Thailand Institute of Justice

# A GLOBAL STUDY ON THE IMPACT OF COVID-19

## *ON PRISON HEALTH*

*About*

## THE THAILAND INSTITUTE OF JUSTICE (PUBLIC ORGANIZATION)

Thailand Institute of Justice (TIJ) is a public organisation established by the Government of Thailand in 2011 and officially recognised by the United Nations Office on Drugs and Crime (UNODC) as the latest member of the United Nations Crime Prevention and Criminal Justice Programme Network Institutes in 2016. TIJ promotes the protection of human rights with a focus on vulnerable populations in particular women and children in contact with the criminal justice system. In addition, TIJ focuses on strengthening national and regional capacity in formulating evidence-based crime prevention and criminal justice policy.

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Tel: +66 (0) 2118 9400 Fax: +66 (0) 21189425, 26
www.tijthailand.org

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## AFRICA

### BURKINA FASO

- Administration Pénitentiaire et de la Réinsertion Sociale
- Mr. Bessolé René Bagoro, The Minister of Justice
- Mr. Eloi Guigma, Director General, Administration Pénitentiaire et de la Réinsertion Sociale
- Mr. Ousséni Ouedraogo, Directeur general adjoint de l'Administration pénitentiaire

### CABO VERDE

- Ms. Iradvi Gonçalves, Director Social Reintegration Service, DGSPRS (Direcção-Geral de Gestão Prisional e Reintegração Social)

### KENYA

- Ms. Aidah Mnyolmo, Deputy Officer in charge, Machakos Prison, Kenya Prisons Service
- Mr. Dancan Ogore, Director of Operations, Kenya Prisons Service
- Ms. Jane Kuria, CEO, Faraja Foundation, Kenya

### MADAGASCAR

- Administration pénitentiaire de Madagascar

## ASIA

### BANGLADESH

- Mr. Abdul Quddus, Superintendent, Department of Prisons

### INDIA

- Ms. Madhurima Dhanuka, Programme Head, Prison Reforms Programme, Commonwealth Human Rights Initiative

### INDONESIA

- Dr. Hetty Widiastuti, Deputy Director of Special Healthcare and Rehabilitation, Directorate General of Correction

### THAILAND

- Department of Corrections
- Ms. Na, House of Blessing Foundation
- Rev. Soonthorn Soonthorntarawong, Chairman, House of Blessing Foundation

## AUSTRALIA

- Ms. Debbie Kilroy, CEO, Sisters Inside
- Ms. T

## EUROPE

### SWEDEN

- The Swedish Prison and Probation Service

### UNITED KINGDOM

- Mr. James Mapstone, Chief Executive, Alliance of Sport
- Ms. Olivia Rope, Executive Director, Penal Reform international
- Ms. Rosie Meet, Professor, Department of Law and Criminology, Royal Holloway University of London
- Ms. Triona Lenihan, Policy and International Advocacy Manager, Penal Reform International

## NORTH AMERICA

### CANADA

- Ms. Marcia Kran, Member UN Human Rights Committee

### CALIFORNIA, UNITED STATES OF AMERICA

- Prof. Barbara Owen
- Mr. Chris Chambers, Deputy Director, Office of Research, CDCR
- The California Correctional Health Care Services

## SOUTH AMERICA

### ARGENTINA

- Dr. Sonia Quiruelas, Provincial Director of Prison Health, Province of Buenos Aires, Ministry of Justice and Human Rights of the Prov. Buenos Aires

### BRAZIL

- Dr. Andreia Beatriz Silva dos Santos
- Dr. João Marcos Buch

### PANAMA

- Ms. Sharon Diaz

# Foreword

The world we live in today is no longer the one we lived in two years ago. Our homes, communities, economies and nations have been drastically altered by the COVID-19 pandemic, exposing existing cracks in our healthcare systems. We have witnessed countries reach the brink of collapse, with hospitals running short of beds, medicines and even oxygen, irrespective of economic wealth.

The catastrophic impact of the pandemic has been felt by some sections of society more than others, leading to greater levels of inequality, especially in terms of access to timely and quality healthcare. In the midst of the chaos, prisons – unsurprisingly – have emerged as hotbeds for the virus. Being severely overcrowded and underfunded, prisons and the people inside them have been left vulnerable and forgotten. From riots to suicides, prisons have witnessed it all during the pandemic, resulting in gross human rights violations with adverse long-term consequences on physical and mental health, rehabilitation, reoffending and the rule of law.

As countries and prisons slowly adapt, and start thinking about a world post-COVID-19, the message is clearer than ever before: PRISON HEALTH IS PUBLIC HEALTH. We need systems and mechanisms to safeguard the health and well-being of persons deprived of their liberty in times of crisis, applying similar standards of healthcare available in the community. There needs to be greater investment in existing prison health, with simultaneous efforts for long-term reform of the criminal justice system to move towards non-custodial measures, especially for special categories of prisoners such as women, children, the elderly, pre-trial detainees and those convicted of non-violent and petty offences. Only then will we be able to reach a higher standard of community health and move towards achieving goal 3 (good health and well-being) and goal 16 (peace, justice and strong institutions) of the Sustainable Development Goals by 2030.

While the existing picture seems bleak, there is still hope. As a global community, there are many lessons we can learn from the COVID-19 pandemic and prison health. Through open dialogue, cross-sectoral collaboration and knowledge sharing, we can learn from our mistakes and increase preparedness for any future crisis. This report aims to provide such a resource, by compiling challenges, promising practices, lessons learned and recommendations from more than 22 countries across six continents.

As we move forward, let us pledge to promote and protect the health and welfare of people behind bars, to avoid any preventable loss of life in the future, and truly ensure that no one is left behind, even in times of crises.

Ms. Pornprapai Ganjanarintr
*Chairperson of the National Human Rights Commission of Thailand*

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# Introdu

Prison health is extremely important to public health, not only because of the high prevalence among prisoners of people with serious and often life threatening conditions, but also because of the continuous exchange between those in prison with outside communities.[1] In fact, while there are currently over 11 million people held in penal institutions throughout the world[2], the annual figure is much larger given the high turnover in the prison population, with people being admitted to, and released from prison all the time.

Since December 2019, the world has been grappling with a new global health threat: the outbreak of COVID-19 caused by the novel coronavirus[3]. Prisons have turned into potential hot spots of the disease.

The reported numbers of confirmed COVID-19 cases and related deaths among prisoners worldwide is significantly lower than the true figures. In fact, many prisoners and staff are asymptomatic and not many prison administrations are able to conduct regular testing. Indicatively, as of 12 July 2021, 575,884 cases of COVID-19 positive prisoners had been confirmed in 122 countries, while more than 4,082 prisoners had been reported having died because of COVID-19 in 47 countries[4].

Research in individual countries has indicated that, compared to the general population, prisoners are more likely to be become infected with the coronavirus and more likely to die from COVID-19[5].

Persons deprived of their liberty do not have the privilege to practice social distancing. They often have limited access to soaps and hand sanitizers, not to mention Personal Protective Equipment (masks and gloves). Thus, prisoners and prison staff are left confined to settings in which the risk of COVID-19 transmission is enhanced[6].

In May 2020, UNODC, WHO, UNAIDS and OHCHR issued a joint statement on COVID-19 in prisons and other closed settings. In this statement, the organizations underlined "the heightened vulnerability of prisoners and other people deprived of their liberty to the COVID-19 pandemic, and urge(d) (political leaders) to take all appropriate public health measures in respect of this vulnerable population…"[7]

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Prison systems already under strain because of overcrowding and insufficient resources have been struggling to prevent the spreading of COVID-19. Some of the measures adopted to curb the virus in the prisons have resulted in violations of prisoners' rights. In several Latin American and Western countries, COVID-19 has indirectly contributed to prison riots, triggered by lockdown measures, such as the limitation or suspension of family visits. In any case, the COVID-19 outbreak seems to have magnified and intensified all preexisting problems affecting prisons worldwide, forcing many administrations to acknowledge longstanding shortcomings in terms of overall infrastructure, equipment and human resources.

As underlined by the General Assembly in its resolution E/RES/2021/23, the COVID-19 pandemic "poses cross-cutting, multifaceted challenges to the criminal justice system" requiring "comprehensive, integrated, multisectoral and coordinated responses, including through cooperation between the justice and health sectors."[8] Mindful of the abundance of excellent articles and research analyzing and describing the various ways in which the pandemic has affected prisons in many countries, this paper is focusing on how, in the past year, COVID-19 has affected not only prisoners' human rights, but also living and working conditions in prison.

If COVID-19 has been defined as a "game changer" in many respects, it also represents an opportunity for criminal justice systems to reflect on the suitability of incarceration as a punishment and the importance of applying relevant international standards, first and foremost the United Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) and the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), to ensure humane and dignified conditions of detention.

1 *World Health Organization, Prison and Health, 2014, p.2*

2 *World Prison Population List (twelfth edition), 2018, p.2*

3 *World Health Organisation, https://www.who.int/news-room/detail/29-06-2020-covidtimeline (accessed on 13 August 2020)*

4 *COVID-19 and Prisoners, Justice Project Pakistan, https://www.jpp.org.pk/covid19-prisoners/ (accessed on 9 August 2021)*

5 *United Nations System Common Position on Incarceration, 2021, p.6*

6 *UN OHCHR, COVID-19 and Protection of Right to Life in Places of Detention, 2020, p.1*

7 *UNODC, WHO, UNAIDS and OHCHR Joint Statement on COVID-19 in Prisons and Other Closed Settings, https://www.who.int/news-room/detail/13-05-2020-unodc-who-unaids-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-closed-settings (accessed on 9 August 2020)*

8 *UN General Assembly, Resolution on 'Strengthening Criminal Justice Systems During and After the Coronavirus Disease (COVID-19) Pandemic' (E/RES/2021/23), 2021*

# METHODOLOGY

The paper is based on a wide range of open sources, replies to a questionnaire that was sent by the Thailand Institute of Justice (TIJ) to a sample of prison administrations in different regions, and follow-up interviews with officials and experts in selected countries. The paper is not solely academic or scientific but rather aims to point to some practical solutions for decision makers in prison systems as countries move to build back from the devastating effects of the pandemic. It recalls the international standards underpinning prison health care and captures some positive experiences, encouraging discussion on the "new normal" in prison. While many prison administrations were caught unprepared and had to improvise solutions to face the threat posed by the pandemic, the lessons learned in the first year of this global health crisis could help prison administrations to be better prepared in the future.

Many countries are still coming to terms with the pandemic and its devastating socio-economic effects. Prisons tend to be shrouded from external observers at the best of times and even more so during a crisis of this magnitude. Many of the prison administrations contacted for this paper were not in a position to respond as they were too occupied with day-by-day emergencies.

*CHAPTER*
*— 02*

# Prison Health

# Care

# RIGHT TO HEALTH

The 2030 Agenda for Sustainable Development[9] includes 17 Sustainable Development Goals (SDGs), which reflect a holistic approach to transforming the world into a more peaceful, just and inclusive global community, addressing social inequalities and human rights so that no one, including persons deprived of their liberty, is left behind.

Prison reform and the treatment of offenders should be viewed as an integral part of the 2030 Agenda, in particular with regard to SDG 16 on peace, justice and strong institutions; SDG 3 on good health and well-being; SDG 5 on gender equality and SDG 10 on reduced inequalities.[10] In particular, Sustainable Development Goal 3 is a specific commitment to "ensure healthy lives and promote well-being for all at all ages" with other Goals also including many health-related commitments.[11]

Health is central to the SDGs, as it is both an outcome of and a path to achieving poverty reduction and sustainable development.[12] Importantly, where the health-related Goals show lack of clarity with regard to implementation, the right to health will be a powerful tool to ensure effective and equitable achievement of the Goals.[13]

Prisoners are deprived of their freedom but retain the fundamental rights to which they are entitled as human beings. Thus, they enjoy the same right to the highest attainable standard of physical and mental health conducive to living a life in dignity enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights. While interpreting the right to health as "an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health", the Committee on Economic, Social and Cultural Rights in its General Comment No. 14 (2000)[14] recognizes that States are under the obligation to respect the right to health by, inter alia, refraining from denying or limiting equal access for all persons, including prisoners or detainees, to preventive, curative and palliative health services. As elsewhere, health-care services, goods and facilities for prisoners should be "available, accessible, acceptable and of good quality".[15]

Furthermore, prisoners are in a position of subordination vis-à-vis the State, i.e. they are dependent in law and in fact for all of their needs. Thus, the State acquires a special level of responsibility and it owes a duty to protect the health of prisoners by providing them, among other things, the required medical care, as well as the underlying determinants of health, such as space, ventilation, food, drinking water, bathing and shower installations, sanitation, natural and artificial light, etc. Even when the State has outsourced prison health to private companies or agencies, it remains responsible for the adequacy of such care.[16]

However, as the United Nations High Commissioner for Human Rights noted in its report on human rights in the administration of justice of 2019, access to health care is often inexistent or inadequate and infringements of the right to health contribute to deaths in situations of deprivation of liberty. Rates of disease, drug dependency and mental illness in the prison population are much higher than in the general population. Indeed, mortality rates are high and have been shown to be as much as 50 per cent higher for prisoners than for people in the wider community. Infectious and communicable diseases are often not adequately treated with potential lethal consequence.[17] Prisoners often come from impoverished and marginalized backgrounds. They may have been exposed to inadequate nutrition and some of them may have neglected their health and may never have been treated by a qualified doctor before their imprisonment.[18]

Prison management and the treatment of offenders are a low priority in many countries. Prisons tend to be under resourced and struggle to provide for the most basic needs of prisoners.[19] Inadequate access to health care often stems from routine underfunding, understaffing and lack of prison health policy.[20] Common organizational and structural challenges, such as the shortage of means of transportation or personnel to transfer inmates from detention facilities to hospitals or the lack of personalized medical records, may also limit access to proper health care for prisoners. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health[21] observed that safeguarding the right to health once a person is incarcerated is a challenging task. In fact, prison itself becomes a determinant of poor health as a result of abysmal conditions of detention, the enormous psychosocial pain and hopelessness linked to being deprived of liberty and untreated pre-existing health conditions attributable to the conditions of living in poverty.[22]

He also warned that Sustainable Development Goal 3 will not be reached if the global community neglects to seriously address the use of detention as a public-health policy.[23]

9 *UN General Assembly, Resolution on 'Transforming our world: the 2030 Agenda for Sustainable Development' (A/70/1), 2015*

10 *United Nations System Common Position on Incarceration, April 2021, p.2*

11 *UN General Assembly, Resolution on 'Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (A/71/304), 2016, p.3*

12 *Ibid. p.4*

13 *Ibid. p.23*

14 *UN OHCHR, CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), 2000*

15 *Ibid. p.4*

16 *Inter-American Commission on Human Rights, Report on the Human Rights of Persons Deprived of Liberty in the Americas, 2011, p.187-188*

17 *UN General Assembly, Report of the United Nations High Commissioner for Human Rights (A/HRC/42/20), 2019, p.9*

18 *Penal Reform International, Coronavirus: Healthcare and human rights of people in prison, 2020, p.4*

19 *United Nations System Common Position on Incarceration, April 2021, p.6*

20 *UN General Assembly, Report of the United Nations High Commissioner for Human Rights (A/HRC/42/20), 2019, p.9*

21 *Henceforth "Special Rapporteur on the right to health".*

22 *UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/38/36), 2018, p.6*

23 *Ibid. p.20*

# INTERNATIONAL, REGIONAL AND NATIONAL PROVISIONS ADDRESSING PRISON HEALTH

The Nelson Mandela Rules[24] were adopted in 2015 at the end of a thorough revision process. The chapter on prison health care was amended and expanded extensively to reflect the advances in public health since the 1950's when the original Standard Minimum Rules for the Treatment of Prisoners were adopted. Rule 1 stipulates that "all prisoners shall be treated with the respect due to their inherent dignity and value as human beings". Humane treatment for persons in custodial care includes providing adequate, accessible and appropriate health care.[25]

Furthermore, ensuring the health and well-being of prisoners, prison officers, other prison personnel and visitors must be at the heart of infection prevention and control measures, while respecting the fundamental safeguards outlined in the Nelson Mandela Rules.[26]

In the Kyoto Declaration on Advancing Crime Prevention, Criminal Justice and the Rule of Law: Towards the Achievement of the 2030 Agenda for Sustainable Development, Member States undertook to "Improve the detention conditions for both pretrial and post-trial detainees and the capacities of prison, correction and other relevant officers in this regard, including by promoting the practical application of relevant provisions of the Nelson Mandela Rules, as well as the Bangkok Rules".[27]

The Special Rapporteur on the right to health has urged States to "fully abide by, and implement, the Nelson Mandela Rules, in particular as regards the provision of health care in prisons" as part of the right-to-health framework.[28]

The section entitled "Health-care services" (Nelson Mandela Rules 24 to 35), introduces fundamental principles of prison health.

Prisoners have no alternative but to rely on the authorities to protect their health and to provide them with the necessary medical treatment. As stressed in Rule 24.1, when a state deprives a person of his/her liberty, it takes on a special duty of care, i.e., "the provision of health care for prisoners is a state responsibility".

Rule 24.1 also affirms the fundamental principle of equivalence of care, according to which "Prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status".

Rule 24.2 stresses the importance of the principle of integration, stipulating that "health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of

treatment and care …" This is critical upon admission to a prison but also facilitates the uninterrupted treatment of prisoners with specific medical conditions upon release.

Accurate, up-to-date and confidential individual medical files on all prisoners should be maintained by the health-care service. The requirement to provide continuity of care also includes the duty to properly manage and transfer a prisoner's medical files.[29] Upon transfer of a prisoner to another prison, his/her medical file shall be transferred under confidentiality to the health-care service of the receiving institution.[30]

Rule 25.2 introduces another fundamental aspect, i.e. the "full clinical independence" that should inform the health care provided by an interdisciplinary team of qualified personnel. This provision is complemented by Rule 27.2: "Clinical decisions may only be taken by the responsible health-care professionals and may not be overruled or ignored by non-medical prison staff." Health care personnel in prisons should act in their professional capacity completely independent of prison authorities and in the closest possible alignment with public health services, while remaining in effective liaison with prison staff to enable health care to be delivered efficiently.[31]

Similarly, Principle X of the Principles and Best Practices on the Protection of Persons Deprived of Liberty in the Americas[32] is dedicated to health and stresses that persons deprived of liberty shall have the right to health, understood to mean the enjoyment of the highest possible level of physical, mental, and social well-being. It also stresses that "the State shall ensure that the health services provided in places of deprivation of liberty operate in close coordination with the public health system so that public health policies and practices are also applied in places of deprivation of liberty.

In the European Prison Rules[33], health care is covered in Part III. Rule 39 states that "prison authorities shall safeguard the health of all prisoners in their care". Rule 40 on the organisation of prison health care stresses important fundamental principles of prison health: medical services in prison shall be organised in close relation with the general health administration of the community or nation (R. 40.1); health policy in prisons shall be integrated into, and compatible with, national health policy (R.40.2); prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation (R. 40.3); medical services in prison shall seek to detect and treat physical or mental illnesses or defects from which prisoners may suffer (40.4); and all necessary medical, surgical and psychiatric services, including those available in the community, shall be provided to the prisoner for that purpose (R.40.5).

The Committee of Ministers of the Council of Europe in its official commentary to the European prison Rules concluded that "…the most effective way of implementing Rule 40 is that the national health authority should also be responsible for providing health care in prison, as is the case in a number of European countries."[34] Close links or integration between public health services and prison health are crucial not only to ensure continuity of treatment but also for prisoners and staff to benefit from wider developments in treatments, in professional standards and in training.[35]

However, as shown in the following examples from Europe and other countries, there is a variety of schemes under which medical staff is hired to provide health care in prisons. In the UK, medical staff providing health care in prison are employed by National Health Service bodies or contractors to the National Health Service, overseen by the Health Department in England and by the Health Departments of Devolved Administrations in Wales and Scotland.

24 *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules), 2015*

25 *UN General Assembly, Interim report of the Special Rapporteur on torture and other cruel, inhuman or degrading treatment or punishment (A/68/295), p.9*

26 *UNODC Position Paper, COVID-19 preparedness and responses in prisons, 2020*

27 *UNODC, Kyoto Declaration on Advancing Crime Prevention, Criminal Justice and the Rule of Law: Towards the Achievement of the 2030 Agenda for Sustainable Development, 2021, P.7*

28 *UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/38/36), 2018, p.7 & p.20*

29 *Office for Democratic Institutions and Human Rights (ODIHR), OSCE and Penal Reform International, Guidance document on the Nelson Mandela Rules, 2018, p.145*

30 *Nelson Mandela Rule 26*

31 *World Health Organization, Good governance for prison health in the 21st century, 2013, p.9*

32 *Approved by the Inter-American Commission on Human Rights during its 131st regular period of sessions, held from 3 to 14 March 2008*

33 *Council of Europe, European Prison Rules, 2006*

34 *World Health Organization, Good governance for prison health in the 21st century, 2013, p. 10-11*

35 *Institute for Criminal Policy Research (ICPR) in cooperation with the International Committee of the Red Cross, A Human Rights Approach to Prison Management, Handbook for prison staff, third edition, 2018, p.52*
*See also World Health Organization, Moscow Declaration on Prison Health as part of Public Health, 2003*

In Catalonia, health care services in prison depend on the Ministry of Health and care is provided through the public medical network. In Malta, prison doctors are hired by the prison on a service contract basis. Therefore, they are contractors and are not considered as prison staff. In Latvia doctors, also hired directly by the Prison Administration, have better contractual conditions than in the public health sector.

In Swedish prisons, medical staff is employed by the Swedish Prison and Probation Service (Ministry of Justice) but is under supervision by the National Board of Health and Welfare (Ministry of Health and Social Affairs). Nurses are employed by the Swedish Prison and Probation Service. On a monthly basis, they earn an average of 100 euro more than in the public health care system. Other benefits attached to these positions are more work independence, increased responsibility and pre-defined working hours. Medical doctors are procured as self-employed.

**COMPARED TO THE GENERAL POPULATION, PRISONERS' HEALTH CARE IS QUITE EXPENSIVE TAKING INTO ACCOUNT THEIR MANY NEEDS, ESPECIALLY IN TERMS OF MENTAL HEALTH CARE.**

Slovakia is an example of the difficulties encountered by various prison administrations worldwide to attract and retain good health care staff for the prisons. Medical staff is employed by the General Directorate of the Corps of Prison and Court Guard either as uniformed or civilian employees. In spite of the efforts by the General Directorate to motivate prospective candidates by improving working and economic conditions, prison health care is generally still non-attractive and financially less remunerated than public health care. Thus, it is difficult for the General Directorate to fill all vacancies even by providing non-financial benefits (e.g. longer holidays and accommodation to a limited extent).[36]

In Austria, prisoners are not insured under the public health care scheme. In 2015, the total budget of the prison system was around 450 million Euros, out of which about 80 million were spent on health care for the 9,000 (average) prisoners.[37] Compared to the general population, prisoners' health care is quite expensive taking into account their many needs, especially in terms of mental health care. Recently, the "Rechnungshof" (Court of Auditors) has recommended to identify a more cost-effective alternative for the provision of health care to prisoners, although – looking at preliminary data – inclusion of prison health-care services in the public health system would generate additional costs to the community.[38]

In Cabo Verde, the health-care team is tasked with the provision of its services in articulation with the National Health-care Services. It is directed by a medical professional designated by the Director General of the Prison Administration. He/she reports to the prison director for administrative matters.[39]

In Kenya, health care is a national issue and is not devolved to the regions. The Ministry of Health is responsible for the prisoners' wellbeing and provides health-care staff for the prisons, while additional uniformed health workers are paid by the Kenya Prisons Service (KPS). Basic medical care in prisons is covered by the Ministry of Health and KPS has a budget to cover extra necessary services available either in a public or a private health facility (e.g. MRI, scans, etc.). Most equipment is bought by the Ministry of Health and KPS supplements medicines.[40]

In the Province of Buenos Aires, a region characterized by the highest number of prisoners in the country, the Provincial Directorate of Prison Health is run by the Under-Secretariat for Prison Policy of the Ministry of Justice of the Province of Buenos Aires, and works in conjunction with the Buenos Aires Prison Service and the provincial Ministry of Health. Its mission is to safeguard the health of the prison population, guaranteeing one of the inherent rights of human beings. At the beginning of 2020 the Government of the Province decided to invest considerable funding in prison health to improve the prisoners' access to health. By the end of March 2021 sixteen modular hospitals should be operational in 12 prison complexes for a total of 384 additional beds. This will cut down on transportation costs and will considerably alleviate the pressure on local hospitals, especially in the context of the COVID-19 pandemic.[41]

In Thailand, the Department of Corrections is responsible for 142 prison clinics. The clinic in Nakhonpathom Detention Centre is registered in the National Health Insurance System. Out of the 142 clinics, 140 are primary care units and 2 are permanent and referral services based in the Medical Corrections Hospital and Bang Kwang Central prison. The Ministry of Justice has signed a Memorandum of Understanding with the Ministry of Public Health, which includes the development and support of prisoners' healthcare as well as the management and referral of their medical treatment. Therefore, the prison medical staff can directly coordinate with the relevant hospital in case there is a need for referral, medical supplies, or additional medical treatment.[42]

In the USA, for example, health-care services in California Department of Corrections and Rehabilitation (CDCR) facilities are provided by California Correctional Health Care Services. Funding and staffing are handled on a state level. The Health Care Department Operations Manual (HCDOM) outlines the delivery of medical and dental care provided to patients. All of the provisions are designed to meet the minimum community standard of health care.[43]

Nelson Mandela Rule 2 states that the rules shall be implemented impartially and without discrimination. However, "in order for the principle of non-discrimination to be put into practice, prison administrations shall take account of the individual needs of prisoners, in particular the most vulnerable categories in prison settings." The rule also adds that "measures to protect and promote the rights of prisoners with special needs are required and shall not be regarded as discriminatory".

Reinforcing this principle, Nelson Mandela Rule 25.1 stipulates that "every prison shall have in place a health-care service tasked with evaluating, promoting, protecting and improving the physical and mental health of prisoners, paying particular attention to prisoners with special health-care needs or with health issues that hamper their rehabilitation." Thus, prisoners' health is recognized as a key factor for successful rehabilitation and social reintegration programmes. Depending on the composition of a specific prison population, there can be different categories of prisoners with special health care needs, such as e.g., foreigners, LGBTQ+, prisoners with physical or mental disabilities, etc. In many countries, older prisoners represent a growing group characterized by a wide array of age-related medical problems, spanning from mobility limitations to chronic diseases, to dementia. They place further pressure on underfunded prison health-care services and may be difficult to accommodate in prisons traditionally conceived for young men.

Newly arrived prisoners shall be examined by a physician (or other qualified health-care professional) as soon as possible upon admission in keeping with Nelson Mandela Rule 30. The initial medical screening is fundamental to identify any health conditions or mental health needs of a prisoner, as well as his/her needs for treatment. Attention shall also be paid to detecting any signs of ill-treatment in newly admitted prisoners, as well as early signs of distress that may increase suicide or self-harm risk. Special protocols should be foreseen for clinical isolation and adequate treatment of prisoners diagnosed with a contagious disease.

36 *European Prison Information System, 110619: Medical Prison Staff, responses by agencies, https://www.europris.org/epis/kms/?detail=344 (accessed on 13 February 2021)*

37 *With the exception of working prisoners and persons who maintain a job while subject to house arrest with electronic surveillance. Katharina Mittelstaedt, Häftlinge nicht versichert: Behandlungskosten steigen, Der Standard.at, 26 August 2016, https://www.derstandard.at/story/2000043360105/privatpatient-haeftling-steigende-kosten-fuer-krankenversorgung (accessed on 14 February 2021)*

38 *Karl Ettinger, Jeder Tag in haft kostet rund 130 Euro, Wiener Zeitung.at, 2020 https://www.wienerzeitung.at/nachrichten/politik/oesterreich/2084776-Jeder-Tag-in-Haft-kostet-rund-130-Euro.html (accessed on 14 February 2021)*

39 *Atribuições da equipa de trabalho dos Serviços Clínicos, Artigo 18, Decreto-lei Nr. 84/2020, (accessed on 18 December 2020)*

40 *Conversation with Mr. Dancan Ogore, Director of Operations, KPS, 19 February 2021*

41 *Conversation with Dr. Sonia Quiruelas, Provincial Director, Provincial Directorate of Prison Health, Ministry of Justice and Human Rights, Argentina, 1 February 2021*

42 *Reply to the TIJ questionnaire by the Department of Corrections, Thailand*

43 *Reply to the TIJ questionnaire by the California Department of Corrections and Rehabilitation (CDCR), USA*

# GENDER SPECIFIC HEALTH CARE IN PRISON

*WOMEN PRISONERS MAKE UP*

**7%**

*OF THE GLOBAL PRISON POPULATION*

**53%**

*INCREASE IN THE FEMALE PRISONER POPULATION*

Women only represent an estimated 7% of the prisoners worldwide and in four-fifths of prison systems they constitute between 2% and 9% of the total prison population. The total number of women in prison has increased by some 53% in the last twenty years, compared to the 20% increase in the number of male prisoners.[44] In many countries, a growing number of women are being imprisoned for petty offences as a consequence of tougher criminal justice policies. In particular, drug-related offences are being criminalized and more seriously penalized, thus contributing to the increase of women in prison. Because of the small number of female prisoners, prisons worldwide and their regimes – from the architecture and security procedures to healthcare, family contact and training opportunities – are usually designed for men and the needs of women are largely ignored.

While the Nelson Mandela Rules address the rights of all prisoners and shall be applied impartially, they only contain few provisions especially dedicated to women, namely concerning prenatal and postnatal care. The Bangkok Rules[45] provide a gender-specific framework for health care which emphasizes reproductive and sexual health, mental health care, treatment for substance abuse and counselling victims of physical and sexual abuse.[46] They represent an important step forward in recognising the gender-specific needs of women in criminal justice systems and providing the standards that should be applied in the treatment of such women. The Bangkok Rules are also the first international instrument which specifically addresses the issue of the children of women prisoners.[47]

**MANY WOMEN PRISONERS HAVE A PAST OF ABUSE AND VICTIMIZATION AND THEIR NEEDS FOR TREATMENT ARE OFTEN NOT RECOGNIZED AND MET IN PRISON. THEY MAY ENDURE FURTHER MENTAL AND PHYSICAL ABUSE, HARASSMENT AND VIOLENCE IN PRISON.**

A number of problems affect women when they are detained. Although pre-trial detention should be used as a measure of last resort, even women accused of petty non-violent offences often do not have the money required to access bail and are thus excluded from non-custodial measures. Most women committed to detention have children and this fact enhances their vulnerability, especially at the time of admission. Additionally, considering that some women in prison are either pregnant, breastfeeding mothers, or women with accompanying children in prison adds to their vulnerable status. Because they are not numerous, women prisoners are usually concentrated in a few facilities and may end up spending long periods far from home and their families. Furthermore, women's prisons are often converted unsuitable buildings offering less facilities and less options for education and training than men's prisons. In spite of the fact that women frequently represent a low security risk, they are often kept in prisons under higher security than is needed and this further contribute to the emotional distress caused by the fact of being imprisoned. Many women prisoners have a past of abuse and victimization and their needs for treatment are often not recognized and met in prison. They may endure further mental and physical abuse, harassment and violence in prison.[48]

Women prisoners often have greater primary health care needs in comparison with men. In fact, the majority of women prisoners usually come from socially disadvantaged communities and groups. They tend to be young, unemployed, with little education and to have dependent children. Large percentages of women prisoners have a history of mental health care needs, including drug use. Physical, mental and sexual abuse, and the resultant trauma and PTSD is a common experience in women prisoners' lives. It is widely recognized that imprisonment has a devastating impact on women's mental health, generating new problems and exacerbating existing ones, especially for women with children. Therefore, women are at higher risk of self-harm and suicide in prison.[49]

The Bangkok Rules take these aspects into account and promote the establishment of mental health services oriented to the gender-specific needs of women prisoners. Likewise, they also complement the provisions of the Nelson Mandela Rules to reflect the specific needs of women prisoners in term of health care and hygiene. Many drug-using women prisoners neglect their health while outside prison and this, coupled with the frequent occurrence of sexual violence, sex work and unsafe sexual practices in this segment of the population, make women prisoners particularly vulnerable to HIV and other sexually transmitted diseases. For some women, their time in prison may be the first opportunity to have access to preventive health care and treatment, social support and counselling.[50] Women at different ages require special health care and hygiene and this needs to be taken into account by national prison administrations.

44 *Institute for Criminal Policy Research (ICPR), World Female Imprisonment List (fourth edition), 2017*

45 *UN General Assembly, United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules), (A/65/229), 2010*

46 *UNODC, Handbook on Women and Imprisonment (2nd edition), Criminal Justice Handbook Series, 2014, p.60*

47 *Penal Reform International and the Thailand Institute of Justice, The Bangkok Rules Index of implementation, 2013, p.4*

48 *Piera Barzanò, The Bangkok Rules: An International Response to the Needs of Women Offenders, Resource Material Series No. 90, 153rd International Senior Seminar, UNAFEI, 2013, p.87*

49 *ICPR, 'Towards a health-informed approach to penal reform?', 2019, p.11*

50 *UNODC and WHO Europe, Women's health in prison, 2009, p.21*

# RESOURCES FOR HEALTH CARE IN PRISON

Penitentiary populations contain an over-representation of members of the most marginalized groups in society, people with poor health and chronic untreated conditions, drug users, the vulnerable and those who engage in risky activities such as injecting drugs and commercial sex work. The movement of people already infected with or at high risk of disease to penitentiary institutions and back into civil society without effective treatment and follow-up gives rise to the risk of the spread of communicable diseases both within and beyond the penitentiary system.[51]

Against this background, the provision of health-care services is fraught with considerable difficulties. Among the responses to the questionnaire distributed to selected prison administrations by TIJ, more than half indicated that their prison health-care services were understaffed and lacked the funding, medical equipment and supplies to attend to the prisoners' needs.


In particular, Thailand indicated that the budget allocated to the Department of Corrections for procurement of drugs, non-pharmaceutical- and medical supplies and equipment is not sufficient as it remains the same even if the number of prisoners increases. For example, on 16 November 2020, Thailand reported 348,653 prisoners against a capacity of 299,048. Each prison receives its share of money to procure the necessary health-care articles. To offset this shortage, each prison ties up with outside hospitals to obtain the required medicines and medical supplies under the National Health Insurance System.

With a total of 587 health-care staff members, of which 439 registered nurses, Thailand prisons suffer from a shortage of personnel as well. In fact, the staffing table does not consider the increase in the number of prisoners. There are usually 1-2 but not more than 5 registered nurses working in each prison, with the exception of the Medical Correctional Hospital that has 131 nurses on shift 24/7 to treat prisoners.[52]

In some countries, procurement of medicines and medical supplies is delegated to each prison, which usually ensures that only items that are really necessary are purchased but may lead to bottlenecks and delays in the process and to higher prices because of the smaller quantities ordered. This system often puts smaller prisons and those situated in remote areas at a disadvantage as it may be more difficult for them to procure the required medical drugs and equipment. Other countries rely on a centralized procurement system, either by the Prison Administration or the Ministry of Health. In this case, prisons may end up receiving drugs or supplies that do not respond to their needs or are delivered late. There might also be operational problems with the distribution of supplies to prisons far away from headquarters. On the other hand, prices for bulk purchases are usually cheaper. As mentioned before, there are cases like Kenya and Thailand that supplement basic allocations with additional resources.

Health-care services in California Department of Corrections and Rehabilitation (CDCR) prisons are provided by California Correctional Health Care Services (CCHCS). Procurement of medical drugs and equipment is handled in a hybrid manner. Prisons purchase locally and they also have a central fill pharmacy that purchases and distributes medication. Additionally, some equipment is purchased at a headquarters level for volume discount.[53]

In Italy, in 2008 the responsibility for prison health care was transferred from the Ministry of Justice to the National Health System, which is devolved to the regions. Over ten years later, the picture is not very encouraging and shows considerable regional variations. In 2019, there was only one general practitioner in each prison for every 315 prisoners, for a total of 1,000 physicians and on-call doctors in around 200 prisons. As 70% of the doctors are temporarily employed, their services are not entirely sufficient, at least not in all prisons.[54]

51 *World Health Organization, Moscow Declaration on Prison Health as part of Public Health, 2003*

52 *Reply to the TIJ questionnaire by the Department of Corrections, Thailand*

53 *Reply to the TIJ questionnaire by the California Department of Corrections and Rehabilitation (CDCR), USA*

54 *Antigone, 'Have prisons learnt from COVID-19?', Antigone, Anno XV, N. 1, p.213*

# UNDERLYING DETERMINANTS OF HEALTH IN PRISON

Considering the promiscuity and limited space characterizing many prisons, as well as the large number of persons forced to share cells, sanitary facilities and common areas, detention conditions may often represent a health hazard for both prisoners and prison staff and contribute to a higher risk of transmission of infectious diseases. Various factors may affect the physical environment of prisoners. Common problems in prisons are monotonous diets poor in proteins and vitamins, often prepared in unhygienic kitchens and not adapted to the prisoners' individual nutritional needs in case of diabetes, hypertension, etc. or insufficient for pregnant and lactating women. In many countries, prisoners have to rely on their families to supplement the meagre food provided by the prison administration, or to bring soap for their personal hygiene or cleaning products for their accommodation.

Sufficient and uninterrupted access to clean and safe drinking water is a basic requirement that is often unmet in prison. Lack of ventilation, caused by small windows, sometimes covered by the prisoners to filter out the light or to protect themselves from the cold, can make the air unbearably stuffy and facilitates spreading of air borne diseases. In cold countries, insufficient or no heating can also be detrimental to the prisoners' health.

Natural light is another important factor supporting mental and physical well-being, especially by improving sleep and regulating biorhythms.[55] An unreliable electricity supply may force prisoners to be in the dark after sunset and, in warm climates, if electric fans do not work, cells - especially dormitories - can become so stifling hot that prisoners may die of heatstroke.

The insufficient number of toilets and washing facilities and the lack of maintenance are other frequent problems. Laundry facilities are non-existing in many prisons and prisoners do not always dispose of adequate mattresses and bedding without paying for them. Infestations of rodents and parasitic insects are common signs of inadequate hygiene in prisons and contribute to unhealthy living and working conditions.

Prisoners require regular physical activity to remain fit and healthy, especially given the limited range of spaces and activities they have access to in prison. Not many prisons offer adequate opportunities for exercise outdoors. Access to nature and fresh air contributes to decreasing the stress of being confined in a small area and the lack of privacy experienced by most prisoners.[56]

Nelson Mandela Rule 35, among the areas of responsibility of the prison physician (or competent public health body), foresees the regular inspection of food (quantity, quality, preparation and service); hygiene and cleanliness of the premises and the prisoners; sanitation, temperature, lightning and ventilation of the prison; suitability and cleanliness of the prisoners' clothing and bedding, as well as the observance of the rules concerning physical education and sports if no technical personnel is in charge of these activities. The inspecting official should advise the prison director accordingly so that the appropriate corrective measures can be adopted by the director or a higher authority.

55 *International Committee of the Red Cross (ICRC), Towards Humane Prisons, 2018, p.151*

56 *Ibid., p.158*

# FREQUENT HEALTH PROBLEMS IN PRISON

Prisoners often arrive in prison with pre-existing health problems which may have been caused by neglect, abuse or the prisoner's previous lifestyle. Not only in high-income countries but also in middle- and low-income countries are prisoners at higher risk of non-communicable diseases (NCDs), such as cardiovascular disease, cancers, chronic respiratory diseases and diabetes.[57]

Drug use disorders are highly prevalent among those entering prison, with a rate that is higher for women than for men.[58] The availability of treatment services for drug use, including pharmacological and psychosocial treatment, and services for social rehabilitation and aftercare, remains much lower in prison than in the community.[59]

As a consequence, the prevalence of HIV, hepatitis B and hepatitis C is particularly high in pre-trial detention centres and in prisons. In Italy for example, it is estimated that 25% to 35% of the prisoners suffer from Hepatitis C, i.e., between 25,000 and 35,000 prisoners a year.[60] All modes of transmission of these diseases occurring in the community also occur in prisons: through blood, sexual activity and vertical transmission to a child.[61] TB in prisons is a major public health problem particularly in countries with a high incidence of TB. The TB notification rate in in prisons range from 11 to 81 times higher than in the general population.[62]

Particular care should be exercised in protecting the health of prisoners awaiting trial. Due to the fact that they are considered as temporary places of detention, prison facilities for this category of prisoners are often more crowded and ill-equipped to deliver health services. In some countries, these prisoners are excluded from treatment programmes in prison by virtue of their not being yet convicted. Often the pre-trial status is protracted for months or years and the health needs of this category of prisoners may remain unrecognized and unmet. For people who have been receiving treatment for a medical condition (e.g. HIV or TB) in the community, arrest and detention represent a potentially deadly interruption of treatment.

A disproportionately large number of prisoners have mental or behavioural disorders. Many of these disorders may be present before admission to prison, and may be further exacerbated by the stress of imprisonment. However, mental disorders may also develop during imprisonment itself as a consequence of prevailing conditions and also possibly due

**RESEARCH POINTS TO THE FACT THAT PRISONERS TEND TO DISPLAY AGE-RELATED BIOLOGICAL CHANGES EARLIER THAN PEOPLE LIVING IN THE COMMUNITY DUE TO THEIR ACCELERATED AGEING BECAUSE OF POOR NUTRITION, DRUG AND ALCOHOL USE, STRESS, LACK OF EXERCISE, ETC.**

to torture or other human rights violations. In some countries, people with severe mental disorders are inappropriately locked up in prisons simply because of the lack of mental health services. People with substance abuse disorders or people who, at least in part due to a mental disorder, have committed minor offences are often sent to prison rather than treated for their disorder. These disorders therefore continue to go unnoticed, undiagnosed and untreated.[64]

Additional challenges are facing prison health-care services considering that the world's population is ageing rapidly. The UN estimates that by 2050, people aged 60 or over will account for 9% of the population in Africa at one end of the scale and as much as 34% of the population in Europe at the other. Thus, in many countries, the number of older people in prisons is on the rise.[65]

For example, in France,[66] in less than 20 years, prisoners over 60 have quintupled. Longer sentences for sexual offences, people sentenced for serious offences in later life, life sentences without parole all contribute to the increase in the percentage of older inmates worldwide. Among the elderly prison population in Italy, 64% of a representative sample from various prisons suffered from one or more pathologies. Women prisoners over 50 represent a minority in the minority (women account for only 4% or the prison population in Italy). Their specific health-care needs are often overlooked.[67]

Research points to the fact that prisoners tend to display age-related biological changes earlier than people living in the community due to their accelerated ageing because of poor nutrition, drug and alcohol use, stress, lack of exercise, etc. For this group of prisoners, a needs assessment through an initial screening followed by regular check-ups, coupled with appropriate preventive and health maintenance strategies can delay the onset or worsening of chronic diseases and loss of independence in everyday life.[68]

Foreign prisoners represent a large percentage of the prison population in many countries, especially in Europe. They also tend to have specific needs that have to be addressed taking into account individual customs and habits, verbal and non-verbal communication styles and the substantial lack of emotional and civil references.[69]

57 *WHO Regional Office for Europe, Prisons and Health, 2014, p.81*

58 *UNODC, World Drug Report 2019, p.32*

59 *Ibid., p.39*

60 *Antigone, 'Have prisons learnt from COVID-19?', Antigone, Anno XV, N. 1, p.214*

61 *WHO Regional Office for Europe, Prisons and Health, 2014, p.45*

62 *Ibid., p.56*

63 *Ibid., p.37*

64 *WHO and ICRC, Mental health and prisons, https://www.who.int/mental_health/policy/mh_in_prison.pdf (accessed on 28 February 2021)*

65 *ICRC, Ageing and detention, 2018, p.3*

66 *Libération, Un papy-boom dans nos prisons, 2012, https://www.liberation.fr/societe/2012/08/27/un-papy-boom-dans-nos-prisons_842167/*

67 *Antigone, 'Have prisons learnt from COVID-19?', Antigone, Anno XV, N. 1, p.215*

68 *ICRC, Ageing and detention, 2018, p.3*

69 *Antigone, 'Have prisons learnt from COVID-19?', Antigone, Anno XV, N. 1, p. 218*

# OVER-CROWDING

Prison overcrowding, poor prison conditions and the serious neglect of prison services are long-term deficiencies with immense consequences for public safety, health, and human rights, as well as financial and socioeconomic costs.[70]

Overcrowding has an adverse impact on the quality of nutrition, sanitation, prisoners' activities and health-care services. It affects the well-being of all prisoners, generates prisoner tension and violence, exacerbates existing mental and physical health problems, increases the risk of transmission of communicable diseases and poses immense management challenges to prison administrations. Prison staff working in overcrowded institutions is often exposed to very high stress levels and an enhanced burn-out risk.

Prison overcrowding is generally defined with reference to the occupancy rate and the official capacity of prisons. Thus, overcrowding refers to the situation where the number of prisoners exceeds the official prison capacity. The rate of overcrowding is defined as that part of the occupancy rate above 100 per cent. Out of 206 countries and territories, 118 reported an occupancy rate over 100%, 24 of which had between 2 to 6 times as many prisoners as places in their prisons.[71]

Most countries worldwide are affected by the problem of overcrowding. Drug offenders contribute significantly to overcrowded prisons in many parts of the world. Prison overcrowding can be concentrated not in all but in a few prisons, usually in metropolitan areas. Pre-trial detention facilities tend to be more overcrowded because of the "transitory" nature of the occupants. Considering the small percentage of women among the prison population, women prisoners tend to be grouped in fewer institutions that are often overcrowded.

70 *United Nations System Common Position on Incarceration, April 2021, p.7*
*See also Kyoto Declaration on Advancing Crime Prevention, Criminal Justice and the Rule of Law: Towards the Achievement of the 2030 Agenda for Sustainable Development, 2021, p.7*

71 *Institute for Crime & Justice Policy Research, World Prison Brief, https://prisonstudies.org/highest-to-lowest/occupancy-level?field_region_taxonomy_tid=All (accessed on 28 February 2021)*

*CHAPTER*
*— 03*

# A Globa Health in Priso

Since 31 December 2019, when a significant cluster of cases of a novel coronavirus was reported in Wuhan, China, the world has been grappling with the worst global health crisis in 100 years. On 11 March 2020, the World health Organization (WHO) declared the outbreak of a pandemic of COVID-19, the disease caused by the novel coronavirus.

Within a few weeks, cases of COVID-19 were reported in many countries and prisons became potential hotspots for the virus, while various confinement measures were imposed on the general population in most of the world to limit the spreading of COVID-19. Practicing social distancing and wearing masks became the new social behavioural code to prevent contagion.

# al Crisis ons

As noted by the European Prison Observatory, social distancing is an oxymoron in prison even without overcrowding. The fact that prison administrations suspended most activities in prison at the onset of the pandemic, resulted in the prisoners spending 20-21 hours/day in their cells without family visits for up to 10 months in some cases. Prison leaves and furloughs were also suspended or greatly limited. Thus, there were more prisoners present during the day as well. Volunteers and professionals normally providing services in prison were also prevented from entering. Access to lawyers was restricted. Only prison staff could go in and out of the prisons and they became the main source of contagion in many cases.

72 *Alessio Scandurra, European Prison Observatory, webinar organized by Antigone, 17 December 2020*

**THERE SEEM TO BE CONSIDERABLE GAPS IN GOVERNMENTS' EFFORTS TO PROVIDE RELIABLE, DISAGGREGATED AND TIMELY DATA ON COVID-19 INFECTIONS AND DEATHS IN PRISONS, INCLUDING RATES OF TESTING, POSITIVE CASES AND DEATHS AMONG PRISONERS.**

The initial phase of the pandemic was characterized by a widespread shortage of masks and other protective equipment, including in prisons. Testing kits were also hard to come by and many countries did not have any testing capacity in prison, even for staff.

As noted by WHO, widespread transmission of an infectious pathogen affecting the community at large poses a threat of introduction of the infectious agent into prisons and other places of detention; the risk of rapidly increasing transmission of the disease within prisons or other places of detention is likely to have an amplifying effect on the epidemic, swiftly multiplying the number of people affected.[73] The global effort to tackle the spread of disease may fail without proper attention to infection control measures within prisons.[74]

The Special Rapporteur on Extrajudicial, Summary or Arbitrary Killings, in her COVID-19 Human Rights Dispatch Number 2[75], observed that detention during the COVID-19 pandemic for many prisoners in often overcrowded and unsanitary conditions, without access to adequate health care and unable to practice self-and-mutual protection measures, "may become effectively a death sentence. This dismaying reality is a humanitarian crisis and a longer-term challenge for the future of detention systems."

Prison overcrowding, a common problem across jurisdictions worldwide,[76] is a significant contributor to the damage that imprisonment can cause to the health of both prisoners and prison staff, including severe psychological stress, spreading of infectious diseases due to extremely unhygienic living conditions and promiscuity, as well as limited access to necessary medical treatment and medicine.[77] In this respect, in their joint statement on COVID-19 in prisons and other closed settings, UNODC, WHO, UNAIDS and OHCHR observed that "overcrowding constitutes an insurmountable obstacle to preventing, preparing for or responding to COVID-19.[78]

There seem to be considerable gaps in governments' efforts to provide reliable, disaggregated and timely data on COVID-19 infections and deaths in prisons, including rates of testing, positive cases and deaths among prisoners. Furthermore, a grave indicator of the lack of consideration for women in prison amongst decision-makers is that data remains gender neutral.[79] As noted by Amnesty International, "lack of quality data, under-reporting or misreporting can lead to assumptions that exacerbate existing health inequalities between the incarcerated and the non-incarcerated communities, and undermine efforts to limit the spread of the disease in prisons and protect the most vulnerable detainees".[80]

73 *WHO Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2021, p.1*

74 *WHO Regional Office for Europe, 'Preventing COVID-19 outbreak in prisons: a challenging but essential task for authorities', 2020, https://www.euro.who.int/en/health-topics/health-determinants/prisons-and-health/news/news/2020/3/preventing-covid-19-outbreak-in-prisons-a-challenging-but-essential-task-for-authorities*

75 *UN OHCHR, COVID-19 and Protection of Right to Life in Places of Detention, 2020, p.1*

76 *UNODC, Addressing the global prison crisis: Strategy 2015 – 2017*

77 *ICPR, 'Towards a health-informed approach to penal reform?', 2019, p.14*

78 *UNODC, WHO, UNAIDS and OHCHR, Joint statement on COVID-19 in prisons and other closed settings, 2020*

79 *Olivia Rope, Penal Reform International, Coronavirus and women in detention: A gender-specific approach missing, 2020, https://www.penalreform.org/blog/coronavirus-and-women-in-detention-a-gender-specific/*

80 *Amnesty International, Forgotten behind Bars, 2021, p.17*


COVID19

# INITIAL RESPONSES TO CURB THE SPREAD OF THE VIRUS

It took a while for countries to realize that COVID-19 was a serious threat and that it was quickly spreading worldwide. Prisons were rapidly identified as possible hotspots for contagion. After the outbreak of the pandemic was declared by WHO on 11 March 2020, the first weeks were marred by the widespread lack of Personal Protective Equipment (PPE), particularly masks, and sanitizers. PCR-testing[81] kits were difficult to obtain as there was a global shortage of the necessary reagents and a limited number of machines to process the tests. Only symptomatic people were tested and test results required several hours, thus making it difficult to isolate the first cases before they had passed on the virus to other people.

Overcrowding made social distancing impossible in many prisons. A common problem was the lack of separate space for quarantining suspect cases and newly admitted prisoners or prisoners who had had contacts with the outside, for example, through work, furloughs or court hearings.

The first measures imposed in most countries revolved around closing[82]: suspension of family visits; confinement to the cells and restriction of movement within each prison; interruption or reduction of all activities (work, schooling, training, etc.); no more access to the prisons by volunteers and external observers; blockage of temporary absences; suspensions of court hearings; 'disinfections' here and there but with shortages of products to practice sanitation; absence of water to wash one's hands in many facilities; interruption of the delivery of family packages leading to insufficient supply of food, medicine and hygienic articles for many prisoners.

The second approach to face the pandemic can be qualified as opening[83] and it includes: the release of prisoners (through backdoor policies like amnesties and early or conditional release); sentence adjustments and other forms of early release; the suspension of, or decrease in the use of, imprisonment for short-term sentences and restrictions on pre-trial custody (front door policies); the provision of postal stamps or phone and video calls to preserve family ties.

To frame the context in which the pandemic appeared, the Irish Penal Reform Trust summarized as follows the situation of Irish prisons in March 2020: *they were overcrowded; had an imprisonment rate of 86 per 100,000 after a 15% increase over the previous 2 years; 47% of men and women in prison were sharing cells; 43% had to use toilets in presence of others; 14% of the prison population was locked up for 19 or more hours per day; they had very high rates of prisoners with mental health difficulties.*[84]

Ireland coped rather well with the first wave of the pandemic. The Irish Prison Service established an Emergency Response Planning Team a few weeks before the pandemic was formally declared. This gave them the time to undertake the necessary preventative planning. Interestingly, they had had recent experience of the outbreak of infectious diseases, such as TB, in prisons. Thus, they had already addressed several systemic issues, such as staff training in infection controls and were not caught unprepared by COVID-19.

In March 2020, the Government announced a policy to screen new prison admissions at the point of entry. Prisoners displaying symptoms of COVID-19 had access to testing, medical examination and isolation. Prisoners suspected of being infected were isolated in a specific prison unit and they could only leave this facility upon a negative test result. Contact tracing in prisons included the review of CCTV footage to identify individuals that should be subject to isolation and quarantine measures.[85]

In Europe, most prison services suspended visits as soon as the outbreak began. At the end of May 2020, EuroPris[86] reported that most European countries had restarted family visits but had introduced measures to prevent contagion. These included, e.g., pre-visit health checks for visitors (temperature measurement, questionnaire about health, visitor registration system); adaptations to meeting rooms (larger rooms allowing more space between visit desks, cabins for visits; visits outdoors); hygiene and protective equipment (hand washing or disinfection, mandatory masks for visitors and/or prisoners, prohibition to consume food and beverages during visits, additional cleaning of visiting areas in between visits); no contact visits (either distance or screen partition); limits to the duration of visits and the number of visitors/visits. Many countries give priority to direct family members of the prisoner. Prisoners with underage children are usually granted additional visits.

For example, in Italy, during the initial phase of the pandemic, family visits were stopped in all prisons. As of 1 July 2020 prisoners can receive at least one visit per month, even of a longer duration than the usual (e.g. two or three hours instead of one), within the maximum limit provided for by the law according to each prisoner's category. The visits are subject to the observance of all relevant provisions relating to hygiene and social distancing. In many prisons, glass or Plexiglas partitions were installed in the visitation halls for that purpose. Specific provisions were issued in each prison to regulate the access of visitors, in close cooperation with the Local Health-care Service of the community. Prisoners are encouraged to make use of video-calls through Skype or other technical means to contact their families. In fact, the outside population is subject to constantly evolving lockdown modalities impinging on freedom of movement and this also limits the possibility to visit prisons.[87]

81 *Polymerase Chain Reaction (PCR)*

82 *Prison Insider, Coronavirus: Prison Fever, https://www.prison-insider.com/en/articles/coronavirus-la-fievre-des-prisons (accessed on 18 March 2021)*

83 *Ibid.*

84 *Irish Penal Reform Trust (IPRT), INCLO: Civil society response to COVID-19 in prisons and jails, 21 May 2020*

85 *Amnesty International, Forgotten behind Bars, 2021, p.25*

86 *European Organisation of Prison and Correctional Services, Prison Visits – EuroPris COVID-19 pandemic fact sheet, 2020*

87 *EuroPris, Prevention Measures in European Prisons against COVID-19 – Italy, 2020 https://www.europris.org/ministry-of-justice-department-of-prison-administration-it/ (accessed on 29 March 2021)*

The Department of Corrections of Thailand introduced measures to stem the spreading of coronavirus based on the principle "No Exit for Insiders, No Entry for Outsiders". Visits to prisoners were banned, as well as prisoners' activities involving working outside. Prisoners could only leave the prison to attend court hearing or to seek treatment in a hospital. Furthermore, outsiders were not allowed to organize any activities in prison during the COVID-19 crisis.[88]

**WOMEN WERE PARTICULARLY AFFECTED BY THE SUSPENSION OF VISITS AND WERE ASKING FOR THE POSSIBILITY TO PLACE MORE CALLS TO THEIR FAMILIES. AS WOMEN ARE A SMALL GROUP REPRESENTING ONLY 3% OF THE TOTAL PRISON POPULATION, THEY WERE ALLOWED ADDITIONAL CALLS AND THE MAXIMUM DURATION OF THE CALLS WAS EXTENDED.**

Burkina Faso, a country characterized by a high level of prison overcrowding, reported no COVID-19 cases in its prisons as of 3 February 2021.[89] At the onset of the pandemic, they adopted restrictive measures such as the suspension of family visits, which were then resumed applying the necessary hygienic measures. A Memorandum of Understanding was signed by the prison authorities with ICRC and the National Telecommunication Office. On this basis, a project is currently being implemented to allow prisoners to call their families. It is worth noting that the food brought by the families to the prison was received and distributed to the prisoners throughout the health crisis.[90]

Cabo Verde declared the state of emergency on 29 March 2020 for 20 days. Initially there was shortage of masks and the few available were reserved for the prisoners working outside. The prison administration managed to set up production lines for the masks in prison to solve the problem. After the first coronavirus case in the country was reported, prisoners were informed about the coronavirus and visits were limited, then suspended. As a consequence, prisoners were requesting additional phone calls and needed extra money to buy phone cards. Thus, their family members were bringing them money to the prison more or less all at the same time. This system was leading to crowds of people waiting for their turn outside of the prison, enhancing the risk of contagion. As a preventive measure, the prison administration introduced some order in the money deposit procedure and each prison cell house was assigned a week day for families to bring the cash.

Women were particularly affected by the suspension of visits and were asking for the possibility to place more calls to their families. As women are a small group representing only 3% of the total prison population, they were allowed additional calls and the maximum duration of the calls was extended.

Prison-based activities and working activities outside were also suspended during the state of emergency. Additional initial measures included granting extra air hours to prisoners with respiratory problems, who received daily medical attention and were among the first to be tested.

A Skype account was created in the main prison in Praia to facilitate contact between prisoners and their defense lawyers with 30-minute slots. Skype was also used by psychologists and educators to keep in contact with the prisoners and continue treatment.[91]

In Kenya, initial shortages of protective and hygienic equipment drew the support of civil society organizations like Faraja Foundation and Rotary International that teamed up to distribute handwashing stations and soap in the prisons. More remote areas were provided with water tanks by the Kenya Prison Service (KPS) with the support of Government, counties and donors. During the pandemic, the Ministry of Health bought masks and sanitizers centrally and KPS distributed them to all prisons. Counties also bought some items for the prisons.[92]

In order to overcome the shortage of masks, prisoners started producing masks on the basis of specifications provided by the Bureau of Standards also thanks to the material provided by *Faraja Foundation* and other donors. *Faraja Foundation* also provided distance counselling through 10 counsellors that would call back prisoners in need of support.[93]

In Langata Women prison and Kamity Maximum Security prison, peer counselling was established on the basis of training provided to volunteering prisoners to enable them to support their peers in distress. For Christmas 2020, the KPS tried to alleviate the prisoners' distress providing some extra treats, like sweets and better food.[94]

In Californian prisons, in-person visitation was suspended on 11 March 2020. Further measures included limitations on working hours, programming and movement at institutions. Some of these restrictions have been lifted as cases drop in some of the prisons. As a remote alternative, a minimum of two days per month are set aside for free phone calls at each institution to help maintain connections with families and support networks outside. Additionally, video messages of support from families, partners and even professional athletes are being played on televisions accessible from cells or common areas. Special versions of these videos were featured on Mother's Day and Father's Day.[95]

According to a study published by the *Sociedad de Criminología Latinoamericana (SOCLA)* together with the *Centro de Estudios Latinoamericanos sobre Inseguridad y Violencia (CELIV)*, the 27 prison systems surveyed in 18 Latin American countries were quite unprepared to face the challenges of the pandemic. In this region, most prison systems are overcrowded, and in some cases, the overcrowding rate is over 200%. At the beginning of the health crisis, family visits were suspended in all but one prison system. This had a serious impact not only on the possibility to keep in contact with relatives but also on the provision of food and essential items usually brought to prisoners by their families. In 9 out of 10 prisons, educational programmes and other activities led by staff from the outside were suspended, while work was cut down by over 50%.

The quality of the services provided was also affected as health care professionals, therapists and social workers limited their access to the prisons to prevent contagion. Furthermore, more than half of the prison systems reported that between 5% and 20% of the prisoners belonged to vulnerable groups because of age or pre-existing health conditions. Some of the prison systems afforded more phone calls and the possibility of video calls to alleviate the negative effects of the measures introduced.[96]

88 *Thailand Institute of Justice, Report on the COVID-19 situation in prisons and policy recommendations for Thailand, 2020, p.9*

89 *Reply to the TIJ questionnaire by the Administration Pénitentiaire et de la Reinsertion Sociale, Burkina Faso*

90 *Ibid.*

91 *Reply to TIJ questionnaire by DGSPRS and conversation with Ms. Iradvi Gonçalves, DGSPRS, Cabo Verde, 20 January 2021*

92 *Conversation with Mr. Dancan Ogore, Director of Operations, KPS, Kenya, 19 February 2021*

93 *Conversation with Ms. Jane Kuria, Faraja Foundation, Kenya, 11 January 2021*

94 *Ibid.*

95 *Reply to the TIJ questionnaire by CDCR, USA* ***See:*** *One example of the videos is available here: https://vimeo.com/457118650/d9bae498f9*

96 *Los efectos del Coronavirus en las cárceles de Latino América, SOCLA/CELIV, 12 June 2020, https://criminologialatam.wordpress.com/2020/06/12/efectos-del-covid-19-carceles-de-latino-america/ (accessed on 24 March 2021)*

# QUARANTINE AND OTHER PUBLIC HEALTH MEASURES[97]

WHO has updated its paper entitled "Preparedness, prevention and control of COVID-19 in prisons and other places of detention" providing extensive guidance on COVID-19 to the competent prison and health care officials.[98] The fundamental approach is "prevention of introduction of the infectious agent into prisons, limiting the spread within the prison, and reducing the possibility of spread from the prison to the outside community." [99] The principles guiding the response to COVID-19 in prisons are firmly grounded in human rights law as well as international standards and norms in crime prevention and criminal justice.

According to WHO, "prison outbreaks are most likely to occur as a result of introduction of the virus from external sources, especially if there is widespread community transmission." It is therefore advised that testing, in addition to a 14-day period of quarantine, be considered primarily for all people coming into prison (new arrivals and transfers from other institutions) before they are allowed to join the general prison population.[100]

It is also recommended that in each prison a space is identified for medical isolation of suspected cases or confirmed cases not requiring hospitalization. When this is not feasible, "cohorting – medical isolation of people in prison in groups sharing the same characteristics of exposure" is an alternative.[101]

WHO also recommends "refined allocation procedures", i.e. separate placement of prisoners at highest risk of complications or poor outcome. Such people include those aged over 70 and those with underlying health conditions.[102]

All these measures require considerable efforts in the reallocation of space and cells, especially in


overcrowded prisons. For example, in Sierra Leone, in some prisons there are designated quarantine spaces, often the same ones that were used during the Ebola crisis. In the Freetown male prison new health structures were created to quarantine suspected cases of COVID-19, most other prisons are lacking such dedicated isolation areas.[103]

WHO also stressed that "Any decision to place people in prisons and other places of detention in conditions of medical isolation should always be based on medical necessity as a result of a clinical decision and subject to authorization by law or by the regulation of the competent administrative authority. People subjected to isolation for reasons of public health protection, in the context of prisons and other places of detention, should be informed of the reason for being placed in isolation, and given the possibility to have a third party notified. Adequate measures should be in place to protect persons in isolation from any form of ill treatment and to facilitate human contact as appropriate and possible in the given circumstances (e.g. by audiovisual means of communication and, whenever possible, by exploiting digital technologies)".[104]

During the COVID-19 crisis, in some instances the public health measures applied went beyond the necessity and proportionality test for solitary confinement.[105] In some countries, quarantine and isolation resulted in an isolation regime of up to 23 hours per day for a period exceeding two weeks.[106] Quarantine and isolation may have detrimental effects on the prisoners' mental health, comparable to solitary confinement. The project CAPPTIVE [107] has gathered feedback from prisoners about what helps in coping with quarantine. Breaking up the

97 *WHO definitions: **Quarantine:** Restriction of activities and/or separation from others who are not ill in such a manner as to prevent possible spread of infection or contamination. In the context of the current COVID-19 pandemic, WHO recommends that all contacts of confirmed or probable COVID-19 cases be quarantined in a designated facility or in their cell for 14 days from their last exposure. **Medical isolation:** Separation of suspected or confirmed COVID-19 cases in a single room. Individuals in medical isolation are believed to be infected – i.e., have signs and symptoms suggestive of COVID-19 and/or have tested positive for SARS-CoV-2. In WHO technical guidance, the term "isolation" is used for such separation; however, in the prison context, it is necessary to distinguish medical isolation, in this sense, from isolation of individuals as an application of security rules or punishment.*

98 *WHO Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2021*

99 *Ibid., p.2.*

100 *Ibid., p.23*

101 *Ibid.*

102 *Ibid., p.10*

103 *Antigone, 'Have prisons learnt from COVID-19?', Anno XV, N. 1, p.93*

104 *Ibid., p.6*

105 *For solitary confinement, see Nelson Mandela Rules 43 - 45*

106 *Amnesty International, Forgotten behind Bars, 2021, p.40-41*

107 *Prison Reform Trust, COVID-19 Action Prisons Project: Tracking Innovation, Valuing Experience, Briefing#3, 2021, p.39 – 41*

time in manageable chunks, distraction through exercise or meditation, maintaining contact with the family through video-calls, absorption in reading and writing are some of the techniques that have been considered as helpful. Unlike solitary confinement which is a disciplinary measure, quarantines are public health measures. Prison staff can provide meaningful human contact by being empathetic and imaginative.[108]

Most European countries reported to EuroPris that, by the third quarter of 2020, all new committals to prison were being tested and that procedures for the testing of staff had been put in place either by the Prison Administration or by the public health authorities.[109]

In other regions prison administrations and public health-care services may not dispose of sufficient testing capacity. For example, in Madagascar the real number of COVID-19 cases in prison is underestimated. In fact, testing is limited only to symptomatic prisoners and is carried out through the Ministry of Health.[110]

In Cabo Verde, at the end of the initial national lockdown in May, prison staff members were all tested by the public health services twice, followed by a PCR test in case of doubt. The coordination between the prison administration and the Ministry of Health has been strengthened during the crisis. The most serious problem is that prisons do not have testing kits and have to rely on public health officials. There is shortage of testing kits in the country and private test are quite costly.

At the end of 2020 there were two COVID-19 outbreaks in Sao Vicente and Fogo prisons. In both prisons, isolation space was immediately created as a matter of priority. In Sao Vicente a nurse was hired but there were no nurses available in Fogo. Furthermore, all positive prisoners were checked on a daily basis, their temperature was measured regularly and they were given Vitamin C. Tea was distributed also in the evening and food was increased. Cleaning and disinfecting of the premises were done 3 times/day.[111]

In Praia prison, the largest in the country, there were 2 cases of Covid-19 and the 130 prisoners of that sector were quarantined. For quarantine, they used the building outside of the main complex usually designated for drug free prisoners. For new admissions, generally they used the cells that were used for the initial 2-week observation period that was the rule until the recent prison law reform. Sometimes they had two prisoners from the outside share the same cell during quarantine as space was insufficient. After a period of furlough, prisoners needed to be quarantined and tested before being readmitted to the general population. This caused overcrowding in the quarantine area and a few prisoners were infected with COVID-19.[112]

In some countries, widespread use of quarantine for medical purposes has led to the reduction of solitary confinement as a disciplinary measure, like in Thailand for example. Here, quarantine cells are more spacious and better ventilated than those for disciplinary isolation. Solitary confinement is being increasingly replaced by the reduction in visiting days as a disciplinary measure.[113]

In the Province of Buenos Aires, Argentina, the Bureau of Management (*Dirección de gestión*) bought PPE and medicines at the end of April 2020. If a prisoner or a staff member displayed any symptoms, he/she was tested (PCR). There was a separate sector where those testing positive were quarantined until they tested negative again. Newly admitted prisoners were subject to a 10-day quarantine in separate cells. In case a prisoner was transferred from another prison, he/she had to be accompanied by his/her clinical history or was sent back to the prison of origin.[114]

*108 Ibid.*

*109 EuroPris, Overview of European prison services' responses to the COVID-19 crisis, third edition, 24 July 2020*

*110 Conversation with a senior official from the prison administration of Madagascar, 27 January 2021*

*111 Conversation with Ms. Ms. Iradvi Gonçalves, DGSPRS, Cabo Verde, 20 January 2021*

*112 Ibid.*

*113 Follow-up communication by the Department of Corrections of Thailand, February 2021*

*114 Conversation with Dr. Sonia Quiruelas, Provincial Director, DPSP, Argentina, 1 February 2021*

# THE IMPORTANCE OF PROTOCOLS

Among the countries that responded to the TIJ questionnaire, all reported that they had a protocol in place to deal with suspect cases of transmissible diseases even before the pandemic was declared. Protocols, often designed to detail procedures for TB or influenza cases, were amended and expanded in most cases to better respond to the challenges posed by COVID-19. For example, in Burkina Faso and in Cabo Verde changes were made to the respective protocols for transmittable diseases. In Burkina Faso, the protocol was expanded to cover the construction of isolation areas in 5 prisons, preventive measures at the prison entrance (temperature, hands disinfection and social distancing), as well as procedures to prevent the infections in prison.[116] In Cabo Verde, instead of medical attention being sought only in case the prisoner displayed any symptoms, the COVID-19 required testing every prisoner before his/her admission to prison.[116]

The relevance of national protocols detailing every aspect of prison life for prisoners, staff and all categories of visitors became even more evident during the pandemic. Protocols also enable prison administrations to allocate resources more rationally and to define urgent staff training needs.

For example, the California Department of Corrections and Rehabilitation (CDCR) and the California Correctional Health Care Services (CCHCS) have a robust partnership with local and state health departments to help track and stop the spread of contagious diseases. The Tuberculosis Surveillance Program, for example, evaluates incoming prisoners and staff for TB, with a view to tracing the contacts of positive cases and limit exposure to communities inside and outside the prisons.[117]

Once the COVID-19 crisis started, CDCR and CCHCS modified the existing protocols on the basis of new guidance and research from the Centers for Disease Control and Prevention and the California Department of Public Health. These plans and procedures are subject to constant updates as the situation in California evolves.[118] Throughout the crisis, CDCR and CCHCS have been working together on all COVID-19 related matters, ensuring that resources are directed across California as they are needed during this unprecedented and prolonged emergency.[119]

The Disease Control Department of Thailand, in collaboration with the Medical Service Division of the Department of Corrections, has prepared guidelines on how to control COVID-19 when infections are confirmed in prison.[120]

115 *Reply to the TIJ questionnaire by the Administration Pénitentiaire et de la Reinsertion Sociale, Burkina Faso*

116 *Conversation with Ms. Ms. Iradvi Gonçalves, DGSPRS, Cabo Verde, 20 January 2021*

117 *Reply to the TIJ questionnaire by CDCR, USA*

118 *Ibid.*
***See:*** *The plans and procedures are available on the CCHCS website, COVID-19 and Seasonal Influenza: Interim Guidance for Health Care and Public Health Providers, https://cchcs.ca.gov/covid-19-interim-guidance/ (last accessed on 21 March 2021)*

119 *Ibid.*

120 *Thailand Institute of Justice, Report on the COVID-19 situation in prisons and policy recommendations for Thailand, 2020, p.10*

In Argentina, the National Committee for the Prevention of Torture issued a paper[121] recommending measures to be adopted in places of deprivation of liberty to face the health emergency throughout the country. The first recommendation was for the competent prison authorities to put in place specific protocols and plans of action for the application of the health measures required, without relying solely on lockdowns but also including remedial steps to protect the prisoners' physical and mental wellbeing. In this respect, the Federal Prison Service and the Province of Buenos Aires were the first to take action. In particular, the *Dirección provincial de salud penitenciaria* of the Province of Buenos Aires had already a wide gamut of health care protocols before the outbreak of the pandemic.[122] The *Dirección* issued a detailed series of protocols covering, e.g., measures applicable to prison staff when entering or leaving the prison; prison admission from police lock-up or upon transfer from another prison; and psychological support to the prison population and prison staff during the pandemic. Furthermore, a comprehensive contingency protocol on coronavirus was prepared in June 2020, taking into account the overcrowding in the provincial prisons. The protocol aims at ensuring the identification and early diagnosis of any COVID-19 cases in prison so as to prevent the spread of the virus.[123] A very clear diagram summarizes the recommendations for transferring prisoners with suspected COVID-19 cases.[124]

Although the country was caught by surprise by the pandemic, the Kenya Prison Service (KPS) was proactive in adopting measures before the virus entered the prisons. They adopted and adapted protocols from other agencies concerning hygiene, such as on washing hands and wearing masks. This was the reason why they managed fairly well to deal with the pandemic in prison. Furthermore, KPS designated specific prisons for new admissions, at least one in every region. Thus, prisoners can be tested and quarantined before being transferred to other prisons.[125]

121 *Comité nacional para la prevención de la tortura, Medidas a adoptar en lugares de detención a raíz de la emergencia sanitaria, 2020, p.2*

122 *Conversation with Dr. Sonia Quiruelas, Provincial Director, DPSP, Argentina, 1 February 2021*

123 *Gobierno de la Provincia de Buenos Aires, Protocolo de Contingencia, Contexto de encierro, Coronavirus (COVID-19), 2020*

124 *Coronavirus en context de encierro, Recomendaciones en el traslado de pacientes, DPSP/ Ministerio de Justicia y Derechos Humanos, Gobierno de la Provincia de Buenos Aires*

125 *Conversation with Mr. Dancan Ogore, Director Operations, KPS, Kenya, 19 February 2021*


COVID-19 Vaccination
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After the first Covid-19 case[126] was detected in Madagascar on 20 March 2020, the Ministry of Justice took several measures[127] to prevent the spreading of the virus, such as the suspension of visits, fearing an uncontrolled spreading of the virus given the high level of prison overcrowding in the country.

A contingency plan containing protocols regulating prison admission, release and hygiene measures was deemed necessary to strengthen the measures already in force but also to alleviate the negative impact of such measures on prison staff and the prisoners. It was developed with the financial support of the NGO *Humanité & Inclusion* in consortium with other NGOs. This plan is applicable to all prisons in the country and was validated by the Ministry of Justice. On the basis of an initial assessment, the standard protocols were drafted. The responsibility for the application of such protocols rests with the director of each prison.[128]

The lockdown of the general population translated into less family visits for the prisoners, risk of contagion through the food baskets brought by the families to the prisoners but also a decrease in the number of baskets provided by the families because of financial difficulties and transportation problems. Prisoners released during lockdown would also face transportation restrictions and a curfew between 20:00 and 04:00. Solutions to these challenges were the identification of alternatives to family visits; a protocol for the reception of meals, as well as a request for additional funding to integrate the prisoners' diet in view of the decrease in the food supplied by families; a protocol for the release of prisoners with the creation of a fund to cover their return home, possibly with the support of NGOs and civil society.

Another problem noted was the staff exposure to the risk of contagion, either at work or outside. Thus, a protocol regulating access to the prison was introduced for staff and all other visitors. Financial support was requested to NGOs and civil society for the necessary PPE. As regards external persons contributing to prison activities, only those performing essential work were still allowed to enter the prison following a separate protocol. Other activities would be delegated to prison staff.

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New admissions were also considered a risk, especially given the incidence of asymptomatic cases of Covid-19. Another protocol was proposed to regulate admission to prison and to promote tests for newly admitted prisoners.

Prisoners and staff more vulnerable to Covid-19 were identified and their health was subject to regular checks. The risk of contagion among the prisoners was real given the promiscuity and overcrowding in most prisons. It was proposed to create isolation areas for suspect cases; to strengthen the sensitization activities on coronavirus; to apply the memorandum of understanding between the Ministry of Justice and the Ministry of Health; and to advocate for the decrease in the number of prisoners through alternatives and reduction of imprisonment for minor offences.

Prisoners awaiting trial are exposed to risks whenever they have to be brought to court. Furthermore, the impact of the lockdown on the courts has contributed to further slowing down proceedings and increasing the number of pre-trial detainees. A protocol was proposed to cover prisoners escorted to court and it was recommended to continue court hearing of pre-trial detainees.

Finally, the assessment noted a high level of anxiety and stress among the prisoners due to the lack of communication with their families, as well as concerns over their health. Possible solutions were the continuation, to the extent possible, of activities and psychosocial support services in prison; clear and regular updates on the pandemic situation and sensitization about the risk of stigmatization. Prison staff was also subject to psychosocial stress because of the hardship of working during the pandemic. For this, remote support from external psychologists was recommended.[129]

Among the international organizations that have contributed useful resource material to increase the preparedness of prison administrations to deal with the COVID-19 crisis, there are the World Health Organisation (WHO),[130] the United Nations Office on Drugs and Crime (UNODC)[131] and the UN Department of Peace Operations and the UN Institute for Training and Research.[132]

126 *As of 29 January 2021, there were 98 confirmed cases of COVID-19 among the prison population with one death*

127 *Note from the Ministry of Justice for the prison administration of 5 July 2020*

128 *Conversation with a senior official from the prison administration, Madagascar, 27 January 2021*

129 *Ibid.*

130 *WHO Regional Office for Europe, Checklist to evaluate preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2020*

131 *UNODC, COVID-19 Prevention and control among people working in prison, 2020*

132 *UNITAR, Operational Toolbox, COVID-19 Preparedness and response in places of detention, 2020*

# OTHER HEALTH PROBLEMS

Among the outside population, COVID-19 has absorbed considerable health care resources in many countries since the onset of the pandemic. Doctors and nurses have been summoned to treat COVID-19 patients, leaving other patients with less "urgent" conditions waiting longer for medical attention. Furthermore, people have been ignoring symptoms of potentially serious conditions in fear of being infected with the coronavirus at the doctor's or in the hospital. For example, the effects of COVID-19 are likely to influence cardiovascular health and mortality rates for heart disease for many years, directly and indirectly. People have delayed getting care for heart attacks and strokes, which can result in poorer outcomes. An even more critical issue will be the cardiovascular health risks that are exacerbated by the poor lifestyle behaviours that have been prevalent throughout the pandemic. Unhealthy eating habits, increased consumption of alcohol, lack of physical activity and the mental toll of quarantine isolation and even fear of contracting the virus all can adversely impact a person's risk for cardiovascular health.[133]

Likewise, in prisons, not all countries have been able to provide inmates with timely diagnosis and medical attention for non-COVID-19 conditions. However, as stressed by the Commonwealth Human Rights Initiative (CHRI), "while it is important to ensure adequate facilities are available to respond to the coronavirus, it is equally important to ensure that other existing or future patients are not neglected and adequate medical facilities are available for them."[134]

This is particularly relevant as prisoners with chronic illnesses, including cancer, hypertension, heart or lung disease, diabetes or with other conditions affecting the immune system or those taking medications that suppress the immune system, are more susceptible to serious complications of COVID-19.

In California, the department's dedicated team of psychiatrists, psychologists, social workers, and nursing staff have worked tirelessly to continue to provide mental health delivery services. These include: limiting the number of participants in group programmes to allow for physical distancing, issuing medication directly to patients in the living areas, providing mental health check-ins to patients during COVID-19 health care screenings that occur multiple times daily, and increasing use of telehealth where group programmes have been limited. For institutions with no or low number of COVID-19 cases, group therapy services were adjusted so they could be held with physical distancing measures in place.[135]

Prisons continued to provide urgent health care services. Existing protocols were amended to ensure preventative care and treatments continued with as few interruptions as possible during the COVID-19 emergency, especially for the most vulnerable prisoners.[136] To reduce risks to both patients and staff, some specialty and routine care were delayed as a result of both internal redirections and external closures.

In many US states, concessions have been made for inmate medical visits with the hopes of encouraging prisoners to seek medical attention if they were experiencing COVID-19 symptoms and decrease the spread of the virus through early detection. For example, Alabama, Minnesota and West Virginia have suspended co-payments for prisoners as a result of the epidemic. Co-pays are usually between USD 2 – 5, which is a very high amount for prisoners paid less than USD 1/hour for their work.[137]

In the Province of Buenos Aires, Argentina, thanks to the considerable investment by the Government of the Province, 16 new prison hospitals should be operational by the end of March 2021. This has facilitated the provision of treatment to prisoners and has decreased the need to transfer them to hospitals outside. One of the hospitals should be dedicated to incarcerated mothers and their children. Cancer screening for women has continued. The introduction of a digital clinical history system with already 25,000 (out of about 40,000 prisoners) histories uploaded, has improved the coordination of health care provided in the provincial prisons also in case of a prisoner's transfer.[138]

The *Dirección provincial de Salud penitenciaria* issued a Protocol for the psychological assistance of prisoners and prison staff in the context of the coronavirus pandemic.[139] The protocol recognizes that prisoners are protected because of their isolation from the outside but at the same time are helpless in front of an external threat. Therefore, it is crucial to train all those entering prisons so that they protect the most vulnerable individuals. Mental health-care staff also needs to show the rest of the prison staff how to communicate to maintain calm and promote responsible behavior, especially the prevention of rumours and the circulation of fake news. To this end, a climate based on mutual trust is indispensable to convey the appropriate information on the pandemic and the measures required to stem the spreading of the virus.

In the UK, many prisons introduced alternatives to face-to-face health care appointments, such as video calls for routine consultations. Telemedicine was a new development brought about in prisons by the COVID-19 crisis as a way for prisoners to avoid being exposed to contagion while waiting for the doctor. However, some concerns were raised as to the confidentiality of, for example, phone cell consultations taking place in presence of cell mates or staff.[140]

In Uganda, access to maternal antenatal and post-natal health-care services for pregnant prisoners has been limited because of restrictions on movement. With the suspension of prison visits, prisoners could not receive the supplemental food usually brought by their families. Thus, the nutritional requirements of prisoners with special needs, like pregnant or breastfeeding women, babies incarcerated with their mothers and prisoners with HIV/AIDS could not be met.[141]

133 *American Heart Association Report, 2021, https://newsroom.heart.org/news/heart-disease?preview=fe05 (accessed on 14 March 2021)*

134 *CHRI, COVID-19 and prisons: ensuring an effective response, 2020, p.7*

135 *CDCR, COVID-19 Response Efforts, Mental health delivery services, https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/#HCS (accessed on 14 March 2021).*

136 *Reply to TIJ questionnaire by CDCR, USA*

137 *Catherine D. Marcum, American Corrections System Response to COVID-19: an Examination of the Procedures and Policies Used in Spring 2020, American Journal of Criminal Justice, 2020*

138 *Conversation with Dr. Sonia Quiruelas, Provincial Director, DPSP, Argentina, 1 February 2021*

139 *Protocolo de asistencia psicologica para la población carcelaria y personal de seguridad frente a la pandemia "coronavirus"*

140 *Prison Reform Trust, COVID-19 Action Prisons Project: Tracking Innovation, Valuing Experience, Briefing#3, 2021, p.14*

141 *Information provided by Penal Reform International, Office for Sub-Saharan Africa*

# MEASURES TO REDUCE PRISON POPULATIONS

Prison overcrowding is not only a criminal justice and prison management problem. From a public health perspective, addressing prison overcrowding is a basic measure to decrease the risk of transmission of COVID-19.[142]

At the beginning of the COVID-19 crisis, many countries drastically decreased the number of prisoners to reduce the risk of infection in prisons. For example, by November 2020, the prison population of England and Wales had been reduced by 6%, thus making space to move prisoners to single cells.[143] In Italy, thanks to the commitment of judges in charge of the execution of sentences, 12.3% of the prisoners were released in the year of the pandemic, i.e. around 7,500 persons.[144] In California, USA, between 11 March 2020 and 5 November 2020, 21,836 prisoners were released, i.e. almost 20% of the prison population.[145]

The Department of Justice & Equality and the Irish Prison Service put in pace early pre-emptive measures in response to the pandemic, in particular, through steps to safely reduce the prison population[146], including increasing eligibility for temporary release based on rigorous risk assessments. These releases were supported by seamless cooperation between prison service staff and community-based organizations to ensure planned structured releases from prison. To this end, unprecedented availability of housing in the community was crucial.[147]

The emergency measures adopted to face COVID-19 in Ireland have demonstrated that it is indeed possible to reduce overcrowding by releasing 10% of the prison population over a 4-week period, with fewer than 10 people out of 500 released inmates that have been returned to prison.[148]

Among the examples of successful "front door" measures to reduce overcrowding, there is the Kenyan experience. As a result of good communication between Kenya Prisons Service (KPS), the Police and the courts, new admissions to prison, especially for petty offences, were limited. KPS was instrumental in convincing the courts to issue free bail for petty offenders, i.e. with no financial guarantees. Furthermore, by releasing petty offenders, the number of prisoners was reduced from 54,000 (February 2020) to 44,000 in March 2020.[149]

In many countries, court hearings were greatly reduced during lockdown periods, generally for very urgent cases like those involving expiring terms. In Kenya, video links with the courts were limited to rulings and mentions only, no hearings because of the objective difficulties in ensuring the right of defence with the lawyers not being able to properly consult with their clients. At the beginning of the lockdown, the courts were operating according to the rules set for the pandemic but several prosecutors got infected and they halted the proceedings. Courts have resumed only for urgent cases.[150] Generally speaking,

**PRISONERS WHO BENEFIT FROM EARLY OR CONDITIONAL RELEASE, OR WHO ARE RELEASED ON HUMANITARIAN OR COMPASSIONATE GROUNDS DURING LOCKDOWN PERIODS, OFTEN DO NOT RECEIVE ASSISTANCE WITH HOUSING AND EMPLOYMENT BECAUSE MANY SERVICES ARE CLOSED OR ARE WORKING ON A REDUCED SCALE.**

court backlogs have increased significantly in many countries. Direct contacts between prisoners and their lawyers have been suspended for considerable periods in many countries. Arrangements have been made to facilitate Skype calls (e.g. in Praia, Cabo Verde) or phone calls between lawyers and their imprisoned clients.

In the context of the measures to prevent COVID-19, the prison administration of Burkina Faso reported that, out of an average of 7,000 prisoners, over 1,200 were released by Presidential Decree. They were selected on the basis of their old or very young age (juveniles), or because they had a chronic condition. Several women were also released, as well as prisoners with less than 12 months to serve and having served at least 50% of their sentence.[151]

In Brazil, the National Council of Justice issued Recommendation N. 62 on 17 March 2020 with a view to guiding the adoption of measures to prevent the spreading of COVID-19 in prisons, including non-custodial measures, early release and limitation of pre-trial detention. Being a non-binding recommendation, many judges resisted calls to release large groups of incarcerated people notwithstanding the severe overcrowding in Brazilian prisons.[152] However, in the state of Santa Caterina, over 500 prisoners were released by the *Juiz da Execução* Penal on the basis of Recommendation N. 62. This decongested the two prisons in Joinville allowing the creation of quarantine space.

In Thailand there has been no specific release scheme throughout the COVID-19 crisis but general measures such as parole and royal pardon continued to be applied.[153]

In India, the Supreme Court took cognizance of the high risk of COVID-19 transmission to prisons and directed the State/UT Governments to constitute a High-Powered Committee to determine the category of prisoners to be released on parole or interim bail to address the risk of infection, especially due to overcrowding in prisons.[154] Thousands of prisoners belonging to the categories defined by the High-Powered Committee were released throughout the country. The categories included prisoners who are convicted/under trial for one offence for which the sentence is up to 7 years and other categories identified on the basis of the nature of the offence, duration of sentence and severity of the offence.[155]

Prisoners who benefit from early or conditional release, or who are released on humanitarian or compassionate grounds during lockdown periods, often do not receive assistance with housing and employment because many services are closed or are working on a reduced scale. In Italy, for example, the application of the alternative measure of house arrest (with or without electronic monitoring) depends on the person having a suitable domicile, that is a place where he/she can live securely, without contacts with any victim and easy to check by the police. Given the difficulties for many prisoners to obtain such a dwelling, a project of social inclusion for homeless people eligible for alternative measures was launched by the General Directorate for the external execution of sentences in April 2020.[156]

142 *WHO Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2021, p.5*

143 *CREST, 'Prison and Covid-19: what went right?', 2020, p.14*

144 *Giovanni Bianconi, Coronavirus, nelle carceri 7.500 detenuti in meno per l'emergenza sanitaria, www.corriere.it, 11 March 2021*

145 *Follow-up information complementing the reply to the TIJ questionnaire by CDCR, USA*

146 *IPRT, The impact of COVID-19 on prisons in Ireland, 2020*

147 *Irish Penal Reform Trust (IPRT), INCLO: Civil society response to COVID-19 in prisons and jails, 21 May 2020*

148 *Ibid.*

149 *Conversation with Mr. Dancan Ogore, Director Operations, KPS, Kenya, 19 February 2021*

150 *Ibid.*

151 *Reply to the TIJ questionnaire by the Administration Pénitentiaire et de la Reinsertion Sociale, Burkina Faso*

152 *Antigone, 'Have prisons learnt from COVID-19?', Anno XV, N. 1, p.29*

153 *Reply to the TIJ questionnaire by the Department of Corrections, Thailand*

154 *Commonwealth Human Rights Initiative, 2020, https://www.humanrightsinitiative.org/download/1586851160CHRI%20Note%20to%20assit%20SC%20constituted%20HPC%20&%20Release%20of%20Prisonsers%20amid%20COVID%2019.pdf*

155 *State/UT-wise prisons response to COVID-19 pandemic in India, https://www.humanrightsinitiative.org/content/stetut-wise-prisons-response-to-covid-19-pandemic-in-india*

156 *Joli Ghibaudi, Stare a casa. Per chi ce l'ha, in Il carcere al tempo del coronavirus, XVI Rapporto di Antigone sulle condizioni di detenzione, 2020, p.171*

# PRISONERS' PERSPECTIVES

In many countries, protective measures were introduced in prisons after the outbreak of the pandemic was declared on 11 March 2020. From one day to the other, family and intimate visits were suspended, working opportunities were drastically reduced, schooling and vocational training were put on hold and movement within prisons was limited. Furloughs and external work for prisoners in open institutions were also curtailed to avoid contacts with the outside. Court hearings were suspended and contacts with defence lawyers could only take place remotely. Prisoners were mainly confined to their cells for most of the day.

These constraints were, or are still in place for months and are exacting a heavy toll on the prisoners' life and well-being. When the measures were first imposed, the prisoners reacted violently in several countries. For example, in Dum Dum Central Correctional Home in Kolkata, India, the ban on family visits and reduced court hearings triggered violent clashes on 21 March 2020. As a result, several prisoners and prison staff members were injured, records burnt and property destroyed.[157]

In France, when visits were suspended at the onset of the pandemic, protests broke out in dozens of prisons. Widespread overcrowding impeding social distancing and the ensuing fear of the disease were contributing factors to the prison disorders. Another disgruntled category of prisoners were those paid by the prison administration to do household chores in the prison (cleaning, cooking, laundry, etc.) and who could not continue working because of the limitations of movement imposed in each prison. Unable to work, they lost their income. They were promised Euro 40/each as a monthly contribution from the Ministry of Justice.[158]

Also in the UK, the limitation of working activities has led to a loss of income for many prisoners. As a consequence of the lockdown, there are more prisoners who had to borrow money from other prisoners. Debts increase day by day. For the time being, the situation is still under control as prisoners are restricted and cannot move around. Thus, they are not exposed to risks of attack by their creditors. However, there are safety concerns once prisoners' movement within each prison is restored.[159]

The restrictive measures introduced by prison administrations to prevent contagion were not the only sources of discontent among the prisoners[160]. Since the first case of COVID-19 was confirmed in Brazil in late February 2020, several riots have erupted in Latin America prisons not because of the virus itself but because of fear, uncertainty and poor communication between authorities and prisoners. Lack of protective measures against COVID-19

157 *Commonwealth Human Rights Initiative, 2020, https://www.humanrightsinitiative.org/press-releases/kolkata-jail-incidents-over-covid-19-crisis-reflect-a-need-for-urgent-responses-in-indian-prisons-chri*

158 *Lionel Brossard, Matteo Tiberghien, Coronavirus: plus d'une quarantaine de mutineries dans les prisons françaises, Mediacités, 27 March 2020*

159 *Conversation with Prof. Rosie Meek, Royal Holloway, University of London, 19 January 2021*

160 *Inter-American Development Bank, 2020, https://blogs.iadb.org/ideas-matter/en/pandemic-and-prisons-what-are-the-challenges-for-latin-american-governments/?fbclid=IwAR1wHadXez1raHC (accessed on 24 March 2021)*

and inaction on the part of the prison authorities also contributed to the outbreak of the fierce protests. On 16 March, hundreds of prisoners escaped "semi-open" facilities in the Brazilian state of Sao Paulo, after the authorities announced that they were cancelling a holiday leave because of COVID-19.[161] On 21 March, 23 prisoners were killed and 83 were injured in "*La Modelo*" prison in Colombia, after inmates across the country protested unsanitary conditions, lack of access to water, overcrowding, and inadequate measures to protect them from COVID-19. On 22 March, 2 prisoners were killed and more were injured during protests seeking protection against COVID-19 in Peru.[162]

After China, Italy was the first country heavily hit by the pandemic. As early as 8 March 2020, the Prime Minister signed a decree that, among other measures, suspended family visits, outside work, furloughs and the activities carried out with the support of volunteers and external staff in the prisons in an attempt to "isolate prisons". At the same time, the Department of Prison Administration recommended that all prison directors carry out thorough information and sensitization campaigns within their prisons, involving the prisoners so as to share with them the measures that need to be enforced, as well as their modality and duration.[163]

As everybody else, prisoners were unprepared for the feeling of insecurity and vulnerability to an unknown and potentially lethal virus without being able to protect themselves because of the initial lack of protective masks and sanitizing products. Overcrowded living conditions and conflicting information on the virus that was circulated in prison added to the prisoners' fear and their family members' anguish.[164] Prisoners felt cut out from the outside world and were very concerned about the safety of their families. At first, masks were prohibited in prison, even for staff, to avoid raising alarm among the prisoners. Even after the introduction of the restrictive measures for the prisoners, prison staff continued to go in and out of prisons without protective gear thus representing a potential vehicle of infection. The tension and incertitude generated by the harsh measures led to protests in most Italian prisons and never-before-seen riots that culminated in the death of 14 prisoners and massive damages.

In Thailand, Ms. Na, a long-term former prisoner that was released on 4 January 2021 after 17 years in prison felt confused and afraid after hearing on television of the pandemic outbreak in March 2020. Comparing the COVID-19 crisis with the situation she had experienced at the beginning of her sentence when the SARS epidemic started in 2003, she observed that the Thai prison authorities were much better prepared to deal with COVID-19. Activities in prison were suspended but prisoners were provided with adequate protection, including masks and disinfectants. Prison staff dispensed valuable information on how to prevent COVID-19 and how to practice social distancing in prison.[165] The Thailand Department of Corrections reported that, although physical visitation of prisoners was restricted due to the COVID-19 measures, families could register with the prison for online visits using the Line channel. Once the registration is verified, families are entitled to video calls through smartphones. The frequency of these online visits depends on the policy of each prison taking into account the number of prisoners. As a minimum, each prisoner can visit with his/her family online once a month for around 10-15 minutes and the video calls are free.[166]

**OVERCROWDED LIVING CONDITIONS AND CONFLICTING INFORMATION ON THE VIRUS THAT WAS CIRCULATED IN PRISON ADDED TO THE PRISONERS' FEAR AND THEIR FAMILY MEMBERS' ANGUISH.**

157 *Commonwealth Human Rights Initiative, 2020, https://www.humanrightsinitiative.org/press-releases/kolkata-jail-incidents-over-covid-19-crisis-reflect-a-need-for-urgent-responses-in-indian-prisons-chri*

158 *Lionel Brossard, Matteo Tiberghien, Coronavirus: plus d'une quarantaine de mutineries dans les prisons françaises, Mediacités, 27 March 2020*

159 *Conversation with Prof. Rosie Meek, Royal Holloway, University of London, 19 January 2021*

160 *Inter-American Development Bank, 2020, https://blogs.iadb.org/ideas-matter/en/pandemic-and-prisons-what-are-the-challenges-for-latin-american-governments/?fbclid=IwAR1wHadXez1raHC (accessed on 24 March 2021)*

161 *Human Rights Watch, Latin America: Cut Prison Crowding to Fight COVID-19, 2020 https://www.hrw.org/news/2020/04/02/latin-america-cut-prison-crowding-fight-covid-19 (accessed on 10 March 2021)*

162 *Ibid.*

163 *Il carcere al tempo del coronavirus, XVI Rapporto di Antigone sulle condizioni di detenzione, 2020, p.108*

164 *Claudio Paterniti Martello, Le lettere dei familiari, in Il carcere al tempo del coronavirus, XVI Rapporto di Antigone sulle condizioni di detenzione, 2020, p.97*

165 *Conversation with Ms. Na, former prisoner in Thailand, 18 January 2021*

166 *Reply to the TIJ questionnaire by the Department of Corrections, Thailand*

167 *Conversation with Rev. Soonhorn, House of Blessing Foundation, Thailand, 18 January 2021*

168 *Conversation with Mr. Dancan Ogore, Director Operations, KPS, Kenya, 19 February 2021*

Furthermore, House of Blessing, a charity organization in Thailand, organizes video-calls by Zoom so as to connect mothers with their children for 2 hours/month as a replacement for contact visits.[167]

In Kenya, ICRC has provided cell phones and air time for all prisons. Because of the number of prisoners, entitlement for calls is only 2 minutes/month but the prison officer-in-charge has some flexibility to accommodate special needs, in particular in the case of women prisoners. Since January 2021, families are able to bring essentials to the prison for their relatives.[168]

In Australia, a 44-year old prisoner belonging to the Aboriginal people and subject to community orders described the impact of the pandemic on women in prison.[169] Among prisoners, depression and anxiety were reportedly soaring during lockdown. Because of the suspension of family visits at the onset of the pandemic in March 2020, incarcerated mothers experienced great distress as, in some states, family visits have not fully resumed and some prisoners have spent over 10 months without being able to see their children.

**IN VIEW OF THE SOARING ANXIETY LEVEL DURING THE COVID-19 LOCKDOWN, SOME PRISONS HAVE PROPOSED YOGA, MEDITATION AND RELAXATION PROGRAMMES BROADCAST THROUGH INTERNAL RADIO OR TV CHANNEL AS POSSIBLE COPING STRATEGIES.**

Many incarcerated mothers also worried about their parents outside getting COVID-19 and not being able to look after their children. Likewise, family members also experienced anguish at being unable to receive information on their relatives in prison.

*"Because yes, the prisons say they will notify you if your loved one becomes ill with COVID-19 – but when exactly will they tell you, and at what moment? Will they tell you when they test the patient? Will they tell you when your family member is slung into isolation, a hard cell, to protect the rest of the prison population? Will they tell you on the way to the emergency department? Will they tell you when the person you love is intubated to help them breathe? Or will you find out as the morning news breaks the story that COVID-19 is in our prisons? When? When will they tell you? I know of families who are sick with worry. Every day, they wait for the phone call from their dad, mum, son, daughter, brother, sister, just to know they are OK."*[170]

Zoom and Skype were made available to prisoners to reach their families. However, some of the families are so poor that they cannot afford a computer and in some remote areas cell phones signal is too weak. Even buying post stamps to write to families is too expensive for some of the prisoners who have not received any money from home because of the widespread financial difficulties. Furthermore, because of lockdown, all prison-based activities stopped, including paid work. Thus, prisoners lost their wages like in many other countries.

Another side effect of the measures adopted to counter the spreading of COVID-19 is that pre-release centres in charge of preparing prisoners for release cannot function regularly. As prisoners cannot receive any work releases, productive activities are suspended and there is no gainful employment available, prisoners eligible for release cannot complete their programme and their parole application gets delayed. As there is shortage of low-cost housing, prisoners who are eligible for parole cannot be released during the lockdown phase as long as they do not find a place to stay. Furthermore, conditions for parole include being able to maintain a

minimum level of living. With the financial crisis brought about by COVID-19, many jobs were lost. Prisoners on parole who could not work anymore also lost their accommodation. This has resulted in parole breaches and, as a consequence, in the parolees' return to prison thus increasing overcrowding. Jury trials were suspended and prison on remand had to extend their time in prison.

In the UK, CAPPTIVE, a collaborative project by the Prison Reform Trust (PRT) and the Prisoner Policy Network provides insight from prisoners about their experience under the pandemic. PRT launched an appeal in prison newspapers and the national prison radio for people to tell them how their prisons were managing under COVID-19.

For example, prisoners reported higher levels of anxiety partly due to overthinking during the long periods of empty time in lockdown. The restricted regime also aggravated the prisoners' loss of autonomy preventing them from taking action to resolve problems for themselves. The lack of activities and the absence of family contacts undermined the prisoners' well-being and contributed to depression.[171]

Comparing the adverse effects of lockdown on the outside population and the additional constraints inherent to prison life, a prisoner commented:

*"Everyone outside of prison complained of suffering mental health issues because of their lockdown even though they could go shopping, use their garden, phone whoever they wanted et cetera, also text family and friends, speak to them via the internet – to mention a few. Prisoners are locked up to 23 hours a day for weeks on end – no work only 10 minutes on the phone (hoping that your family are in at the time you phoned) – totally bored, upset, and more angry as each day passes."* [172]

An important aspect of prison life that was greatly affected by the pandemic is physical activity as a way not only to release pent-up energy and aggression, but also as a means to build self-esteem, learn fair play and team spirit and to improve personal well-being. While physical activity is crucial for younger prisoners, it is equally important for older prisoners as a factor contributing to good mental and physical health. In the UK, "In-cell Workout" is a self-help book for prisoners wishing to exercise even during confinement. Its use was discouraged as the risk of injury was too high without proper guidance and supervision. Thus, only the prisoners with prior knowledge kept up their exercise routine. In view of the soaring anxiety level during the COVID-19 lockdown, some prisons have proposed yoga, meditation and relaxation programmes broadcast through internal radio or TV channel as possible coping strategies.[173]

However, physical activity has not been prioritized. Even when gyms were open outside, they were not operational in prisons. Many prisoners feel excluded from physical activities as they may have some limitations or impairments. Many have never exercised so they may not know the benefits or how to start even if they want to. Not much effort was made to build up small groups to exercise even during the confinement.[174]

Furthermore, with prisoners confined to their cells for months in a row in many countries, they have not been able to clock up as many daily steps as before. This decrease in physical activity has no doubt contributed to worsening the general health status of many prisoners, thus exposing them to additional risks in case of COVID-19.

In Cabo Verde, physical activities were suspended during lockdown. This was particularly taxing for young prisoners between 16 and 21 years of age. They only had daily access to the prison yard but could not play in teams. Board and card games were distributed to this group of prisoners to lift their spirits and alleviate boredom and frustration. Interestingly, in spite of the constraints, there has not been an increase in disciplinary offences during the lockdown.[175]

169 *Conversation with Ms. T., Australia, 3 February 2021*

170 *Croakey Health Media, Stand with us. And clean out prisons, 2020, https://www.croakey.org/stand-with-us-and-clean-out-prisons/*

171 *Prison Reform Trust, COVID-19 Action Prisons Project: Tracking Innovation, Valuing Experience, Briefing#3, 2021, p.20*

172 *Ibid, p.21*

173 *Conversation with Mr. James Mapstone, Chief Executive, Alliance of Sport, 13 January 2021*

174 *Conversation with Prof. Rosie Meek, Royal Holloway, University of London, 19 January 2021*

175 *Conversation with Ms. Iradvi Gonçalves, DGSPRS, Cabo Verde, 20 January 2021*

# STAFF ON THE FRONT LINES

Not only prisoners have been affected by the COVID-19 pandemic. Prison staff has also borne the brunt of the crisis. As the inevitable link between prison and outside world, they have involuntarily contributed to introducing the virus into prisons even during the strictest lockdowns. Conversely, where no testing and no quarantine and isolation measures are available in prison, prison staff may get infected by prisoners and spread the virus to the outside community. While many prison administrations have suspended access to the prisons by non-essential external workers, volunteers, educators, therapists, etc., security and health care staff cannot work remotely and have been on the front lines throughout the pandemic.

According to UNODC, prison staff and health-care professionals working in prisons should be acknowledged as a workforce whose functions are essential to the response to the COVID-19 pandemic, and who must receive the necessary education, equipment and support.[176]

The study published by SOCLA and CELIV in June 2020 indicated that among the Latin-American countries and prison systems surveyed, prison staff and other professionals are in constant contact with incarcerated people. Therefore, both groups are susceptible to contagion, especially where there is extreme overcrowding. As of mid-May 2020, two out of three systems reported that prison staff members had been infected, and in half of those cases staff had died of the infection. These numbers have been increasing as the pandemic gained strength in the region. The suspension of many activities within the prisons sought to limit frequent staff contacts with prisoners.[177]

The Marshall Project has been collecting data on COVID-19 cases in US prisons since March 2020. As of 19 March 2021, 106,376 prison staff members have tested positive. Prisons have publicly reported 194 deaths among staff. However the numbers are difficult to assess as many staff members are not being systematically tested.[178]

In the UK, the COVID-19 "#HiddenHeroes" campaign, led by the Butler Trust, focused on raising public awareness of the role of prison staff and showing them that while they may be hidden, they are not forgotten.[179] A report by the Independent Advisory Panel on Deaths in Custody (IAP) noted the generally positive feedback provided by prisoners about the staff and their dedication during the pandemic. IAP highlighted the importance of keeping proper prisoner-staff ratios and preserving time for one-on-one meetings to ensure prisoners have key trusted staff that they can turn to in case of need.[180]

In April 2020, during the first national lockdown, the Ministry of Justice of Austria acknowledged that prisons belonged to the critical infrastructure. Thus, prison employees were not entitled to time off work. Personnel from the high-risk group needed to be protected from a possible contagion and, to this end, a special procedure was defined. Staff over the age of 60 or presenting a documented health-related high COVID-19 risk should have priority for teleworking. If this is not possible, residual leave should be taken before considering any leave of absence. However, for compelling business reasons, the person can be called upon to perform tasks in the prison associated with the lowest possible risk of infection.[181]

*UNODC Position Paper, COVID-19 preparedness and responses in prisons, 2020*

176 *UN General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/HRC/38/36), 2018, p.7 & p.20*

177 *Los efectos del Coronavirus en las cárceles de Latino América, SOCLA/CELIV, 2020, https://criminologialatam.wordpress.com/2020/06/12/efectos-del-covid-19-carceles-de-latino-america/ (accessed on 24 March 2021)*

178 *The Marshall Project: A State-by-State Look at Coronavirus in prisons, 2021 https://www.themarshallproject.org/2020/05/01/a-state-by-state-look-at-coronavirus-in-prisons#staff-cases*

179 *Butler Trust, Covid #HiddenHeroes, https://www.hiddenheroes.uk/covid-hiddenheroes/*

180 *The Independent Advisory Panel on Deaths in Custody, Keep talking, stay safe – A rapid review of prisoners' experience under COVID-19, 2020, https://www.iapondeathsincustody.org/news/keep-talking-stay-safe*

181 *Ministry of Justice (Austria), Update of the Catalogue of Measures, 2020*

As in other prison systems, in Kenya staff limited its interaction with prisoners to prevent contagion. At the beginning of the crisis, staff was skeptical and also worried. They received extensive counselling and testing also for their families. Now staff is quite satisfied as their work time has decreased because most activities in prison are still scaled down and they have less direct contact with the prisoners. They have adjusted to the "new normal".[182]

In the Province of Buenos Aires, Argentina, prison health care staff was rewarded with renewed attention to their career advancement. There had been delays in promotions since 2006 and this was a symbolic way to recognize the tremendous work that they have been carrying out since the outbreak of the pandemic.[183]

In Brazil's Bahia State, while the pandemic is raging and prison overcrowding is severe, prison staff has been trained to monitor the prisoners' health conditions so as to be able to detect COVID-19 symptoms early and to bring such cases to the attention of the health care services. Four staff members for every prison unit have been trained not only on the prevention of COVID-19 but also on basic follow-up of chronic medical conditions. Prison staff is working in extremely difficult conditions. They are constantly confronted with the prisoners' anguish over their families and the daily pain of having to let families know that their imprisoned relatives have succumbed to COVID-19 or, vice versa, to inform prisoners of the death of a family member outside.[184] The Working group on prison health care of the *Sociedade Brasileira de Medicina de Família e Comunidade (SBMFC)* has issued guidelines on measures to reduce the impact of the pandemic on prisoners, prison staff and health care services, taking into account the evolution of the pandemic in Brazil.[185]

182 *Conversation with Mr. Dancan Ogore, Director Operations, KPS, Kenya, 19 February 2021*

183 *Conversation with Dr. Sonia Quiruelas, Provincial Director, DPSP, Argentina, 1 February 2021*

184 *Conversation with Dr. Andreia Beatriz Silva dos Santos, Brazil, 12 March 2021*

185 *Medidas e orientaçoes para o enfrentamento da COVID-19 no sistema prisional, Grupo de Trabalho em Saúde Prisional da Sociedade Brasileira de Medicina de Família e Comunidade, 2020*

# PRISON MONITORING DURING A MAJOR HEALTH CRISIS

In an unprecedented situation, prisons in most countries were closed to the outside for varying periods of time in an effort to limit the spread of the coronavirus. With the suspension of most prison activities and family visits, external professionals, volunteers, therapists, educators, etc., were not able to gain access to prisons. Even internal and external monitoring bodies had to scale down or suspend their activities for several weeks. In many cases, prisoners were left solely in the hands of staff. There are many accounts of the professional and humane dedication of most prison staff members. Ill equipped with masks and sanitizing products, often unable to get tested and fearing for their own and their families' lives, they have ensured the proper functioning of prisons under difficult circumstances. They have done their best to protect the most vulnerable prisoners from contagion and to alleviate the distress of many inmates unable to see or even get in touch with their families.

However, there are documented cases of non-observance of health protective measures (e.g., wearing masks, keeping social distance) by staff and unequal distribution of PPE to prisoners when it was available.[186] There are also disturbing reports of serious violations of prisoners' rights by prison staff in several countries, especially excessive use of force in reaction to the riots that characterized the first weeks of the pandemic.[187]

The Nelson Mandela Rules stress the importance of prison monitoring by both internal and external inspection bodies[188]. Furthermore, National Preventive Mechanisms (NPMs) are mandated by OPCAT[189] to visit all places of deprivation of liberty regularly, in order to prevent torture and other ill-treatment.[190] The OPCAT does not permit any restrictions to be imposed on NPMs visiting mandates. For example, the NPMs of Italy[191] and Senegal[192] reported having visited several prisons during the pandemic. In its Interim Guidance on COVID-19 in prisons, WHO has reiterated the importance of independent monitoring and oversight in prisons and other places of detention.[193]

186 *Amnesty International, Forgotten behind Bars, 2021, p.19*

187 *Ibid. p.47*

188 *Nelson Mandela Rules 83 – 85*

189 *Optional Protocol to the UN Convention against Torture (OPCAT), 2006*

190 *OPCAT, Art.1*

191 *Garante nazionale dei diritti delle persone private della libertá personale https://www.garantenazionaleprivatiliberta.it/gnpl/it/dettaglio_contenuto.page?contentId=CNG10438&modelId=10021*

192 *Observateur national des lieux de Privation de Liberté, Josette Marceline Lopez Ndiaye, 2020, https://www.pressafrik.com/L-Observateur-National-des-Lieux-de-Privation-de-Liberte-note-que-la-covid-19-a-eu-un-impact-sur-les-droits-des-detenus_a221079.html*

193 *WHO Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2021, p.6*

The restrictive measures imposed on the general population have also affected the capacity of NPMs to carry out their visits in many countries. For example, in the OSCE region the visiting activities of all NPMs were reduced one way or the other. Aside from facing risks of infection when conducting monitoring visits, members of NPMs can also introduce the virus from outside when they enter a prison. Thus, during the pandemic NPMs have either continued their monitoring activities using adequate PPE, or have suspended visits or have reconsidered monitoring methodologies, including increased use of remote monitoring.[194] The European Committee for the Prevention of Torture (CPT) and the Subcommittee on Prevention of Torture (SPT) have identified the "do no harm" principle as the guiding principle for NPMs in fulfilling their monitoring mandate under the current crisis.

The Commonwealth Human Rights Initiative (CHRI) compiled a Checklist for Monitoring Prisons based on an advisory issued by the Ministry of Home Affairs of India, entitled "Management of COVID-19 in Indian Prisons – guidelines and protocols which may be followed while dealing with persons arrested, detained and those in Prisons and Correctional Homes". The Checklist should facilitate the task of the Prison Head Office to internally monitor the conditions of all prisons in their respective states. It lays down minimum standards to be followed in each prison for administrative preparedness, establishment of a precautionary framework and handling of suspected/confirmed cases of COVID-19 infection.

Although in Brazil in the first months of the pandemic inspection visits from monitoring bodies were suspended, NPMs were proactive in arranging regular meetings with the public authorities to follow, at a distance, the evolution of the crisis in prisons.[195]

However, in the Brazilian state of Santa Caterina, the Committee to support measures for the prevention and treatment of COVID-19 in the prison complex of Joinville[196] has been carrying out regular inspections in the two prison units throughout the pandemic. It is headed by a Judge of Criminal Execution (*Juiz da Execução Penal*), accompanied by representatives of the Community Council, the Bar Association, Public Defense and prosecution. Monitoring the conditions of detention is part of the mandate bestowed upon the *Juiz da Execução Penal* by the Constitution and such visits should take place even during the health crisis with the appropriate PPE. During the visits, the Committee meets the "voices" of the cell houses, i.e. the representatives of the prisoner, to discuss their needs. For example, the *Juiz* has asked the Government to improve the provision of food after the suspension of parcels brought by the prisoners' families. It also verifies the correct application of the COVID-19 related protocols in the prison. The Director of the prison complex has to report to the *Juiz* about the situation on a daily basis. After each visit, the report of the Committee is sent to the Director with the request to distribute copies to all cells. These regular visits by the Committee have been crucial to let prisoners know that they were not alone during these trying times.

The *Juiz* has also looked into the arrangements for the prisoners' communication with their families. Due to the suspension of visits, only calls by mobile phone or tablet are allowed. However, the equipment does not work properly. Letters from family members are delayed and many prisoners cannot afford the paper to write back. Thus, the *Juiz* suggested using emails sent by the families to the prison, printed out and distributed to the prisoners. The prisoners' replies are typed up and sent to the respective families by the responsible office in the prison.[197]

194 *OSCE/ODIHR and APT, Monitoring Places of Detention through the COVID-19 Pandemic, 2020, p.9*

195 *Brazil: managing uncertainty, 2021, https://www.prison-insider.com/en/brazil-managing-uncertainty*

196 *Comitê de acompanhamento das medidas para prevenção e tratamento da COVID-19 no Complexo prisional de Joinville*

197 *Conversation with Mr. João Marcos Buch, Juiz de Direito, Brazil, 12 March 2021*

# THE HOPE OF VACCINES

Within one year since the beginning of the COVID-19 pandemic, a global effort has led to the development and distribution of safe and effective vaccines that have been approved by the competent health authorities. However, the immunization of a critical mass of the world population — crucial to control the pandemic — is facing a new series of challenges, including new dangerous strains of the virus, the global competition for a limited supply of doses, and public skepticism toward the vaccines.[198]

In spite of the various measures adopted to mitigate the effect of the pandemic in prisons, case- and mortality rates among prisoners remain several-fold higher than most surrounding communities. The number and extent of the outbreaks of COVID-19 in prisons worldwide call for the prioritization of incarcerated persons for vaccination.[199]

The world has high hopes in the vaccines to end the pandemic. WHO defends the position that "everyone, everywhere who could benefit from safe and effective COVID-19 vaccines should have access as quickly as possible, starting with those at highest risk of serious disease or death".[200] This is true also for prisoners, according to the principle of equivalence of care. Taking into account the individual needs of prisoners, particularly the most vulnerable persons, is in accordance with the principle of non-discrimination expressed in Nelson Mandela Rule 2[201]. Furthermore, prison staff move in and out on a daily basis and other personnel providing health-care or supporting programmes may not work exclusively in a single facility.[202] Moreover, detention facilities in several countries still face issues of limited supply of PPE, even for health-care workers, thereby further increasing their already considerable baseline risk.[203] Therefore, WHO also recommends that "the prison workforce (health-care workers and prison staff) should be prioritized for vaccination as health and care workers and as personnel at higher risk."[204]

The Committee on Economic, Social and Cultural Rights issued a statement on universal and equitable access to vaccines for COVID-19,[205] stressing that prioritization of the access to vaccines by specific groups is unavoidable, at least in the initial stages, not only nationally but also at the international level. In accordance with the general prohibition of discrimination, such prioritization must be based on medical needs and public health grounds. According to these criteria, priority may be given, among others, to persons most exposed and vulnerable to the SARS-COV-2 due to social determinants of health, such as incarcerated people and other marginalized and disadvantaged populations.

198 *Inter-American Commission on Human Rights, COVID-19 Vaccines and Inter-American Human Rights Obligations (Resolution 1/2021), 2021, p.2*

199 *EClinical Medicine, Prioritizing incarcerated populations for COVID-19 vaccination and vaccine trials, 2021*

200 *WHO Regional Office for Europe, Preparedness, prevention and control of COVID-19 in prisons and other places of detention, 2021, p.24*

201 *Ibid.*

202 *WHO Regional Office for Europe, Why people living and working in detention facilities should be included in national COVID-19 vaccination plans, 2021, p.3*

203 *Ibid. p.7*

204 *Ibid, p.1*

205 *UN Economic and Social Council, Statement on universal and equitable access to vaccines for the coronavirus disease (COVID-19), p.2*

The Inter-American Commission on Human Rights (IACHR) and its Special Rapporteurship on Economic, Social, Cultural, and Environmental Rights (SRESCER) called on States in the Americas to prioritize public health and compliance with their own international human rights obligations when making decisions or adopting policies to approve, purchase, distribute, and provide access to these vaccines. To guarantee fair and universal access to vaccines for all people under their jurisdiction, States must ensure that there are no restrictions that might particularly affect groups who are particularly vulnerable or who have historically faced discrimination, including people who are deprived of liberty, among others.[206]

Considering that each year over 30 million men and women spend time in prisons and other closed settings[207] and that by 29 March 2021 there had been over 537,000 COVID-19 cases in prisons and over 3,900 prisoner deaths[208] confirmed worldwide, prison staff and prisoners should be considered high-priority for COVID-19 vaccinations for a number of reasons. The first one being that the physical environment, particularly in case of overcrowding and poor ventilation, facilitates rapid transmission and hinders effective social distancing. In many countries, lack of information on steps needed to prevent spread of the virus and shortage of face masks, hand sanitizers or soap and water, together with limited testing capacity, have contributed to the spreading of the virus. Dormitory housing, prevalent in many countries, represent the highest risk factor for infection.[209] Secondly, it is universally recognized that prisoners are disproportionately affected by poor social determinants of health, leading to a higher prevalence of chronic diseases such as hypertension and diabetes that represent vulnerabilities for severe COVID-19 and mortality.[210] Thirdly, and probably more convincingly for the general population, the transmission of coronavirus between prisons and surrounding communities is a well-documented risk, thanks to the porous nature of prisons.[211]

Besides the general shortage of vaccines and the fact that many countries have not been able to secure any vaccines for the time being, the operational aspects of a COVID-19 vaccination campaign in prison may present several challenges, especially in countries with limited resources. For example, distributing the vaccines to prisons in remote areas might prove to be difficult also because of the need for very low temperatures for their proper storage. Because of the physiological turnover of prisoners, it is indispensable to ensure a seamless coordination between health-care services in prison and public health to ensure that each prisoner receives the necessary vaccine doses even if he/she is released before completing the inoculation cycle.

There is a big debate in some countries as to the degree of vulnerability of prisoners when it comes to being prioritized for the vaccinations against COVID-19. As a minimum, public health professionals have called for prisoners to be vaccinated in tandem with their age groups on the outside, bearing in mind the ageing effect of prison itself and the poor health status of people in detention.[212] Canada started vaccinating older and medically vulnerable federal inmates in the first phase of its vaccine program, launched in January 2021.[213]

Some countries, such as Ireland, have included prisoners in the priority list. In many countries, delays in the availability of vaccines for the elderly and health care staff, recognized as having the highest priority, have contributed to stirring public debate towards the exclusion of prisoners from immunization priority lists.

In Colorado (USA), contrary to public health officials' advice to put incarcerated people in line for coronavirus immunization ahead of the elderly and those with chronic conditions, political pressure led to excluding prisoners from immunization priority groups. Considering that the largest number of the most virulent coronavirus outbreaks in that State had

206 *Organisation of American States, IACHR and its SRESCER Call on American States to Make Public Health and Human Rights the Focus of All their Decisions and Policies Concerning the COVID-19 Vaccine, 2021, http://www.oas.org/en/IACHR/jsForm/?File=/en/iachr/media_center/PReleases/2021/027.asp (accessed on 16 February 2021)*
***See also** IACHR Resolution 1/2021, ibid. op. para I.4, p.5*

207 *UNODC, ILO, UNAIDS, UNDP & WHO, HIV prevention, treatment and care in prisons and other closed settings: a comprehensive package of interventions, 2013, p.1*

208 *Justice Project Pakistan, COVID-19 and prisoners, https://www.jpp.org.pk/covid19-prisoners/ (accessed on 29 March 2021)*

209 *WHO Regional Office for Europe, Why people living and working in detention facilities should be included in national COVID-19 vaccination plans, 2021, p.4*

210 *EClinical Medicine, Prioritizing incarcerated populations for COVID-19 vaccination and vaccine trials, 2021*

211 *Penal Reform International, Covid-19 in prisons: why prioritizing staff and prison populations for vaccination matters, 2021, https://www.penalreform.org/blog/covid-19-in-prisons-why-prioritising-staff-and/?mc_cid=2f0a0660b4&mc_eid=840605888f (accessed on 23 February 2021)*

212 *WHO Regional Office for Europe, Why people living and working in detention facilities should be included in national COVID-19 vaccination plans, 2021, p.5*

213 *The Washington Post, Prisons are Covid hot spots. But few countries are prioritizing vaccines for inmates, 2021, https://www.washingtonpost.com/world/2021/01/14/global-coronavirus-vaccines-prisons/*

Photo by Noppol Chuklin A.RPST. A.FPT. A.BPS

taken place in prisons, this episode shows the dilemma between medical priorities and political considerations when it comes to deciding which groups should be inoculated first.[214] Guidance issued on 20 December 2020 by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) in the USA included correction officers in Phase 1b, along with other non-health care frontline workers and people aged 75 and older.[215] However, in a few US States (for example in Massachusetts), priority was given to incarcerated people because of the broader focus on congregate settings considered at risk whether they were long-term nursing facilities or prisons.[216]

California Correctional Health Care Services (CCHCS) and the California Department of Corrections (CDCR) are started vaccinating staff and prisoners for COVID-19 on 22 December 2020, in line with California Department of Public Health (CDPH) priority guidelines. While early vaccination efforts focused on frontline staff and incarcerated patients in long-term/skilled nursing beds, further categories were approved, including all institution staff and all incarcerated persons over the age of 65 and those at higher risk of complications. All CDCR/CCHCS staff and incarcerated individuals will qualify to receive the vaccine by Phase 1C.[217]

In Italy, at the beginning of February 2021, the national vaccination plan was amended to include the immunization of prison staff and prisoners in the priority phases 2 and 3 (together with people older than 80, vulnerable persons, teachers, military, law enforcement, etc.), depending on the age and vulnerability factors of each person.[218]

In the Province of Buenos Aires, Argentina, the *Dirección Provincial de Salud Penitenciaria* (DPSP) has already acquired 80,000 doses of Sputnik-V vaccine for prison and health care staff and prisoners. The vaccination plan of the DPSP foresees three risk levels to prioritize immunization. Even family members of prisoners may be vaccinated under the DPSP scheme if they have no access to other vaccination sites. Taking into account the cold storage requirements of COVID-19 vaccines as one of the possible practical obstacles to a successful vaccination campaign in prison, the plan also involves purchasing 80 freezers and generators to ensure that each prison is able to stock the vaccines at the proper temperature.[219]

In Kenya, prison staff was included in the first priority group for immunization as front line workers, while prisoners are in tier 2 of the vaccination plan. [220]

214 *The Washington Post, Early vaccination in prisons, a public health priority, proves politically charged, 2021, https://www.washingtonpost.com/health/2021/01/02/covid-vaccine-prisons/*

215 *CDC, COVID-19 Vaccine Rollout Recommendations, 2021*

216 *The Washington Post, Early vaccination in prisons, a public health priority, proves politically charged, 2021, https://www.washingtonpost.com/health/2021/01/02/covid-vaccine-prisons/*

217 *CDCR, COVID-19 response efforts, 2021, https://www.cdcr.ca.gov/covid19/covid-19-response-efforts/#Vaccine (accessed on 27 February 2021)*

218 *Dai docenti ai poliziotti: ecco a chi (e quando) andranno i vaccini, SkyTG24, 2021, https://tg24.sky.it/salute-e-benessere/2021/02/03/vaccini-covid#00*

219 *Conversation with Dr. Sonia Quiruelas, Provincial Director, DPSP, Argentina, 1 February 2021*

220 *Conversation with Mr. Dancan Ogore, Director Operations, KPS, Kenya, 19 February 2021*

*CHAPTER*
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# Conclus
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**PROLONGED LOCKDOWNS IN MANY COUNTRIES HAVE LED TO FEWER CRIMES, BUT THE UNPRECEDENTED FINANCIAL DIFFICULTIES AND MASSIVE JOB LOSSES CAUSED BY THE PANDEMIC ARE FORCING SOME PEOPLE TO COMMIT OFFENCES TO SURVIVE.**

After over one year of the global health crisis and considerable pressure to manage the impact of the pandemic in prisons keeping prisoners and staff safe, prison systems and health-care services have acquired better knowledge and understanding of COVID-19. Thanks to the initial release of large numbers of prisoners to reduce overcrowding, prison populations decreased in some countries[221] but their numbers rose again as courts resumed their regular work after the first COVID-19 wave. Prolonged lockdowns in many countries have led to fewer crimes but the unprecedented financial difficulties and massive job losses caused by the pandemic are forcing some people to commit offences to survive. The longer the pandemic lasts, the more challenging it is going to be to ensure that staff stay motivated and prisoners accept the restrictions imposed on them.

Several countries fared well during the first phase of the pandemic but were confronted with considerable challenges in continuing to keep staff and prisoners safe from infection once the virus reached high levels of prevalence in the community. Others went from crisis to crisis, trying to limit damage and loss of lives among staff and prisoners by following international guidance with the limited resources available. Many countries managed to keep COVID-19 out of their prisons only applying very strict measures that greatly limited the rights of prisoners and their families. In a few cases, high numbers of COVID-19 deaths were registered among prison staff and prisoners, mirroring a situation out of control in the outside community.

However, there have been a few positive developments, such as increased use of non-custodial measures and sanctions in many jurisdictions, amnesties and early release schemes to free large number of prisoners and to ease overcrowding, increased attention to prisoners with special needs, opening to technology (e.g., telemedicine) and to modern forms of communication to facilitate the prisoners' contacts with families and lawyers. Among the countries surveyed for this paper, several indicated that the pandemic has strengthened relations and cooperation between the prison administration and the Ministry of Health or public health-care services.

Similar to public health, prison health care has gained in importance during the pandemic. In the last 12 months many people worldwide have had their daily lives turned upside down because of the lockdown periods and the limitations of movement and assembly imposed in

most countries to reduce the spreading of the virus. In the same period, the State's responsibility for the persons under its care has emerged in all its aspects and connections with all other prisoners' rights. There is not only the right to remain alive and healthy during a pandemic, but also the rights to receive medical treatment for chronic conditions or mental health or drug use disorders when prison health care services are under strain because of COVID-19 and external therapists are not allowed in the prison; to maintain contacts with family members, especially children, when visits are suspended and alternative means of communication do not work or are too expensive; to eat nutritious food when families cannot supplement one's diet; to exercise regularly when movement within the prison is restricted for weeks in a row; to pursue educational, vocational or academic goals when all activities are stopped to curb the spread of the virus; to earn some money working when prison production lines are halted and nobody can go in and out of the prison to work outside; to follow an individual plan towards resocialization without a major external interruption that potentially obliterates or at least delays future chances of parole.

The "new normal" for behaviour in prisons includes restrictions and limitations of varying intensity, depending on the prevalence of the virus in the community or the presence of an outbreak in a specific prison. Family visits have resumed in many countries but behind a glass partition. Even when security is not an issue, physical contact with a partner, a parent or a child remains impossible for many prisoners. People talking through masks in noisy prison parlours may have a hard time at understanding each other. Communication is difficult and intimate conversations are not facilitated. One's fears for the future, amplified by the prison environment, cannot be easily discussed.

Schooling and training courses have resumed in smaller groups, or through distance learning programmes. Working activities have started again in many prisons, wearing PPE and practicing social distancing whenever possible, sometimes reorganizing shifts and/or reducing working hours. Depending on the circumstances, a timid normalcy is being reintroduced, often keeping the same group of prisoners together and limiting interaction with other units.

Prison staff has been on the forefront of the health crisis for months, saddened by the loss of colleagues to COVID-19 and worried with the possibility of getting infected with the virus and carrying it outside to their communities. Their work has changed in many respects. Unable to accompany and support the prisoners in their daily activities, they have often reduced their interaction with them to a minimum. Prisoners precluded from seeing their families for weeks or months and deprived of all activities have taken their anger and frustration out on prison staff. Tensions have increased in many prisons. Fake news and rumours on the virus and the measures to curb its spreading have required firm interventions by prison management to convey evidence-based information to the inmates and avoid disturbances.

It is still too early to predict the long-term consequences of the pandemic in prisons but at least two scenarios seem likely. The first one is that, once the pandemic is over, we could strive to resume life as it was before, returning to the same patterns and repeating the mistakes of the past, again forgetting and neglecting the rights of the most vulnerable segments of society, including prisoners. The second scenario would be that we draw some lessons from the pandemic. We could build on the changes imposed by this global tragedy to reflect on the suitability and effectiveness of incarceration as a punishment and the importance of applying relevant international standards, first and foremost the Nelson Mandela Rules and the Bangkok Rules, to ensure humane and dignified conditions of detention.

221 *For Europe, see EuroPris, Overview of European prison services' responses to the Covid-19 crisis, 2020*

# RECOMMENDATIONS

In the Kyoto Declaration on Advancing Crime Prevention, Criminal Justice and the Rule of Law: Towards the Achievement of the 2030 Agenda for Sustainable Development, UN Member States expressed grave concern about the vulnerability of prisons, especially in terms of health, safety and security, to the real risk of a rapid spread of the virus in closed settings, which can be further aggravated by long-standing challenges such as prison overcrowding and poor prison conditions.[222]

The disproportionate impact of COVID-19 in prisons worldwide has demonstrated what can happen when a large crisis hits overburdened and ill-equipped prison systems. The post-COVID-19 recovery will hopefully provide the opportunity to address chronic long-standing problems affecting many prison systems and spearhead a much-needed comprehensive prison reform.[223]

Each country has been dealing with the pandemic on the basis of its own public health, political, social, economic and cultural considerations. The health crisis has spurred discussions worldwide on how to reconcile the need to preserve health and save lives on one hand, with the need to sustain economic activity and the social fabric, on the other hand.

Prison administrations have also found themselves in a similar dilemma, applying tight restrictions to the prisoners to save them from the virus. Is it time for a "health-informed approach to penal reform"?[224] Taking into account the national experiences highlighted in this paper, the set of recommendations below reflect measures that have proved useful in preventing and controlling the spread of COVID-19 in prisons and have limited the distressing effect of the restrictions imposed on the prisoners.

222 *UNODC, Kyoto Declaration on Advancing Crime Prevention, Criminal Justice and the Rule of Law: Towards the Achievement of the 2030 Agenda for Sustainable Development, 2021, p.3*

223 *United Nations System Common Position on Incarceration, April 2021, p.7*

224 *Catherine Heard, Commentary: Assessing the Global Impact of the Covid-19 Pandemic on Prison Populations, Victims & Offenders, 2020, p.858*


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# PREPAREDNESS FOR FUTURE CRISES

## 01

### STRENGTHEN PARTNERSHIP AMONG STAKEHOLDERS

In relation to the current pandemic, it has been observed that "Nobody can be safe until everyone is safe" [225] Thus, multi-stakeholder partnerships are essential both at the national and international level to ensure a comprehensive approach to the management of COVID-19 in prisons. As stressed by the Commission on Crime Prevention and Criminal Justice in its resolution E/RES/2021/23[226], the "importance of a multidisciplinary approach to strengthening criminal justice systems, including the involvement of relevant stakeholders and public-private partnerships, and enhancing domestic inter-agency cooperation,... as well as the importance of improving prison management and preparing for health-related challenges" is crucial.

## 02

### REDUCE PRISON OVERCROWDING

Countries should not wait for the next major global health crisis to address prison overcrowding.

Prison overcrowding requires a multidisciplinary approach.[227] Prison administrations should not be left alone to deal with the problem, but solutions should be identified in concert with a variety of stakeholders such as policymakers, judiciary, prosecution, public defense, probation and parole boards, etc.

Pre-trial detention should not be considered as a normal measure to be applied waiting for justice to run its course. It is a measure of last resort and as such should be limited to a small number of cases fulfilling legally predefined criteria.

Public discussion on criminal policy should include a variety of alternative measures and sanctions so that imprisonment is not the obvious choice to punish socially undesirable behaviours. Efforts should be made to identify measures more appropriate, efficient and cost effective than imprisonment to sanction offences that do not raise particular social alarm and that may be an expression of the offender's social or health problems and vulnerabilities. The response to many undesirable actions may better fall within the scope of social or health-care policies, rather than criminal justice.[228] To this end, fewer people in poor health should be held in prison and health care provision in the community should be strengthened, in particular for mental health disorders and drug and alcohol problems.[229]

The Tokyo Rules[230] continue to inspire international efforts to apply a gamut of non-custodial measures and sanctions as alternatives to, respectively, pre-trial detention and imprisonment. When properly included in a comprehensive and balanced criminal justice system, alternatives to imprisonment can greatly contribute to limiting the use of imprisonment and reducing the risk of reoffending, thus preventing prison overcrowding.

## 03

### INVEST IN HEALTH CARE SERVICES IN PRISON

Resources for prisons seem never to be enough. However, the effects of the pandemic have been more serious in prisons systems that have not accorded sufficient attention and priority to properly funding and staffing prison health-care services. Recalling that prison health care is part of public health and that any health crisis in prison is likely to spill over in the community if it is not properly contained, it makes good political sense to ensure a minimum standard for the health care services provided in prisons.

In countries where public funding is insufficient like Madagascar, when it comes to facing a health crisis, it is useful to seek timely support from civil society and international donors and NGOs or through public-private partnerships.

## 04

## APPLY THE NELSON MANDELA RULES AND THE BANGKOK RULES

There is no better way to prepare for the next global crisis affecting prisons, be it linked to a pandemic or a major security threat, than to thoroughly apply relevant international human rights standards and norms, and translating them into national practice.

The Nelson Mandela Rules set out good principles and practice in the treatment of prisoners and prison management. The Bangkok Rules are equally important as they address the specific needs of women in prison, including gender-specific health care.

## 05

## STRENGTHEN COORDINATION BETWEEN PRISON ADMINISTRATION AND PUBLIC HEALTH-CARE AUTHORITIES

Nelson Mandela Rule 24.2 stipulates that "health-care services should be organized in close relationship to the general public health administration and in a way that ensures continuity of treatment and care."

As underlined in its resolution E/RES/2021/23,[231] the Commission on Crime Prevention and Criminal Justice at its thirtieth session, "the COVID-19 pandemic poses cross-cutting, multifaceted challenges to the criminal justice system and it requires comprehensive, integrated, multisectoral and coordinated responses, including through cooperation between the justice and health sectors."

Countries like Thailand that have set up a well-functioning mechanism of interagency coordination and collaboration between the Ministry of Health/public health agencies and the Prison Administration are able to provide better medical services to prisoners. This approach has proven very useful in leading an effective infection control response during the pandemic.

## 06

## PREPARE PROTOCOLS

Many prison systems do not have a comprehensive corpus of standard procedures covering all aspects of prison life. The pandemic has forced numerous prison administrations to develop protocols on unaddressed issues in an emergency situation. As the coronavirus is a novel virus, abundant international guidance has been progressively made available on the COVID-19 mode of contagion, prevention, containment, etc.

While no prison administration can foresee future procedural needs, it is important to examine which protocols already exist and assess what should be integrated so as to increase the level of preparedness for future crisis situations and identify on time the corresponding staff training needs.

The example of Ireland is quite relevant as they addressed systemic problems in dealing with infectious diseases, including staff training in infection controls way before the outbreak of the pandemic. Therefore, they were better prepared to face the COVID-19 crisis. The examples of the province of Buenos Aires, Kenya and Madagascar illustrate the usefulness of protocols to ensure a coordinated and consistent response to a health crisis in prison.

225 *The Telegraph, No government can address the threat of pandemics alone – we must come together, 2021, https://www.telegraph.co.uk/politics/2021/03/29/no-government-can-address-threat-pandemics-alone-must-come/ (accessed on 23 July 2021)*

226 *UN General Assembly, Resolution on 'Strengthening Criminal Justice Systems During and After the Coronavirus Disease (COVID-19) Pandemic' (E/RES/2021/23), 2021, p.4*

227 *See UNODC & ICRC, Strategies to reduce overcrowding in prisons, Criminal Justice Handbook Series, 2013*

228 *Ibid. p.46*

229 *Catherine Heard, Commentary: Assessing the Global Impact of the Covid-19 Pandemic on Prison Populations, Victims & Offenders, 2020, p.858*

230 *UN General Assembly, United Nations Standard Minimum Rules for Non-Custodial Measures (the Tokyo Rules) (45/110), 1990*

231 *UN General Assembly, Resolution on 'Strengthening Criminal Justice Systems During and After the Coronavirus Disease (COVID-19) Pandemic' (E/RES/2021/23), 2021, p.3*

# PREVENTING AND CONTROLLING COVID-19 IN PRISONS

## 07 REDUCE THE NUMBER OF PRISONERS RAPIDLY

As mentioned before, prison overcrowding per se increases the prevalence of transmissible and chronic diseases and other health problems. Thus, reducing the number of prisoners is the first step to prevent the spreading of COVID-19. Given the high percentage of prisoners in poor health, particular attention has to be paid to the possibility of releasing certain categories of inmates considered at particularly high risk of complications or poor outcomes in case of infection, such as those of older age.

Limiting the use of pre-trial detention is another key measure. For example, in Kenya, cooperation between prison administration, police and courts was essential to limit new admissions to prison, especially for petty offences. Likewise, free bail (with no financial guarantees) should be considered to decrease the number of prisoners awaiting trial and thus decongest the prisons.

Women, especially mothers with young children should be eligible for alternatives measures or sanctions whenever possible. During the pandemic, women in prison face the additional worry of not being able to take care of their children outside, who are often entrusted to grandparents or older relatives, a category at high risk for COVID-19. Suspension of family visits has a dramatic impact on women and their children.

Early and conditional release of large numbers of prisoners without taking into account possible reactions by the public and the risk of the political instrumentalization thereof are to be avoided. Amnesties and unprepared release of large groups of prisoners, especially during a lockdown period, can be counterproductive. Released prisoners require assistance with housing, employment, health care and the pandemic has made the work of support organizations more challenging.

In countries like Italy or Brazil, where there are members of the Judiciary in charge of the execution of sentences, the role of these judges and their constructive relations with prison authorities are crucial in ensuring the proper handling of cases.

## 08 PROVIDE CLEAR INFORMATION

Some of the disorder and prison riots that took place in various countries at the beginning of the pandemic were due to the fact that prisoners did not know what was going on outside with the virus and were worried about their health and their family's safety. The unbridled circulation of fake news and rumours in certain prisons certainly contributed to the lack of control.

Thus, during a crisis, it is crucial to keep prisoners well informed, updating them regularly on the situation inside and outside the prison. It is important to give prisoners clear and easy-to-follow instructions on how to prevent infection and how to use the protective equipment and hygiene products distributed. Such information should be conveyed not only in writing but also using audio-visual media (e.g. internal TV or radio channel; posters and leaflets with images; etc.).

The messages and the written texts should be made available in the languages widely spoken among the prison population, bearing in mind the importance of reaching all prisoners with this potentially lifesaving information. Extra efforts should be made to ensure that illiterate prisoners, prisoners with learning disabilities and foreigners are effectively informed and instructed on the required measures.[232]

The experience of the Province of Buenos Aires in this respect can be quite inspiring.

## 09 INCREASE THE USE OF TECHNOLOGY

The pandemic has accelerated the use of new communication technologies such as video calls, Zoom, Skype, mobile phones, e-mails, etc. by prisoners. Once considered particularly problematic for security, these communication tools have been used extensively as a replacement for family visits, consultations with defence lawyers, court hearings, medical consultations, psychological therapy and support.

Not all countries have been able to offer the same access to these means of communication in prison because of infrastructure shortcomings – particularly poor internet connections – and the extra costs attached. ICRC and other donors have stepped forward in some countries to provide mobile phones and air time for prisoners.

While the availability of modern forms of communication for prisoners is a welcome step towards normalization, there is the risk that, once the health crisis is over, in-person visits might be replaced by these cheaper and easier remote technology-enabled communication and learning. This should be discouraged as direct contact with family, friends and volunteers, face-to-face therapy and consultations are key components of resocialization. Such technological innovations should therefore be available in addition to, and not as a replacement of, traditional real-life communication channels and visits.

## 10 COLLECT DISAGGREGATED DATA ON COVID-19 IN PRISON AND PROMOTE RESEARCH

Many countries do not have enough capacity to gather and process comprehensive and updated information on the number of prisoners, their profiles, sentences, health status, etc. During the COVID-19 pandemic, these problems have been exacerbated. As noted by several researchers, there is scarcity of updated data on COVID-19 cases and deaths in prisons worldwide.

Data is hardly ever disaggregated by age, legal status, sex, etc. Thus, only partial information is available on the number of COVID-19 cases that have occurred in prisons worldwide. Thus, additional evidence-based research is crucial to explore the incidence of COVID-19 among prisoners and prison staff, not only in relation to the incidence within the outside community, but also in relation to age, pre-existing pathologies, sex, length of prison stay, level of overcrowding, interaction with outside world, sanitary measures introduced, etc. Such research could greatly contribute to identifying shortcomings in the current health crisis management so as to improve the readiness of prison systems to better face future challenges.

In particular, attention should be devoted to gathering additional information on the impact of COVID-19 on women prisoners. In order for prison administrations to adopt measures that are gender-sensitive and take into account the specific needs of women also regarding health care, more data on COVID-19 in women's prisons is required.

As it transpires in the present report, some countries have acquired considerable experience in tackling the COVID-19 health crisis in prison. International cooperation through the exchange of experiences and lessons learned can benefit all prison systems leading to the identification of good practices for the future.

232 *The Conversation, Coronavirus: why prison conditions can be a perfect storm for spreading disease, 2020, https://theconversation.com/coronavirus-why-prison-conditions-can-be-a-perfect-storm-for-spreading-disease-134106*

## 11 PRIORITISE PRISON STAFF AND PRISONERS FOR COVID-19 VACCINES

In keeping with international recommendations, it is important to consider prison staff and other prison service providers, as well as prisoners, as priority groups for national coronavirus vaccination plans in view of their adverse social determinants and the risk of outbreaks in closed settings like prisons. Setting clear criteria for a vaccination plan and providing transparent information to the public on the importance of including prisons in the priority list for vaccination as a public health measure are good practices to avoid politicizing the debate.

## 12 INVEST IN STAFF WELFARE

Prison staff and prison health-care have been on the forefront of the COVID-19 crisis for months. They deserve recognition and appreciation. As the pandemic drags on, their motivation may falter. Depending on the situation of each country, they may have lost colleagues, family members and friends to COVID-19. They may have become infected themselves. Their work has changed as prisoners' activities have been suspended or scaled down.

Prison authorities and authorities in charge of the health care of staff should ensure that all those working in prisons are properly trained on how to protect themselves and others from infection, have enough protective equipment and sanitizers and receive psychological support as required.

## 13 OFFSET THE STRESS BROUGHT ABOUT BY THE RESTRICTIONS

As a reaction to the limitations introduced to prevent COVID-19 infections in many countries, the general population outside is showing increasing signs of distress and dissatisfaction. Prisoners are suffering even more because of the added layer of restrictions imposed on them.

Lack of direct contact with family and friends, fear over their own health and the wellbeing of their families, suspension or reduction of activities and treatment, etc. are having a distressing effect for many prisoners. Thus, prison administrations should do whatever possible to maintain meaningful and stimulating activities for the prisoners while ensuring their safety. In the UK, availability of locked mobile phones and secure videoconferencing for prisoners were successful and contributed to making the first lockdown in prisons bearable.[233]

In several countries, prisoners were asked for their feedback on the safety measures applied. Projects like CAPPTIVE have given a voice to prisoners on how prisons in the UK have been responding to COVID-19.

The effects of protracted restrictions on the prisoners' mental health should be taken into account and properly addressed.[234]

*233 CREST, 'Prison and Covid-19: what went right?', 2020*

*234 Prison Reform Trust, COVID-19 Action Prisons Project: Tracking Innovation, Valuing Experience, Briefing#3, 2021*


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