

Title: A legal-realist assessment of the Zimbabwean correctional system response to COVID-19 during state disaster measures.

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Abstract

Purpose The first prison system case in Zimbabwe was notified in July 2020 shortly after State declaration of disaster. We conducted a legal-realist assessment of the Zimbabwean correctional system response to COVID-19 during state disaster measures, with a focus on right to health, infectious disease mitigation and the extent to which minimum State obligations complied with human and health rights standards.

Design/Methodology/Approach The Zimbabwean correctional system operations during COVID-19 disaster measures are scrutinized using a range of international, African and domestic human rights instruments in relation to the right to health of prisoners. We focused particularly on standards of care, environmental conditions of detention, and right of access to healthcare.

Findings Systemic poor standards of detention are observed, where prisoners experience power outages, water shortages and a lack of access to clean drinking water and water for ablution purposes, a severe lack of safe space and adequate ventilation, poor quality food and malnutrition, and a lack of sufficient supply of food, medicines, clothing and bedding. Whilst access to healthcare of prisoners in Zimbabwe has greatly improved in recent times, the standard of care was severely stretched during COVID-19 due to lack of government resourcing and reliance on NGO and faith based organisations to support demand for personal protective equipment (PPE), disinfection products and medicines.

Originality Prison conditions in Zimbabwe are conducive to chronic ill health and the spread of many transmissible diseases, not limited to COVID-19. The developed legal-realist account considers whether Zimbabwe had a culture of respect for the rule of law pertinent to human and health rights of those detained during COVID-19 disaster measures, and whether minimum standards of care were upheld.

Key Words

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

Background

The COVID-19 global pandemic outbreak has highlighted the enormous challenges faced by criminal justice and penal systems worldwide (UNODC, 2020a; UNODC/WHO/UNAIDS/OHCHR, 2020; OHCHR, 2020; WHO, 2020a; WHO, 2020b; Kinner et al. 2020; Barnert et al. 2020). The situation is especially grave, where in Africa, approximately one million people are incarcerated, with on average 42% of the prison population are held in pre-trial detention, and consequent severe congestion and over capacity (highest in Uganda at 318%) (World Prison Brief, 2020). The first COVID-19 case was reported in Egypt, then Algeria and spread across the continent to 23 southern and east African countries, with exception of Lesotho in the period from March 5th 2020 until April 15th 2020 (Muntingh, 2020). There was variance across African states in relation to the declaration of the state disaster or emergency in the face of the COVID-19 public health crisis (Muntingh, 2020). By May 26th 2020, prisons in South Africa, Algeria, Cameroon, Guinea, Ghana, Sierra Leone, Egypt, Democratic Republic of Congo, Morocco and Kenya confirmed cases of COVID-19 (Prison Insider, 2020).

On March 25th 2020, the UN High Commissioner for Human Rights called on States to decongest their prisons through a range of means (early prison release schemes, presidential pardons, alternative sentencing, amnesties) as critical component of the domestic COVID-19 response (OHCHR, 2020; UNODC et al. 2020; Amon, 2020; Simpson and Butler, 2020; Lines et al. 2020; Van Hout and Wessels, 2021). Several technical guidance documents were released from UN agencies and leading international organisations (WHO, 2020b; WHO, 2020c; UNODC, 2020a; PRI, 2020). Collectively these protocols specify that States should take all measures to address the risks posed by COVID-19, by limiting contamination, detecting ill prisoners and staff and providing medical treatment to those infected. They further outline that disease control measures must never result in inhumane or degrading treatment of prisoners and detention conditions should not contribute to the development, worsening or transmission of disease; restrictions may only be applied on the grounds of medical necessity and must comply with the human rights principles of legality, proportionality, oversight, time-limitation, and non-discrimination; and lastly that monitoring bodies' must be guaranteed access to prisons. The African Commission on Human and People's Rights (ACoHPR) promulgated a range of effective human rights-based responses to COVID-19 in prisons (including decongestion and stringent disease control measures) (ACoHPR, 2020a; ACoHPR, 2020b). This was echoed in regional documents published by the Southern African Development Community (SADC) (SADC, 2020). Despite the promulgation of guidelines for the selection of prisoners qualifying for release, there is little published data provided by African states regarding actual numbers and types of prisoners released (Muntingh, 2020; Van Hout and Wessels, 2021).

The health of prisoners is by default a neglected political issue in Africa (O'Grady, 2011). This is due in part to the State prioritisation of prison security rather than to basic health rights and minimum standards of space, ventilation, access to clean water, nutrition and medical care (Habeenzu et al. 2007; Telisinghe et al. 2016). Prison conditions are historically poor, and continue to be conducive to chronic

ill-health of prisoners and the spread of communicable disease via poor sanitation, insufficient space, high population density and turnover (ACoHPR, 2012; Todrys and Amon, 2012; Telisinghe et al. 2016; Beaudry et al. 2020; Van Hout and Aaraj, 2020). With already weak and stretched health systems in Africa (Nkengasong and Mankoula, 2020), the COVID-19 threat has exacerbated the existing and significant risks to health for those living and working in African prisons (Muntingh, 2020; Van Hout, 2020a; Van Hout, 2020b; Van Hout, 2020c; Van Hout, 2020d; Badu et al. 2020; Nweze et al. 2020; World Prison Brief, 2020; Kras and Fitz, 2020; Chireh et al. 2020; Katey et al. 2021; Van Hout and Wessels, 2021; Van Hout et al. 2021a; Van Hout et al. 2022). COVID-19 responses in African prisons are compromised by lack of general government resourcing of the prison system, and inclusion of prisons in the national COVID-19 health budget, and the existing environmental determinants of health (severe congestion, poor standards of detention, basic provisions and dated infrastructure) (Amon, 2020; Bulled and Singer, 2020; Kras and Fitz, 2020; Rapisarda et al. 2020; Muntingh, 2020; Badu et al. 2020; Nweze et al. 2020; Chireh, and Kwaku Essien, 2020; Amnesty International, 2020; Katey et al. 2021; Van Hout and Wessels, 2021). There are extensive reports of human rights breaches and protests by prisoners and prison officials in many African states amid the continued intake of prisoners, severe congestion and inadequate efforts to prevent COVID-19 outbreaks and fatalities (Prison Insider, 2020; Kras and Fitz, 2020; Muntingh, 2020; Van Hout and Wessels, 2021; Katey et al. 2021; Mekonnen et al. 2021; Van Hout et al. 2022).

Health surveillance and academic research on standards of care in African prisons are historically under-resourced and underdeveloped (Mhlanga-Gunda et al. 2020; Ako et al. 2020). However, since the start of the COVID-19 pandemic, there has been a growing evidence from academic and human rights based investigations into prison system COVID-19 preparedness in African prisons (Ethiopia, South Africa, Zimbabwe, Malawi) (Van Hout and Wessels, 2021; Kras and Fitz, 2020; Mekonnen et al. 2021; Van Hout et al. 2022; Mhlanga-Gunda et al. 2022). Hence, we conducted a legal-realist assessment of the Zimbabwean correctional system response to COVID-19 under the state of emergency, with a focus on right to health, infectious disease mitigation and the extent to which minimum State obligations complied with human and health rights standards. Legal realism as a naturalistic theory underpins this assessment due to its emphasis on the law as derived from real world observations regarding welfare, social interests and public policies (Leiter, 2015). The assessment adhered to several steps. Firstly, we present a brief contextual section on Zimbabwe and its prison system up to the COVID-19 declaration of disaster. Secondly, we present and assess all relevant international, African and domestic instruments (environmental conditions of detention, protection from infectious disease, access to and equivalence of healthcare, prohibition of torture and discrimination) in light of the scholarship published since the first prison system case was notified in July 2020 (Netsianda, 2020; Muronzi, 2020; Mavhinga, 2020). In the final step, by adopting a legal-realist approach, we critically assess whether and to what extent Zimbabwe complied with human and

health standards of detainees and whether minimum standards of care were upheld during contagion and the application of state disaster measures.

Prison standards in Zimbabwe

The last and only ACoHPR Special Rapporteur report on prisons in Zimbabwe in 1997 placed emphasis on the serious problem of overcrowding (ACHPR, 1997). The legacies of President Mugabe and now President Mnangagwa rule are evident in terms of the continued lack of government resourcing and systemic poor standards of detention, where prisoners experience power outages, water shortages and a lack of access to clean drinking water and water for ablution purposes, a severe lack of safe space and adequate ventilation, malnutrition and a lack of sufficient supply of food, medicines, clothing and bedding (USSD, 2016; United Kingdom Home Office, 2017; Zimbabwe Human Rights, 2018; Jongwe, 2019; Chivandikwa et al., 2020; Pillay et al. 2021; Mhlanga-Gunda et al. 2022). The reliance on family and NGO/faith based organisations to bring clean water, food and medicines to prisons in Zimbabwe is well documented (Prison Insider, 2019). The UN CEDAW has also more recently reported on concerning levels of inter-personal violence against women in Zimbabwean prisons (Zimbabwe & UN CEDAW, 2020; Van Hout et al. 2021b). The official occupancy level across the 46 prisons is 129.4% (World Prison Brief, 2020).

At the time of writing, Zimbabwe recorded 128,804 cases of COVID-19, 4592 deaths and 121,653 COVID-19 recoveries (Worldometer COVID-19 Data, 2021). The first prison system case was in July 2020 with a spiral of subsequent case notifications and deaths thereafter (Netsianda, 2020; Muronzi, 2020; Mavhinga, 2020). Of cautionary note however is that the Zimbabwean prison system unlike its neighbour South Africa (Van Hout and Wessels, 2021) did not publish transparent COVID-19 data on COVID-19 positivity (active or recovered) in its prison system, nor does the prison system liaise with health authorities to track cases on release from prison (Mhlanga-Gunda et al. 2022).

International and regional human rights frameworks pertinent to right to health during COVID-19

Under international law States have positive obligations to uphold the right to health and to protect those living and working in prison from contagion. The International Covenant on Economic, Social and Cultural Rights (ICESCR) specifically obliges States Parties to take steps necessary regarding disease prevention, treatment and control and assurance of access and provision of all required medical support and care during illness (*Article 12 (2)*). 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*) (OHCHR, 2012). Zimbabwe ratified the ICCPR and ICESCR in 1991, but does not accept individual complaints procedures under the ICCPR- Optional Protocol (UN, 1966) or the ICESCR-OP (UN 2008).

The Convention against Torture and Other Cruel, Inhumane or Degrading Treatment or Punishment (CAT) (UN, 1984) or CAT-Optional Protocol (UN, 2003) creates further binding obligations on States not to ill-treat those deprived of their liberty. The CAT recognises “*an inadequate level of health care can lead rapidly to situations falling within the scope of the term ‘inhuman and degrading treatment’*” (Council of Europe, 2015). The UN Human Rights Committee states that it is “*incumbent on States to ensure the right of life of detainees, and not incumbent on the latter to request protection*” (Lines, 2008). Concluding observations by the Committee reflect the binding State obligation to “*take action to safeguard the health of prisoners*”, with explicit reference to taking positive steps to prevent spread of communicable disease such as COVID-19. Extant UN Human Rights jurisprudence includes reference to the health rights of those detained and reference to State failure to instigate adequate measures in tackling disease in prisons, by placing a prisoner’s right to health in serious jeopardy in violation of *Articles 6, 7, 9 and 10* of the ICCPR and indicative of an overall inhuman or degrading condition whilst detained (see for example *Khokhlich v Ukraine 2003*; *Catalin Eugen Micu v Romania, 2016*). Of great importance to prisons in Africa is the UN Human Rights Committee jurisprudence (including where African States are concerned), which indicates that the right to adequate living space sufficient to safeguard health constitutes the pre-conditions of health, with environmental health determinants (water, sanitation, overcrowding) recognised as potentially subjecting prisoners to disease. Zimbabwe has not ratified the CAT or the CAT-Optional Protocol.

There are further a range of non-binding UN norms and minimum standards for the treatment of prisoners and medical declarations particular to the rights of prisoners regarding their health and medical ethics in detention settings (UN, 1982; UN, 1988; UN, 1991; Lines, 2008). The WHO (WHO, 2003) and World Medical Association (WMA) (WMA, 2011) declarations provide for the rights of prisoners to humane treatment and appropriate medical care, including against disease. The UN Principles of Medical Ethics relevant to prisons (*Principles 1, 6*) contain a non-derogation clause during State declaration of emergency (UN, 1982). The Standard Minimum Rules for the Treatment of Prisoners (“*Mandela Rules*”) (UN, 2016) specifies the State duty to provide prisoners with access to necessary health-care services (free, equivalent to the community and non-discriminatory care), and access to medical assessment, care and treatment (*Rules 24, 25, 30, 31, 35*). This includes the continuum of disease prevention, quarantine and care for communicable diseases.

At the regional African level, the African Charter on Human and Peoples’ Rights (ACHPR) (OAU, 1981) is a legally binding treaty designed to promote and protect human rights in the African continent. The ACHPR observes that state obligations regarding the right to health are “*heightened*” when an individual is in the custody of the State, and with their integrity and well-being wholly dependent on the State (*Article 16*). It has two special mechanisms on prisons (Special Rapporteur on Prisons, Conditions of Detention and Policing in Africa, Committee for the Prevention of Torture in Africa) as well as non-binding instruments to support criminal justice and penal reform. These include the *Robben Island Guidelines* (ACHPR, 2008) which are aligned to the Basic Principles for the

Treatment of Prisoners (UN, 1991) and the *Mandela Rules* (UN, 2016). The African Court on Human and Peoples' Rights, which is mandated to implement the ACHPR, has developed a copious jurisprudence related to the prohibition of cruel, inhumane or degrading treatment and the right to life, based on deplorable conditions of detention (congestion, lack of adequate food, sanitation and ventilation) (Muntingh, 2020).

To date there are no cases based on the violation of human rights pertinent to conditions during COVID-19, however 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 Témoins de Jehovah v. Zaïre* in 1996; *International PEN and Others v. Nigeria* in 1998 and *Malawi African Association and others v. Mauritania* in 2000). Where denial of medical intervention is cited, this is additional to a ruling of inhumane or degrading treatment as constituting physical abuse of prisoners (*Krishna Achuthan (On behalf of Aleke Banda), Amnesty International On behalf of Orton and Vera Chirwa v. Malawi* in 1994 and *Constitutional Rights Project and Civil Liberties Organisation v. Nigeria* in 1999). More recently cases refer to deplorable conditions of detention relating to congestion, lack of food, sanitation and ventilation (*Konaté v. Burkina Faso and Abubakari v. Tanzania* in 2016; *Guehi v. Tanzania* in 2018), and the rights of prisoners to adequate medical care (medication and appropriate nutrition for chronic ill health) when in detention (*Lohé Issa Konaté v. Burkina Faso* in 2013 and *Mugesera v. Rwanda* in 2017).

Assessing Human Rights, Right to Health and Management of Disease in Zimbabwean prisons during COVID-19

At the domestic level, the Constitution of Zimbabwe contains a range of fundamental rights protections pertinent to detention settings and 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. *Section 44* of the Constitution of Zimbabwe provides for State obligation and duty to respect fundamental human rights and freedoms of all persons; ***“the State and every person ... and every institution and agency of the government at every level must respect, promote, protect and fulfil the rights and freedoms set out in this Chapter.”*** Non-discrimination and equality provisions are provided for in *Section 56 (1)* ***“All persons are equal before the law and have the right to equal protection and benefit of the law”***. Additional fundamental rights applicable to detention settings are provided for in *Section 51* (right to human dignity); ***“Every person has inherent dignity in their private and public life, and the right to have that dignity respected and protected”*** and in *Section 52* regarding right to personal security in terms of bodily and psychological integrity. Those deprived of their liberty are further specifically protected by *Section 50 (5) (d)* of the Constitution of Zimbabwe; ***“... Any person who is detained, including a sentenced prisoner, has the right to conditions of detention that are consistent***

with human dignity, including the opportunity for physical exercise and the provision, at State expense, of adequate accommodation, ablution facilities, personal hygiene, nutrition, appropriate medical treatment...'

Similarly to its neighbour South Africa, Zimbabwe declared a state of disaster under *Section 27* of the Civil Protection Act. This Act provides that the state of disaster may be extended, curtailed or terminated by the President through a statutory instrument. The state of disaster in Zimbabwe was characterized by the lack of an effective parliamentary oversight and the President's statutory measures may prompt breaches of fundamental rights and freedoms. On the March 30th 2020, the Zimbabwean Government gazetted the Civil Protection (Declaration of State of Disaster: Rural and Urban Areas of Zimbabwe) (COVID-19) Notice. This essentially consisted of a national lockdown, and was followed by the promulgation of seventeen COVID-19 related statutory instruments (Lawyers for Lawyers 2020). The basic framework guiding the COVID-19 response of Zimbabwe was the Constitution of Zimbabwe Amendment No. 20 Act 2013, the Public Health Act (particularly *Section 68(1)* pertaining to epidemic disease outbreaks), the Prisons Act and other statutory instruments enacted from time to time in terms of the enabling Acts of Parliament. Several regulations enabled by *Section 68 (1)* of the Public Health Act were enacted, which included the Statutory Instrument 77 of 2020 titled Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) Order; the 2020 Public Health (COVID-19 Prevention, Containment and Treatment) (National Lockdown) (No. 2) (Amendment) Order, 2020 (No. 7) and the Public Health (COVID-19 Prevention, Containment and Treatment) (Amendment) Regulations, 2020 (No. 8) which enacted the national lockdown, quarantine measures at national borders, the closing of schools and businesses, the suspension of court processes, and restriction of all non-essential visits to prisons.

In June 2020, the Zimbabwe Prisons and Correctional Services (ZPCS) released a COVID-19 standard operational plan, designed to prevent and mitigate against COVID-19 transmission (OCHA 2020), and it was largely aligned to the 2020 SADC, WHO and UN protocols (WHO, 2020b; WHO, 2020c; UNODC, 2020a). Prison decongestion schemes were implemented under the President Mnangagwa's COVID-19 amnesty, reducing the prison population from March to June 2020 by 4,208 prisoners (Mavhinga, 2020). The General Notice 688 of 2020 provided detail on the categories of prisoners considered for amnesty (Zimbabwean Government Gazette Extraordinary, 2020), with several categories of prisoners excluded (those convicted of murder, treason, rape or any sexual offense, carjacking, robbery, stock theft and public violence). This was followed by further rounds of releases in 2021 (Matsuka, 2021; Marawanyika, 2021; Moyo and Goldbaum, 2021). By March 2021 the Zimbabwean prison population had reduced to 20,407 (March 2019 it was 22,000) (World Prison Brief, 2021). There was no detail available on who was released or on the application of non-custodial sentencing for non-violent offences (US State Department, 2020). The prison capacity to instigate robust COVID-19 prevention measures was confounded by the continued intake of remand detainees and the continued human traffic of detainees and staff from court to prison.

Lengthy pre-trial detention in Zimbabwe continues to violate the standards set out in the Constitution of Zimbabwe (for example *Sections* 50(2)(b) and 50(6) and *Section* 32(2) of the Criminal Procedure and Evidence Act (Chapter 9:07), and a range of international and regional human rights instruments (Zimbabwe Human Rights Forum, 2018) (for example as illustrated in the cases of *R v. Sambo* in 1964; *Fikilini v Attorney General* in 1990; *S v. Kusangaya* in 1998; *Re Masendeke* in 1992; *S v. Mukwakwa* in 1997 and *S v. Kusangaya* in 1998). *Section* 50 of the Constitution of Zimbabwe specifically provides that if a detained person pending trial is not tried within a reasonable time, they must be released unconditionally. Regional and international human rights frameworks mandate that 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). However, this provision was overlooked in Zimbabwe during COVID-19 as the state disaster measure was regarded as a *vis major*. Whilst the Zimbabwean Prisons Act operates in compliance with the 2004 *Lilongwe Declaration on Accessing Legal Aid in the Criminal Justice System in Africa* to constitute a monitoring mechanism for the welfare of prisoners, it remains unclear as to whether inspection visits actually took place (*Section* 46 Prisons Act) during state disaster measures, despite reporting that the Zimbabwe Human Rights Commission (ZHRC) was permitted to conduct monitoring visits to its 46 prisons when conditions allowed (US State Department, 2020).

On the outside, courts were not functioning properly, judicial harassment, arrest, detention, and prosecution of lawyers occurred with many opposition activists arrested, the holding of public hearings for constitutional amendments and other laws were fast-tracked, and freedom of movement was curtailed with curfews being imposed (Lawyers for Lawyers, 2020). It is clear that malicious criminal prosecutions of high-profile human rights defenders, anti-corruption activists and journalists such as *Hopewell Chin'ono*, *Jacob Ngarivhume*, *Linda Masarira*, *Ostalos Siziba* and *Job Sikhala* violate the rule of law (human rights, fair trials and access to justice) (Cassim, 2020; Mavhinga, 2020; US State Department, 2020; Lawyers for Lawyers 2021). Regarding remand detainees and those awaiting trial, access to legal representation was denied, with lawyers not defined as providing an essential service during national lockdown and excluded from visiting prisons (Lawyers for Lawyers, 2020; Zimbabwe Peace Project, 2021). This was in reality a '***an initial total lockdown on the provision of legal services***' (Lawyers for Lawyers, 2020). The net effect was that prison lockdowns and the suspension of visits by lawyers (and family) affected prisoners' rights to access legal representation and family support for basic provisions (contra the *Mandela Rules* 61(1)(3)). This was especially the case in prisons where right to contact via alternative technological means (*Mandela Rule* 58(1a)) was not facilitated by the ZPCS (Mhlanga-Gunda et al. 2022) and where lack of outside contact was viewed as inhibiting access to timely COVID-19 public health information, and family supports in providing sufficient personal protective equipment (PPE) (face masks), food, water, clothing and medicines (Whizz, 2020; Mukwenha et al. 2021; Mhlanga-Gunda et al. 2022). There were some reports of NGOs backfilling the

ZPCS response, however these efforts were stifled due to the protracted economic crisis in Zimbabwe at the time (US State Department, 2020; Mhlanga-Gunda et al. 2022).

Despite domestic law and minimum State obligations to comply with human rights norms, and the ZPCS efforts to implement a range of health responses and disease control measures aligned to international and the 2020 SADC regional responses (WHO, 2020b; WHO, 2020c; UNODC, 2020a; PRI, 2020), the state of disaster declared by the Zimbabwean government incurred significant hardship on those detained in its prisons, reinforced by the deficits in prison system resourcing, capacity and infrastructure. Media reports emerged from within the prison walls itself, from recently released prisoners, incarcerated journalists and political activists who described appalling and life threatening conditions inside (exacerbated by deprivation of PPE such as face masks and hand sanitizer, food, ablution and water), the impossibility of social distancing and a range of human rights abuses perpetrated by officials against those deprived of their liberty (solitary confinement) (Chingano, 2020; Chinowaita, 2020; Cassim, 2020; Whizz, 2020). A broad range of potential fundamental rights violations at the domestic level were observed. Conditions in prisons were contra *Sections* 48(1), 50 (5) (d), 51, 52(a) and 56 (1) of the Constitution of Zimbabwe, and where life threatening contra *Section* 48 (right to life).

Central to the fundamental rights violations of those detained in Zimbabwe during COVID-19 disaster measures were the rights to reasonable accommodation (space, ventilation, water, sanitation) and rights to an environment free from torture and inhumane treatment. The 2020 US State Department report on Zimbabwe at the time underscored the level of security forces engagement in severe human rights violations including arbitrary killings and torture of civilians, the harsh, degrading and life threatening conditions for opposition activists, political prisoners and detainees and the lack of PPE (face masks, hand sanitizer, gloves, disinfectant) for staff and prisoners in Zimbabwean prisons. Environmental health conditions were reported to be grossly inadequate (cubic content of air, floor space) with a clear lack of access to clean water and adequate disinfection measures (hygiene, sanitation, ablution) (contra *Mandela Rules* 13 to 18, 21, 25, 35). *Mandela Rule 13* is crucial here by stating; ***‘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). Cassim (2020) describes the experience of *Linda Masarira* a popular protester who said; ***‘I am yet to be convicted but I was meant to work in the fields and fetch water; unfortunately, we had no shoes and [we were] forced to walk into sewer effluent. The water and food shortage is so acute at prisons that inmates rely on supplies from relatives; however, prison officers, who often complain about not receiving their salaries on time, would also steal food from inmates.’*** Shortages in clean drinking water, water for personal hygiene and food experienced by those detained violate basic human rights (*Articles* 25(1) of the UDHR; 11(1) of the ICESCR, CESCR General Comment No. 12 and 15) and are contra the *Mandela Rules* 22(1) and (2), and 42.

Conditions in Zimbabwean prisons are conducive to chronic ill health, and the spread of many transmissible diseases, not limited to COVID-19. Of grave importance is the complete lack of ability of those deprived of their liberty to protect themselves in severely congested and unsanitary prison conditions from COVID-19, particularly at night where prisoners sleep side by side in communal cells not more than 10-30cm apart (Chinowaita, 2020; Muronzi, 2020; Mavhinga, 2020; Whizz, 2020; Mukwenha et al 2021; Mhlanga-Gunda et al. 2022). Zimbabwean 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; Mhlanga-Gunda et al. 2022). Muronzi (2020) reported; ***‘Behind bars and confined in a tight space shared by dozens of other detainees, Zimbabwean opposition leader Jacob Ngarivhume was anxious about catching coronavirus. Designed to hold 16 people, the cramped cells at the Chikurubi Maximum Security Prison were full with more than 40 people . If prison authorities had observed social distancing rules of a metre (3.3 feet) apart, the cell would have accommodated only 10 people. Detainees were barely 30cm (12 inches) apart. At night, the inmates spread filthy and lice-infested blankets on the hard concrete floor, forming elongated rows for going to sleep’.***

There are some parallels to be drawn with the historical situation in Zimbabwe regarding contagion within prison confines, especially relating to the spread of communicable diseases such as HIV/AIDS, tuberculosis (TB) and typhoid, the lack of effective disease control measures, lack of routine testing and denial of treatment for those infected in Zimbabwean prisons (see the Constitutional Court case of *Muzanenhemo v. Officer in Charge CID (Law & Order) & Ors* in 2013) (Truscott, 2012; Prison Insider, 2017a: Prison Insider, 2017b; US State Department, 2020). The 2018 briefing paper on HIV/AIDS in Zimbabwean prisons observed, ***‘the disparity between what is known and unknown about HIV in Zimbabwean prisons is alarming.’*** (Machingura et al. 2018). More recently, Pillay et al. (2021) have observed this to be the case for airborne disease such as TB, and we speculate that COVID-19 is no different. For example Journalist *Lindi Whizz* reported in November 2020; ***‘the prison complex has had no running water since November 8 following a power outage that has affected pumping. The shortage of water has resulted in an outbreak of serious diseases including diarrhoea, hepatitis B and tuberculosis. Regrettably, prison officials do not separate sick prisoners from the healthy ones.’*** The malicious nature of deliberate exposure to disease was evident in the case of political activists and journalists. According to Chinowaita (2020); ***‘It is reported that Sikhala was locked, in the D class section of Chikurubi, four inmates had tested Covid 19 positive. Nevertheless, Sikhala was not given Personal Protective Equipment exposing him to the savages of the disease’.*** A similar finding was reported by the US State Department report in 2020, ***‘the ZPCS ignored requests from medical personnel to isolate journalist Hopewell Chin’ono when he exhibited symptoms of COVID-19 while incarcerated in August’.***

The right to health care is a justiciable fundamental right, and specifically enshrined in *Section 76 (1)* of the Constitution of Zimbabwe. *Section 50(5)(d)* of the Constitution of Zimbabwe provides for

detained persons' right to medical treatment at the State's expense, and does not appear to be subject to progressive realisation. Health services in prisons are recognized and provided for in *Section 29 (1)(2)(3)* of the Constitution of Zimbabwe as a '*National Objective*' whereby the State must; ***'must take all measures to ensure the provision of basic, accessible, and adequate health facilities throughout Zimbabwe; take, appropriate, fair and reasonable measures to ensure that no person is refused emergency medical treatment at any health institution and take all reasonable measures within the limits of the resources available to it, including education and public awareness, programs against the spread of disease.'*** The Constitution of Zimbabwe (2013) however specifies that state measures to prevent disease will be ***'within the limits of the resources available to it.'*** (*Chapter 4*).

Right to health care is enshrined in the Prisons Act (*Sections 36(1)(2), 37, 38(2) and 41*), and includes detail on the duty of medical practitioners to prevent disease outbreaks (inspect mechanisms pertinent to COVID-19 include the screening on committal, segregation from the prison population until medically assessed and the duty to prevent spread of disease to the community on release). In general, the ZPCS complies with the obligation to take the necessary measures to protect the health of prisoners and to ensure that they receive medical attention when they are sick as required by international and domestic standards (Zimbabwean Human Rights NGO, 2018). As with other aspects of prison standards of care, the lack of resourcing impacts on the quality and coverage of care. This was especially the case during COVID-19 state disaster measures, with reliance on NGO and faith based organisations to support demand for PPE (especially face masks), disinfection products and medicines (Mhlanga-Gunda et al. 2022).

There were serious violations of normative standards of care, particularly relating to disease control and the non-derogated rights of prisoners to access to equivalence of care (including testing, quarantine and treatment) (*Mandela Rules 24(1), 25, 30, 31*, UN Principles of Medical Ethics, WHO and WMA declarations). Despite medical and correctional staff efforts and commitment to supporting the right to health of prisoners, there were difficulties in implementing routine disease surveillance and COVID-19 testing on intake (at best thermo screening and assessment of COVID-19 symptomatology was recorded), adhering to the advised length of quarantine due to lack of adequate accommodation, inability to segregate vulnerable prisoners due to severe congestion and a lack of adequate staff protection from COVID-19 when caring for prisoners who had tested positive (Netsianda, 2020; Chinowaita, 2020; Muronzi, 2020; Mavhinga, 2020; Daily News 2020; Whiz, 2020; Mukwenha et al. 2021; Mhlanga-Gunda et al. 2022). The lack of health care coverage and training, the scarcity of medicines and PPE (face masks, hand sanitizer, gloves, disinfectant), and ad hoc nature of medical professional access and provision of care and health education to prisoners in Zimbabwe inhibited disease mitigation responses and violated State obligation to prevent and control disease outbreaks as required by international and national law (*Articles 12(1) and 16(2) of the ICESCR, 16(1) ACHPR, Sections 48, 50(5)(d), 51 and 52 of the Constitution of Zimbabwe*).

Conclusion

Despite all efforts to mitigate and control COVID-19 transmission and disease in prisons, human traffic between prison and community creates a bridge of disease which cannot be underestimated (Van Hout 2020a; Van Hout 2020b). A strategic public health and human rights based approach is crucial to control warranted to mitigate transmission of disease in prisons and improve health for all affected (Amon, 2020; Kinner et al., 2020; Van Hout, 2020a; Van Hout, 2020b; Van Hout, 2020c; Van Hout, 2020d). This is the first legal realist assessment of the Zimbabwean prison system approach to tackling COVID-19. Similar to neighbouring South Africa (Kras and Fitz, 2020; Van Hout and Wessels, 2021) and Malawi (Van Hout et al. 2022), the Zimbabwean approach to mitigating COVID-19 in the prison system was relatively successful in preventing serious outbreaks within its prison walls (Netsianda, 2020; Muronzi, 2020; Mavhinga, 2020; Mhlanga-Gunda et al. 2021). An encouraging development is that in February 2021, the COVID-19 roll out programme was approved by government, and with the ZPCS falling under the priority category first phase of the vaccination programme (Mupopery, 2021).

This legal realist assessment during COVID-19 however highlights how the weak judicial system and the lack of resourcing of the ZPCS continues to violate basic fundamental rights of prisoners and fails to adhere to the minimum standards of care, including during state disaster measures. Continued efforts to advocate for prisoners and to improve their conditions of accommodation and their basic needs and medical care are warranted, via dedicated actions to decongest the ZPCS via pardoning of minor offences, and the application of non-custodial community based sentences; the enhancement of criminal justice system operations; upgrading of overall environmental standards of care (sanitation, hygiene, ablution) in all prisons; support of a robust disease control response via sufficient health education, medical training, and PPE for prisoners and staff (face masks, hand sanitiser, disinfectant, gloves); resourcing of sufficient medical care teams to conduct assessments; and provision of a platform of enhanced technology assisted communication (video, audio) so that prisoners can access legal representation and their families. Basic level needs in the form of water and food are crucial (Mavhinga, 2020; Mukwenha et al. 2021; Mhlanga-Gunda et al. 2022). Open prison systems with minimal security measures such as the Marondera Female Open Prison and the Connemara Male Open Prisons, should be further expanded and utilised to relive capacity issue.

Despite the international and regional treaties, constitutional rights and non-binding normative minimum standards of care, States have discretion in defining humane treatment and the adequate medical care of prisoners (Lines, 2008). Whilst the 2018 Public Health Act of Zimbabwe seeks to align public health laws with the Constitution of Zimbabwe which enshrines the right to health, it does not incorporate a rights-based framework consistent with the Constitution of Zimbabwe, and nor does it fully support the very vulnerable such as prisoners (Pillay et al 2021). The Zimbabwe Human Rights Commission will play a central role in the continued monitoring and inspection of prisons, particularly in the monitoring of compliance with COVID-19 measures to protect the health of prisoners. The lack of sufficient government resourcing of the ground level implementation of the ZPCS COVID-19

standard operational plan is of grave concern and evident in the insufficient supply of COVID-19 disease control measures (testing, quarantine, distribution of PPE), and the State could be held liable for this failure to provide adequate provisions to protect against disease. The right to adequate accommodation, personal hygiene and appropriate medical treatment are justiciable fundamental rights and freedoms for those deprived of their liberty in Zimbabwe under *Section 85* of the Constitution of Zimbabwe. Any person and or association of persons can approach a Court of law seeking redress of allegations of the State's breach of his or her or their '*right to health care*'. Further strategic public interest litigation on the fundamental rights of those in detention is warranted, moving beyond that of civil society advocacy and inclusive of individual actions against the State (Van Hout and Wessels, 2021).

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