). Despite the African Commission on Human and Peoples' Rights' (ACoHPR) promulgation of effective human rights-based responses to COVID-19, including in prisons (ACoHPR, 2020a; ACoHPR, 2020b), efforts to tackle COVID-19 were obstructed by ill-resourced prison systems, poor infrastructure and basic detention conditions, insufficient healthcare and lack of prison based COVID-19 disease surveillance data and the continued intake of remand detainees fuelling congestion (Muntingh, 2020; Nweze et al. 2020; Van Hout, 2020c; Kras and Fitz, 2020; Mukwenha et al. 2021; Van Hout and Wessels, 2021; Katey et al. 2021; Mekonnen et al. 2021).

The limited capacity of prisons to adequately respond to COVID-19 was highlighted in open letters by human rights organisations to the Southern Africa Development Community (SADC) (SADC, 2020). We report here from Malawi, which was classified as one of the top ten most vulnerable African countries to respond to COVID-19 (Surgo Foundation, 2020). Malawi has been severely challenged by COVID-19 due to its economic and political situation and by its stretched health system (Patel et al. 2020; Sonenthal et al. 2020). The National COVID-19 Preparedness and Response Plan was launched with a budget of $28 million in March 2020. The first COVID-19 cases were notified on April 2nd 2020 (Ministry of Health, 2020; Patel, 2020; United Nations, 2020; Mzumara, 2021). Despite having a population of over 18 million, the Malawi health system only had 25 intensive care beds and seven respirators in April 2020 (Vidal, 2020). At the time of writing in early 2022, Malawi has reported 85,033 COVID active cases, 2,598 deaths and 72,867 recoveries (Worldometer COVID-19 Data, 2022).

In order to assess the Malawian prison system response to COVID-19 during state disaster measures, we conducted a legal-realist assessment of the situation with a specific focus on the right to health, disease mitigation and access of healthcare and the extent to which minimum State obligations complied with human rights standards (including prevention, detection and treatment of disease, right to safe working conditions, right to access of legal representation and families during visitation restrictions, and equivalence of healthcare provisions) under international, African and domestic law. The developed realist account is underpinned by legal realism as naturalistic theory due to its emphasis on the rule of law as derived from real world observations regarding welfare, social interest and public policies (Leiter, 2015). We critically assess whether, and to what extent, Malawi complied with humane standards of care of prisoners and whether minimum standards of care, particularly healthcare in its broadest sense, were upheld during contagion and the application of state disaster measures. All relevant international, African and domestic protections and rights assurance mechanisms respecting the human rights of prisoners and minimum standards of care are presented and then scrutinised in light of existing and historical human and health rights assurances, policies and system operations in the Malawi prison system, together with the extant scholarship published following the first COVID-19 case notification in the Malawi prison system (media, grey and academic literature).

International and continental human rights frameworks pertinent to right to health, health care and mitigation of disease in prisons

A range of positive obligations exist concerning prisoner and prison staff rights, which include the right to health, protection from disease and assurance of access and provision of all required medical support and care during illness under the international treaties. These include International Covenant on Economic, Social and Cultural Rights (ICESR) *Article* 12(1) and 12(2) (UN, 1966a) and the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR) *General Comment No. 14* (UN CESCR, 2000). *Article* 12 ICESR provides for the comprehensive right of every individual to the *'enjoyment of the highest attainable standard of physical and mental health.'* According to the *General*

Comment 14 CESRC States are (at the very least) required to meet a threshold of a '*core minimum'* of social and economic rights, including the right to health. Prisoners are entitled to the same *'core minimum'* health rights as other citizens. *Article* 12(1) is applicable to the right to healthcare when deprived of liberty, including during the COVID-19 health emergency, and it obliges States to take necessary measures for '*the prevention, treatment and control of epidemic, endemic, occupational and other diseases'* and *'the creation of conditions, which would assure to all medical service and medical attention in the event of sickness.*'

Further, whilst the International Covenant on Civil and Political Rights (ICCPR) (UN, 1966b) 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) (UN, 2012). *Article* 6 ICCPR states that '*every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.' Article 10* provides '*that all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'.* Another layer of rights protection is provided by the Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT) (UN, 1984) and the CAT-Optional Protocol (UN, 2003), which create binding obligations on States not to ill-treat those deprived of their liberty. The UN Human Rights Committee (HRC) has stated 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). Concluding observations by the Committee reflect the binding State obligation to *'take action to safeguard the health of prisoners*'. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) recognises that '*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 pertinent in the context of communicable disease outbreaks within prison confines.

Jurisprudence at the UN Human Rights level has referred to State failures to adopt and implement adequate disease mitigation measures in prisons (airborne tuberculosis for example) resulting in a threat to health in violation of the ICCPR (*Articles* 6, 7, 9 and 10) and within the scope of inhuman or degrading treatment. The HRC recognises the right to medical care in addition to other pre-conditions of health including sanitation, hygiene, ventilation and the provision of adequate living space. This is especially pertinent given the severe congestion encountered in many African prisons. The HRC (2019) in its *General Comment No 36 on the Right to Life* states that *'States parties also have a heightened duty of care to take any necessary measures to protect the lives of individuals deprived of their liberty by the state, ...states parties assume responsibility to care for their lives and bodily integrity, and they* ***may not rely on lack of financial resources*** *or other logistical problems to reduce this responsibility. The duty to protect the life of all detained individuals includes providing them with the necessary medical care and appropriate regular monitoring of their health'.*

States however, have discretion in defining humane treatment and the adequate medical care of prisoners (Lines, 2008). Malawi ratified the ICESCR (UN, 1966a) and ICCPR (UN, 1966b) in 1993,

and whilst it accepts individual complaints procedures under the Optional Protocol to the ICCPR (UN, 1966c), it does not accept individual complaints procedures under the Optional Protocol to the ICESCR (UN 2009). Whilst it ratified the CAT (UN, 1984) in 1996, it has not ratified the CAT-Optional Protocol (UN, 2003) and, therefore, does not accept individual complaints procedures under the CAT, *Article* 22. It does however accept the inquiry procedure for Malawi under the CAT, *Article* 20.

Medical declarations particular to the rights of prisoners regarding their health rights and medical ethics in detention settings include the WHO (WHO, 2003) and World Medical Association (WMA) (WMA, 2011) declarations, which provide for the rights of prisoners to humane treatment and appropriate medical care, including the State duty to prevent and treat disease. There is a non-derogation clause during State declaration of emergency contained in the UN Principles of Medical Ethics relevant to prisons (*Principles 1, 6*) (UN, 1982). The UN Standard Minimum Rules for the Treatment of Prisoners (*Mandela Rules*) (UN, 2016) covers States' responsibility for the physical and mental health of prisoners. *Rule* 1 states that: '*All prisoners shall be treated with the respect due to their inherent dignity and value as human beings and no prisoner shall be subjected to, and all prisoners shall be protected from, torture and other cruel, inhuman or degrading treatment or punishment, for which no circumstances whatsoever may be invoked as a justification'*. A range of *Mandela Rules* encompass aspects of the continuum of medical response to disease (prevention, detection, quarantine and care) and contain State provisions to provide prisoners with access to free, non-discriminatory and equivalent health-care. These include the right to receive qualified, consented and confidential medical care, protocols for medical isolation and treatment when suspected of having contagious diseases and a requirement that doctors or public health bodies should make regular inspections of hygiene, screening measures, quarantine processes and the physical conditions of the prison (*Rules* 24, 25, 27, 30, 31, 32, 35). *Rule* 13 is applicable to infectious disease and environmental determinants of health; it specifically states that: *'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 *Mandela Rules* are further supported by the non-discrimination provisions contained in the 2010 United Nations Rules for the treatment of women offenders (*The Bangkok Rules*) (UN, 2010).

With regard to the promotion and protection of human rights in the African continent, the African Charter on Human and Peoples' Rights (ACHPR) (OAU, 1981) recognises that State obligations regarding the right to health are '*heightened'* when an individual is in the custody of the State (*Article* 16) and every individual has *'the right to enjoy the best attainable state of physical and mental health'* 16(1). In addition, it instructs that *'State parties to the present Charter shall take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick' (16(2))*. It is supported by *Article* 4, which states that *'human beings are inviolable, every human being shall be entitled to respect for his life and the integrity of his person. No one may be arbitrarily deprived of this right.'* Two special mechanisms on prisons exist in Africa

(Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa, Committee for the Prevention of Torture in Africa). The *Robben Island Guidelines* (ACHPR, 2008) are aligned to the Basic Principles for the Treatment of Prisoners (UN, 1991) and the *Mandela Rules* (UN, 2016). The *Kampala* declaration on prison conditions in Africa further protects the rights of prisoners: '*prisoners should have living conditions that are compatible with human dignity, ...retain all rights that are not expressly taken away by the fact that they are in detention and the detrimental effects of prisons should be minimised so that prisoners do not lose their self-respect and sense of personal responsibility.'*

Jurisprudence at the African Court on Human and Peoples' Rights complements the ACHPR and refers to the right to life and prohibition of cruel, inhumane or degrading treatment, including health threatening conditions of detention (overcrowding, malnutrition, lack of clean water, space, sanitation and ventilation) (Muntingh, 2020). Decisions of the African Court on Human and Peoples Rights are binding on Member States of the African Charter. State parties are responsible for ensuring execution of judgements and, where a State fails to comply, its failure is noted on the Court report to the Assembly. There is however no definite way of dealing with those who fail to comply. States at times only comply due to external political influence or general political will by the State itself to execute the decisions of the Court. There are several cases that refer to Malawi, which is a Member State bound by such decisions.

Several African States have been 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). Denial of medical care is cited in addition to a ruling of inhumane or degrading treatment (*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). Recent cases pre COVID-19 have referred to health threatening conditions of detention *(Konaté v. Burkina Faso and Abubakari v. Tanzania* in 2016*; Guehi v. Tanzania* in 2018) and the rights of prisoners to adequate medical care and basic provisions to protect health (medication and appropriate nutrition for chronic ill health) (*Lohé lssa Konaté v. Burkina Faso* in 2013 *and Mugesera v. Rwanda* in 2017).

Standards of care (including health care) and fundamental rights assurances in the Malawi prison system

Rights relevant to the fundamental right to health of those deprived of their liberty are enshrined in the Constitution of Malawi, with *Section* 12(1)(d) of the Constitution of Malawi providing that '*the inherent dignity and worth of each human being requires that the state and all persons shall recognize and protect human rights and afford the fullest protection to the rights and views of all individuals, groups and minorities whether or not they are entitled to vote*.' *Section* 12(1)(e) provides that all persons have equal status before the law, with the only justifiable limitations to lawful rights being those necessary

to ensure peaceful human interaction in an open and democratic society. *Section* 19 prohibits any violation to the dignity of any person as well as any acts of torture and degrading treatment. *Section* 19(1) provides that every person has the right to life and no person shall be arbitrarily deprived of his or her life. *Section* 42(2)(1)(b) supports *Section 19* and states that: *'every person who is detained, including every sentenced prisoner, shall have the right-…to be detained under conditions consistent with human dignity, which shall include at least the provision of reading materials, adequate nutrition and medical treatment at the expense of the state.' Section* 169 provides for the constitutional rights of prisoners regarding provision of adequate nutrition, healthcare and medical treatment, and the monitoring of prison standards: *'administration and general functioning of penal institutions, taking due account applicable international standards.'*

The Malawi Health Sector Strategic Plan II of 2017-2022 incorporates a human rights-based approach and equity (3rd and 4th guiding principles) to health and access to healthcare in the country: '*All people of Malawi shall have the right to good health and equitable access to health services without any form of discrimination, whether it is ethnicity, gender, age, disability, religion, economic …or other status.'* The principles of national policy set out in *Section* 13 further aim to instil certain goals to ensure that the State shall actively promote the welfare and development of the people of Malawi. This includes: *'to achieve adequate nutrition for all in order to promote good health and self-sufficiency and to provide adequate health care, commensurate with the health needs of a Malawian society and international standards of health care.'* This includes prisons and other closed settings. *Section* 14 provides that these principles of national policy: '*shall be directory in nature but courts shall be entitled to have regard to them in interpreting and applying any of the provisions of this Constitution or of any law or in determining the validity of decisions of the executive.'* Such principles are relevant where rights violations require court intervention to ensure prisoners welfare. They are aligned to most international human rights instruments (the UN Charter, *Article* 10 ICCPR, ICESCR, *Article* 5 ACHPR) and the non-binding minimum rules, principles and guidelines (*Rule* 1 *Mandela Rules*, *Principle* 1 of the Body of Principles) with the right of all persons deprived of their liberty to be treated with respect for their inherent dignity and with humanity.

Part IV of the 1948 Public Health Act of Malawi provides for special provision regarding Ministerial declaration of certain formidable epidemic or endemic disease, powers for prevention and notice to local authorities (*Sections* 30, 31 and 32). The Public Health Act of 1948 is outdated (for example it still refers to smallpox) and does not reflect the contemporary needs of public health in Malawi. It warrants updating based on scientific evidence and adequate consultation and interaction with multi-disciplinary experts and stakeholders (Sambala et al. 2020). Part XII of the Prison Act of Malawi provides for the maintenance of prisoners. Despite these rights protections, the Malawi Prison Inspectorate reported between 2018 and 2019 that the system had reached 260% capacity with no change in the situation for prisoners (Prison Inspectorate of Malawi, 2019). Prison conditions relating to the right to reasonable accommodation and an environment free of inhumane treatment centre on

cubic content of air, floor space, clean water, and disinfection measures (hygiene, sanitation, ablution) continue to be inadequate in Malawi and are contra the *Mandela Rules* 13 to 18, 21, 22(1) (2), 25, 35 and 42. Conditions continue to violate the fundamental human rights to access to clean drinking water and food (*Article* 25(1) UDHR; *Article* 11(1) ICESCR, CESC *General Comment No. 12 and 15*; and *Section* 50(5)(d) of the Constitution). In the 2020 report submitted to the UN Committee against Torture, Malawi reported that 414 people had died in prison between January 2014-September 2018, with no cause of death provided (UN, 2020). The prison is mandated to provide food to all prisoners daily. The Prison Act however allows for un-convicted prisoners to receive food supplements from their relations outside and prison officials are not allowed to take that food away from the prisoners. Of grave concern are the reports of fatalities caused directly by severe malnutrition (CHREAA, SALC, IRLI, 2021). The denial of adequate food (based on one meal per day) violates the Malawian Constitution, international and regional human rights law including State obligations under the ICESRC and a range of soft law normative minimum standards of care (Gauld, 2021).

The Prison Act of Malawi *Section* 13 provides for the powers of the Commissioner of Prisons to issue standing orders in relation to a matter at hand (for instance a disease outbreak). *Section* 30 further recognises the right of prisoners to healthcare and medical treatment and *Section* 25 outlines the responsibility of the prison medical officer for ensuring *'that every prisoner is medically examined on admission to and before discharge from a prison.'* Provisions are also included regarding delivery of healthcare that is equivalent to that provided in the community (*Sections* 74 and 75). The medical inspection of prisons is provided in *Regulation* 31, medical examination and treatment of prisoners in *Regulations* 33 (a) and (b)) and the notification of serious illness/infections or communicable disease is detailed in *Regulation* 33 (c). The Prison Act does not however provide for mandatory medical examination.

The Malawi Law Commission has criticized the Malawi prison legislation and stated that it failed to: *'entrench and safeguard the right of prisoners to access health services by ensuring that the standards of services that are available to prisoners are the same as those that are available to the general public accessing public dispensaries*' (Malawi Law Commission, 2018). It has reported on the failures of the prison system to adhere to the provisions contained in the *Prisons Act* and cited overcrowding in prisons as '*leading to unacceptable and dehumanizing levels of congestion.'* It also reported a lack of vigilance around the health of prisoners, lack of prison monitoring inspections and lack of medical examination on entry, as well as observing that unqualified medical staff were treating prisoners and that in the event of a communicable disease, most prisons lacked the infrastructure to quarantine sick prisoners (Malawi Law Commission, 2018). The Commission recommended that a new Prisons Act would require mandatory medical examination, screening for communicable diseases upon admission and appropriate healthcare responses.

With regard to pertinent domestic jurisprudence in Malawi, in the ground-breaking case of *Gable Masangano v. Attorney General* (Constitutional Case No. 15 of 2007), the Constitutional Court

of Malawi found that prison overcrowding, lack of sanitation, hygiene and ventilation in prisons violated the Malawi Constitution and international and regional African human rights norms, as they were conducive to the transmission of disease. It ruled that the situation where: *'... packing inmates in an overcrowded cell with poor ventilation with little or no room to sit or lie down with dignity, but to be arranged like sardines violates basic human dignity and amounts to inhuman and degrading treatment.'* (Gauld, 2021). The Court also ruled on the justiciability regarding the health of prisoners, including right to medical treatment and healthcare, dismissing the States contention that prisoners' right to adequate nutrition and health were non justiciable and that '*the judicial process is not equipped to deal'* with questions of resource allocation of the State (Kapindu, 2013; Childemba, 2016). The Court added that the prison population was to be reduced by half over 18 months and supported by periodic decongestion measures.

Assessing human rights, right to health and healthcare, and management of disease in Malawian prisons

Malawi was similar to other sub-Saharan African countries such as South Africa and Zimbabwe (Van Hout and Wessels, 2021; Jumbe et al. 2022), in that on March 20th 2020, the President of Malawi declared a state of national disaster in response to the COVID pandemic under *Section* 32 of the Disaster Preparedness and Relief Act, 24 of 1991 (United Nations Malawi COVID-19 Update, 2020; Muntingh, 2020). The Minister of Health and the Chairperson of a specially convened cabinet committee on COVID-19 declared COVID-19 a '*formidable disease*' and published the Public Health (Corona Virus Prevention, Containment and Management) Rules, 2020 (the Rules) under the Public Health Act, 12 of 1948. The Rules, whilst constituting delegated legislation, were not brought before Parliament nor did the legislature have any role in relation to their adoption. Subsequently, on the 13th of April, a 21day lockdown was announced by the Minister of Health to take effect days later; this was, however, challenged on April 17th 2020 in the case of *The State (on the application of Esther Kathumba & Others) v. The President* via an injunction and application for judicial review by a human rights coalition (individuals and civil society). This action was based on the argument that procedural irregularities in the lockdown declaration constituted a derogation from the fundamental rights enshrined in the Malawi Constitution (News 24, 2020; South African Litigation Centre (SALC), 2020; Gauld, 2021). At the first hearing, the High Court granted an interlocutory injunction and before the second hearing, the Minister of Health revoked the Rules. The Court held that the matter was not moot as the *'issues…are capable of repetition'* and so agreed to make a ruling on the merits of the application [para. 3.6]. The matter was certified as a constitutional matter in which the Constitutional Court recommended the government to always ensure that practical and realistic social security measures are put in place before implementing a drastic action like a lockdown, thus ensuring that the fundamental rights of the citizenry are not breached (*Constitutional Referral Case No.1 of 2020 pg. 42*).

The 2020 Public Health (Corona Virus and COVID-19) (Prevention, Containment and Management) Rules were formulated by the Minister of Health through the powers vested in her by *Section* 29 as read with *Section* 31 of the Public Health Act and included detail on disease preventive measures (wearing of face masks, social distancing, hand washing) (*Section* 3(1)) and COVID-19 testing and medical isolation (*Section* 4). In *Rule* 5, a person diagnosed with COVID-19 was to isolate until certified to be COVID-19 negative. *Rule* 8 provides for an enforcement officer to order a person certified as COVID-19 positive to mandatory treatment or further medication, onsite detention, isolation or quarantine. The Rules further state that where one has been in detention, isolation or quarantine, reasonable provision shall be made to ensure the individual has access to, or is being provided with, basic necessities to enable them to maintain an acceptable standard of nutrition and hygiene (*Rule* 8(3)(b) (i)). Whilst prison wardens were recognized as essential service providers, the COVID-19 rules did not specifically consider the unique situation and vulnerabilities of prisoners themselves as a specific group. There were a series of standing orders for the Malawi Prisons Service on the Prevention and Management of COVID-19, in pursuance of *Section* 13 of the Prison Act 1956. *Part One* covered the medical screening of prisoners and staff on admission, with those meeting the criteria of case definition to be isolated and clinically assessed. *Part Two* detailed the social distancing, respiratory etiquette, disinfection, ventilation, hygiene and personal protective equipment (PPE) measures for staff and prisoners and *Part Three* outlined the visitation restrictions.

On March 30th 2020, a press statement by Irish Rule of Law International (IRLI) and Reprieve was released, which underscored the threat to health of COVID-19 to those deprived of their liberty in Malawi, particularly those with chronic ill health and elderly prisoners (IRLI, 2020). The statement contained recommendations to decongest the prisons, relax bail conditions, not arrest those accused of petty crimes, and supply the prison system with basic hand washing provisions (Gauld, 2021). 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). Despite the detailed Malawi prison system COVID-19 plan, which was aligned to international and 2020 SADC regional responses (WHO, 2020b; WHO, 2020c; UNODC, 2020; PRI, 2020), the state of disaster declared by the Malawi government worsened prison conditions for those working and living there. Standards of care, healthcare responses and provision of basic needs in Malawi's prisons were further compromised. Lack of resourcing of the COVID-19 health and medical response in prisons and existing infrastructure and resource deficits, under-staffing of clinical personnel, severe congestion and environmental threats to health (lack of adequate ventilation, sanitation, hygiene and nutrition) (Malawi Inspectorate of Prisons, 2019; Water Supply and Sanitation Collaborative Council, 2020; Van Hout, 2020c; Gadama et al. 2020; US Department of State, 2020), impacted on the ability to adhere to the normative standards of care during disease outbreaks and the non-derogated rights of prisoners to equivalence of health care (including testing, quarantine, testing and medical supplies) and medical treatment (*Mandela Rules* 24(1), 25, 30, 31, UN Principles of Medical Ethics, WHO and WMA declarations).

The first COVID-19 cases were notified on July 14th 2020 at Mzimba Prison where a prison officer tested positive and in Chichiri Central prison where a prisoner tested positive (Southern African Litigation Centre, 2020). By September 26th 2020, this had increased to 26 staff and 408 prisoners with two COVID-19 deaths reported (Prison Insider, 2020). Efforts to mitigate COVID-19 disease in the prison system included segregation of COVID-19 positive prisoners in isolation centres, visitation restrictions at facilities and suspension of out of prison formations to work (Masina, 2020a). In late 2020, human rights organisations reported on the lack of COVID-19 testing and isolation capacity and raised concerns around the potential for significant COVID-19 outbreaks and deaths in the Malawian prison system due to existing co-morbidities (tuberculosis, HIV, hepatitis C) and poor health of many prisoners (including malnutrition) (Pensulo, 2020a). Media and situation assessment reports highlighted the cell capacity issues inhibiting social distancing (particularly at night), inadequacy of provisions of basic sanitation, disinfection and PPE for prison officials, medical staff and prisoners, the insufficient resourcing of disease control measures and timely COVID-19 test results, continued intake of remand detainees and mixing with sentenced prisoners despite the '*Justice and Accountability Chilungamo Programme'* prison release schemes. It was also noted how visitation restrictions disrupted prisoner dependence on family and civil society supports of food, medicines, soap and clothing (Van Hout, 2020c, Guta, 2021; Amnesty International, 2020; Muntingh, 2020; Chireh and Kwaku Essien, 2020; Van Hout and Wessels, 2021; Katey et al., 2021; Mukenwa et al. 2021; Nweze et al. 2021; Mhlanga-Gunda et al. 2022; Jumbe et al. 2022).

Of relevance to this legal realist assessment, were the detailed and continued concerns provided with regard to overcrowding in the Malawi prison system in 2021, the inability of the Inspectorate of Prisons to adequately discharge its functions, inadequate medical treatment for prisoners with mental illness, food shortages and lack of adequate nutrition for prisoners (single meal per day of beans and *nsima [steam cornmeal]*), all of which were deemed to exacerbate risk to health and the transmission of communicable and opportunistic disease (CHREAA,SALC,IRLI, 2021). Severe congestion exacerbated by continued intake of remand detainees (12,000 prisoners in the system against the official holding capacity of 5640 persons) was reported: *'We have witnessed detainees having to sleep in a kneeling position or side by side on the ground, due to the lack of space. Inmates suffer from long-term knee problems and other ailments that are related to being placed in a confined space for prolonged periods.'* (CHREAA,SALC,IRLI, 2021). Malawian prison cells do not provide the bare minimum floor space set by the CAT at four square meters per person in a communal cell, which could be declared by courts as cruel or degrading (Steinberg, 2005). Pre-trial detention may only be permissible if undertaken in accordance with procedures established by law in a place of detention that has been authorised (*Robben Island Guidelines*, para 23) and such detention must not be arbitrary (UDHR, *Article* 9; ICCPR, *Article* 9(1), ACHPR Article 6). This provision was overlooked during COVID-19 restrictions, as the state disaster measure was regarded as a *vis major*.

Appeals to decongest the prison system occurred and the subsequent '*Justice and Accountability Chilungamo Programme'* resulted in the release of 1,397 prisoners, with 499 receiving a Presidential pardon (Face of Malawi, 2020; Chilundu, 2020; Phiri, 2020; Masina, 2020b). Presidential releases to decongest the prisons were permitted under *Section* 89(2) of the Constitution of Malawi and *Sections 108 and 110* of the Prison Act. Whilst six months were deducted from those serving minor offences, the elderly and women with children leading to large numbers qualifying for release, there was a lack of formal communication and transparency around the criteria employed by the Pardon Committee (law enforcement, prison officials, Ministry of Justice and Ministry of Homeland Security). Some prisons, despite operating at severe over-capacity, were omitted in the initial decongestion rounds (Chilora, 2020) and others closed their female wings to create COVID-19 isolation centres (Zomba, Maula, Mzimba), resulting in the transfer of female remand detainees and sentenced prisoners (with children) to remote prisons (Kapalamula, 2020; Pensulo, 2020b; Van Hout, 2020c; Southern African Litigation Centre, 2020). The Centre for Human Rights Education Advice Assistance (CHREAA) started judicial proceedings before the Zomba Magistrate Court in the case of *The State (on application of) Hastings Mwinjiro and 3 others and The Attorney General and Two others* (Judicial Review case No. 18 of 2020). However, at the time of writing, the Court has not decided yet whether to suspend the implementation of the amended Standing Orders of the Malawi Prisons Service on the Prevention and Management of Covid-19, which also freezes prison visits.

Of grave concern, in the broader domestic sense, were the reports of extensive mismanagement of COVID-19 funds (Kateta, 2021). The continued back filling of government support of prisons by non-governmental organisations and the United Nations High Commissioner for Refugees (UNHCR) in the form of donations of basic provisions (soap, PPE, detergent, food) and in the medical and disease control response was evident (Chikoti, 2020; Gondwe et al. 2021). Staff strikes and riots demanding hazard pay and further provision of PPE were reported by the media (Muheya, 2020; Masina, 2020c; Guta, 2021). Prisoners continued to experience insufficient nutrition, lack of access to clean water, were unable to distance themselves from infected peers and, ultimately, protect themselves from COVID-19 (Jumbe et al. 2022). The joint submission by the human rights organisations in 2021 observes; '*the denial of adequate food as specified in Malawi Prison Regulation 53 is a violation of the State's obligations under s.42(1)(b) of the Constitution to and international human rights law, to protect the lives and wellbeing of inmates'*. (CHREAA,SALC,IRLI, 2021). Failure to provide these basic provisions constitutes a threat to life under *Sections* 19(1), 19(3) and 16 of the Malawi Constitution, violate international law standards and are deemed contra to the right to dignity and the prohibition against torture, inhuman and degrading treatment (CHREAA,SALC,IRLI, 2021).

The Malawi prison system continues to suspend relational visits during every wave of the pandemic. Visitation restrictions breached prisoner rights to access legal representation and family support for basic provisions (*Mandela Rules* 61(1)(3)). This was especially the case in prisons where contact via alternative technological means (*Mandela Rule* 58(1a)) was not facilitated and where lack

of outside contact with family was viewed as inhibiting access to timely COVID-19 public health information, PPE, food, water, clothing and medicines. The transfer of women to remote rural prisons and lack of access to family and legal support when COVID-19 isolation wings were enacted constitute observable breaches of human rights (Pensulo, 2020b; Van Hout, 2020c). This is contra the *Bangkok Rules* 4 and 28.

Conclusions

Health rights and health conditions for prisoners in Africa are by default a neglected political issue in Africa (O'Grady, 2011) and prison health research is historically under resourced, ad hoc and under developed (Mhlanga-Gunda et al. 2020; Ako et al. 2020). Since March 2020, there is a growing evidence base of human rights-based investigations into standards of detention, disease preparedness and healthcare responses in African prisons (Ethiopia, South Africa, Zimbabwe) has emerged (Van Hout and Wessels, 2021; Kras and Fitz, 2020; Mekonnen et al. 2021; Mhlanga-Gunda et al. 2022; Jumbe et al. 2022).

This is the first legal realist assessment of the Malawian prison system approach to tackling COVID-19. Similar to South Africa (Kras and Fitz, 2020; Van Hout and Wessels, 2021) and Zimbabwe (Netsianda, 2020; Muronzi, 2020; Mavhinga, 2020; Mhlanga-Gunda et al. 2022), the Malawi prison system was relatively successful in preventing serious outbreaks in its prisons. Its healthcare approach, however, has been viewed as ad hoc and reactive and lacking a strategic approach capable of mitigating future outbreaks (Jumbe et al. 2022). Despite the efforts to decongest during State disaster measures, severe overcrowding persists and conditions are conducive to spread of a range of communicable diseases (TB, HIV, COVID-19, malaria, typhoid) (Kapalamula, 2020; CHREAA, SALC, IRLI , 2021; Guta, 2021; Jumbe et al. 2022). Malawi is not meeting its obligations under the ICSECR (Gauld, 2021). Equally, and despite State disaster measures, there is potential State liability in violation of their obligation to provide adequate provisions to protect against disease and prevent and control disease outbreak as required by international (ICCPR *Article* 4(1) and national law (regarding the right to life and prohibition of torture, cruel, inhuman or degrading treatment in *Section* 45(1) of the Constitution).

According to Ilze Brands Kehris, the UN Assistant Secretary-General for Human Rights, the pandemic demonstrates the *'urgent need for institutional reforms and societal transformation where human rights must be front and centre'* (Brandze Kehris, 2020). Malawi is now recommended to utilise lessons learned during the COVID-19 experience to update its Prison Act in line with contemporary normative and human rights-based standards for prisoners and staff. At the time of writing, the new Prisons Bill moving beyond the colonial focus on security and punishment, and with a greater focus on human rights, has not yet been enacted. Meaningful realisation of the right to health of prisoners needs to be promoted and implemented through the ICESCR, and the work of civil society, non-governmental organisations and the Malawian criminal justice system itself (Gauld, 2021). Continued and transparent efforts to decongest prisons using relaxed bail provisions, application of non-custodial sentences,

adherence to the pre-trial custody limits, the conditional release of the elderly, sick, pregnant women, those who have significantly rehabilitated, and those with low risk of reoffending and the use of camp courts is warranted (Gauld, 2021). Further human rights investigations and monitoring of health care and detention standards in Malawi and sub-Saharan prisons is warranted.

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