



GOOD PRACTICES IN MANAGING INFECTIOUS DISEASES IN PRISON SETTINGS

A SNAPSHOT OF RESPONSES TO COVID-19
IMPLEMENTED AROUND THE GLOBE
BETWEEN MAY AND SEPTEMBER 2020

Abstract

This report captures various health-related policies and practices that were implemented inside prisons and other places of detention during the COVID-19 pandemic. It is intended as a resource for policy-makers, prison managers and health-in-prisons practitioners, highlighting the preparedness, responsiveness, risk assessment, risk mitigation and case management of COVID-19 inside prisons. The report presents good practices from countries and regions, selected according to specific criteria, in enhancement of health-care practices in prisons. It is structurally based on, and thematically complementary to, *Preparedness, prevention and control of COVID-19 in prisons and other places of detention: interim guidance*, developed by the WHO Regional Office for Europe and issued in March 2020 (revised February 2021). The robust methodology used to capture good practices and their selection within a fixed submission window within 2020 mean that some developments in response measures in prisons could not be covered in this report.

Keywords

COVID-19

INFECTION, PREVENTION AND CONTROL

PRISONS

HEALTH IN PRISON

HEALTH POLICY

HUMAN RIGHTS

PUBLIC HEALTH SURVEILLANCE

EUROPE

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Foreword

COVID-19 has changed the world as we knew it before 2020. By the end of 2020 more than 175 million people worldwide had contracted the disease and more than 3.7 million lives had been lost to this vicious pandemic. But the pandemic effect on people worldwide goes beyond those numbers, with almost everyone on the planet changing the way they live in response.

In prisons and other places of detention a variety of environmental factors and the behaviour of the SARS-CoV-2 virus mean that COVID-19 has posed an even more serious challenge. Working tirelessly, authorities and communities have adopted a number of measures to prevent COVID-19 spreading in prisons.

This compilation presents a range of good practices in prison settings from around the globe, specifically in the areas of preserving human rights and providing alternatives to incarceration, contingency planning and risk assessment, training and education, risk communication, COVID-19 prevention and case management. The WHO Regional Office for Europe appreciates and thanks practitioners from around the world who shared with us their country's or institution's good practices and worked on further enhancing those practices according to specific WHO criteria. We also value the work of international key experts who evaluated the practices and provided feedback and comments.

This report of good practices provides important evidence on the practicality and applicability of WHO guidance on preparedness, prevention and control of COVID-19 in prisons and other places of detention. It demonstrates that creating partnerships and applying innovative approaches deliver positive results in combating not just COVID-19 but also similar communicable diseases. The practices also shed light on the urgency and relevance of addressing health gaps and challenges within prisons and other places of detention and highlight the importance of dealing with prison health as an integral part of public health.

The WHO Regional Office for Europe will continue to support Member States by providing evidence-based approaches and promoting intersectoral collaboration and whole-of-society and whole-of-government engagement to ensure that no one is left behind.

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Abbreviations

CBH	[Red Cross] Community Based Health [in Prisons Programme] (Ireland)
CPD	continual professional development
CSC	Correctional Service of Canada
EOC	Emergency Operations Committee (Canada)
EOH	environmental and occupational health
FFP2	filtering facepiece 2 [masks]
HMP	Her Majesty's Prison (United Kingdom)
HMPPS	Her Majesty's Prison and Probation Service (United Kingdom)
IPC	infection prevention and control
IPS	Irish Prison Service
LPHA	local public health authority
MSF	Médecins Sans Frontières
NGO	nongovernmental organization
NHS	National Health Service (United Kingdom)
NIPS	Northern Ireland Prison Service
NPM	National Preventive Mechanism (Kazakhstan)
NSW	New South Wales (Australia)
OHCHR	Office of the United Nations High Commissioner for Human Rights
OPCAT	Optional Protocol to the Convention against Torture
PCR	polymerase chain reaction
PHAC	Public Health Agency of Canada
PHE	Public Health England
PMC	public monitoring commission
PPE	personal protective equipment
PRI	Penal Reform International
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
SDG	Sustainable Development Goal
SEHSCT	South Eastern Health and Social Care Trust (Northern Ireland)
TFCM	Task Force under the Cabinet of Ministers (Azerbaijan)
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
VoIP	voice over internet protocol

Executive summary

Since its identification on the last day of 2019, COVID-19 has affected the lives of almost all people. The newly detected virus SARS-CoV-2 caused countries to apply restrictive measures, including introducing physical distancing and imposing national lockdowns, to limit the spread of the virus and ensure that health services were not overwhelmed with COVID-19-related demands. The pandemic widened socioeconomic divides and shifted policy priorities globally. The physical and mental health consequences and the social and economic effects of the COVID-19 pandemic, together with the measures taken to combat it, have affected vulnerable and marginalized communities the most, including people living in prisons and other places of detention. The environmental and contextual conditions of prisons and other places of detention, including overcrowding, limited preventive capabilities, reduced access to water and delays in diagnosis, expose people living in these settings to a higher risk of COVID-19 infection and transmission. In addition, health services inside prisons might not be able to accommodate management of patients with highly infectious diseases, especially when cooperative arrangements with external providers are suboptimal.

To support Member States, the WHO Regional Office for Europe developed interim guidance on preparedness, prevention and control of COVID-19 in prisons and other places of detention in March 2020 (WHO, 2020e). The guidance was used by health-in-prisons practitioners worldwide to manage COVID-19 in prisons and other places of detention.

In light of the guidance, and to capture and document good practices in Europe and globally, the WHO Regional Office for Europe launched a special call on 15 May 2020 for good practices in preparing, preventing and controlling COVID-19 in prisons. The aim of this report is to capture evidence-based practical interventions that achieved tangible results while respecting the rights of people living in prisons. Examples of good practice were collected over four months, from May to September 2020, and were compiled and evaluated against predefined selection criteria that were set out in the call for submissions (see Annex 1). A technical committee was formed to review the practices submitted by countries and regions and to select those to be included in the report based on the selection criteria. The committee was formed of 23 technical experts in the areas of prison health, human rights, public health, infectious diseases and drug dependence. Practices were divided up so that each was independently assessed by three committee members using a scoring system developed by the Health in Prisons Programme.

The report follows the structure of the interim guidance, categorizing the good practices submitted by countries and regions in six main domains. These domains, together with the main recommendations they contain, are as follows.

(1) Human rights and alternatives to incarceration

- Noncustodial measures should be applied at all stages of the administration of criminal justice.
- Early-release measures should be used to decrease prison populations, focusing on low-risk offenders and prioritizing the most vulnerable.
- The COVID-19 pandemic should not be used to justify cessation of external inspection of prisons and other places of detention.
- Whenever restrictive measures are applied, it is recommended that mitigation measures are used to ensure mental well-being.





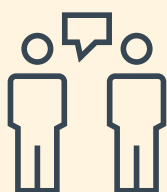
(2) Preparedness, contingency planning and level of risk

- Risk assessments should be conducted and action/preparedness plans implemented that are integrated into national plans.
- Such plans should anticipate contingencies, which should include surveillance, detection procedures, case management, staffing and resources available.
- Such plans need to be communicated to ensure that they are known to all.



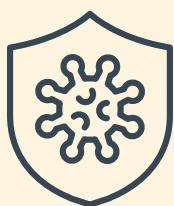
(3) Training and education

- Training on basic COVID-19 disease knowledge, including pathogen, transmission route, signs and clinical disease progression, should be made available to all prison staff.
- Training to all staff and people living in prisons should also cover hand hygiene practice, respiratory etiquette and appropriate use of personal protective equipment (PPE).
- Prison staff (including cleaning personnel) should receive training on environmental prevention measures, including cleaning and disinfection.



(4) Risk communication

- Resources that take account of possible language and cultural barriers should be developed so that key messages are communicated in a clear, accurate and relevant manner to people living in prisons, staff and visitors.
- Such resources should cover preventive measures (especially hand hygiene practices and respiratory etiquette), and disease signs and symptoms, including warning signs of severe disease requiring immediate medical attention.



(5) Preventive measures

- Risk assessments should be conducted at every entrance to the prison or detention setting.
- Routines and facilities that allow hand hygiene and physical distancing should be implemented.
- Availability of masks should be ensured.
- Space should be created for quarantine of new entrants and contacts.
- Transfers between prisons should be kept to a minimum.
- Visits should be halted; alternative means of communication, both with friends and family and with external health-care providers (telehealth), should be provided.
- Creating separate wings for the most vulnerable should be considered.
- Quarantined individuals should be medically observed at least twice a day.
- Protocols should be created to manage staff who meet the definition of a suspected or confirmed case, allowing them to stay at home and seek medical attention.



(6) Case management

- A prison surveillance system integrated into the local/national epidemiological surveillance system should be developed; the system should be adhered to at all times.
- Space should be created for isolation of cases and procedures developed to ensure medical observation.
- Suspected or confirmed cases should be able to use separate facilities (including toilets); otherwise, appropriate and frequent disinfection should be performed.
- Protocols for transfer of severe cases to specialized care when needed should be developed.
- Intersectoral mechanisms should be established so that isolation is not broken upon release.

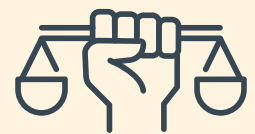
It should be noted that this report reflects the recommendations issued in March 2020, which were updated in February 2021 to reflect changes in knowledge and practices (WHO, 2021b). The changes include updated information on case definitions, COVID-19 signs and symptoms, transmission scenarios, prevention and control measures (including use of masks, testing and quarantining), and management strategies (including implementation of medical isolation and modified strategies for the prison context). Additional issues covered include vaccine availability and allocation procedures and indicators advised for surveillance purposes in detention settings. Furthermore, as new variants keep emerging and more data from real-world studies are published daily, constant changes in recommendations applicable to the general population would be impossible to reflect in a report that requires a time-consuming process to ensure robust methodology. Therefore, this report should be seen as a snapshot of the reality observed in 2020 and any extrapolations to the situation in 2021 and beyond should be made with that consideration in mind.

Human rights and alternatives to incarceration

While COVID-19 has posed an imminent risk to the health of people living in prisons and prison staff, a human rights framework approach in managing the pandemic behind bars must nevertheless be upheld. Public health measures should be implemented without any discrimination, especially considering that environmental factors and the behaviour of the virus make people living in prisons more vulnerable to contracting the SARS-CoV-2 virus. Measures taken to combat the pandemic should be gender-responsive and accommodate the needs of people of ethnic and religious minorities inside prisons. Prison authorities should work towards providing tailored information and communication to people in prisons on the pandemic, its symptoms, modes of transmission and how to prevent spread. In addition, enhanced attention should be given to applying noncustodial measures at all stages of the administration of criminal justice, particularly for low-risk offenders,* pregnant women and women with dependent children.

As prisons and other places of detention are closed environments, once introduced into prisons – especially overcrowded prisons – COVID-19 can be amplified and cause an outbreak if not managed properly. Accordingly, the WHO guidance suggests that Member States should consider applying early-release measures to decrease prison populations, allowing more space to apply physical distancing measures. When restrictions are applied in the general community and in prisons, authorities should work towards maintaining communication between people in prisons and their families through any mean of communication, preferably audiovisual. Authorities should also take into consideration that restrictive measures applied in prisons amid COVID-19 might have psychological and behavioural consequences for people in prisons and apply mitigation measures to ensure their mental well-being. The COVID-19 pandemic should not be used to justify cessation of external inspection of prisons and other places of detention by national, regional or international third-party mandated entities.

Several countries and regions shared their good practices in applying WHO's guidance on a human rights approach to managing COVID-19 in prisons. In **Kazakhstan** restrictive measures were applied in prisons, including halting all physical visits, but independent and state monitoring bodies were granted access to monitor the situation inside prisons. A call centre was set up for people in prisons to maintain contact with their families and access legal aid. The call centre was also used by representatives of the National Preventive Mechanism and public monitoring commissions (PMCs) to provide legal, health and psychological support



* Low-risk offenders are identified at national level and mostly include nonviolent offenders and nonsexual offenders.

for people in prisons.* The authorities ruled out large-scale temporary release measures as they were not able to ensure protection of people released into the community, but 407 individuals who had served more than two thirds of their sentences and those eligible for parole or reduced sentences were released. To mitigate the effect on people in prisons of halting vocational training programmes, the authorities encouraged people in prisons to make protective masks and equipment. While positively affecting their psychological well-being, sewing masks also provided people in prisons with an employable new skill.

In **France**, a country that had a long history of overcrowded prisons, the authorities succeeded in decreasing the prison population by 18.6% (13 500 individuals) in the period between March and May 2020 during the COVID-19 pandemic. This was achieved through activation of the Public Health Emergency Law by the French parliament. The released population included people who had less than 2–6 months remaining of their sentence and had not been charged with acts of terrorism, domestic violence or violent crime. France also applied restrictive measures that included complete stoppage of physical visits, but each person living in prison was granted €40 credit per month to conduct family calls, and a dedicated voicemail system for families was made available.

In **Finland** the prison population decreased by almost 16% (404 individuals) in the period between March and June 2020; this figure was made up of 301 sentenced people, 59 in remand prisons and 44 fined individuals. The decrease was a direct result of a Ministry of Justice decree that postponed new imprisonment for up to six months between March and June 2020.

In the **United Kingdom (Northern Ireland)** several interventions involving engaging activities were applied to mitigate the impact of COVID-19 pandemic-related restrictions on the mental well-being of people in prisons. The interventions included weekly competitions, such as creating self-portraits, creative writing and fantasy football, issuing a regular newsletter, conducting relaxation and mindfulness groups, and producing a distraction pack that contained puzzles, health information and in-cell exercise routines. A qualitative survey among people in prisons who were quarantined on entry to prison concluded that keeping in contact with their families was what mattered most to them. Accordingly, the authorities developed a virtual visiting scheme in April 2020 that was fully integrated into prison operations. In addition, clear communication about life in prisons in general and amid COVID-19 restrictions was shared with new entrants to make sure that they were fully aware of when and where to seek help if needed.



Preparedness, contingency planning and level of risk

To manage COVID-19 in prisons, a comprehensive contingency plan has to be in place and collaborative arrangements should be established across sectors responsible for health in prisons. Moreover, a comprehensive risk assessment must be conducted and reviewed regularly to ensure that it is tailored to the epidemiological situation at national and local levels. A multisectoral action plan based on the risk assessment should be developed. The action plan should be integrated within the national emergency plan and should ensure flow of information, surveillance and detection procedures, and case management. The plan should also address staffing and availability of consumables such as PPE and disinfectants.

* Established in 2005 with a remit to visit all prisons and pretrial detention centres in their region, PMCs interview people living in prisons, note their complaints, and formulate observations and recommendations for prison authorities. There are currently 14 regional PMCs composed largely of civil society representatives, human rights activists, journalists, lawyers and academics who work on a voluntary basis.

In this context, several countries and regions shared their good practices. In **Canada** the Correctional Service of Canada (CSC) modified staff rostering when contact-tracing revealed that a high number of staff were in contact with identified cases. Accordingly, the CSC applied a cohorting approach to all staff. Health-care staff were divided into a two-team roster with no overlap between cohorts to limit infection spread to one cohort only. Alongside cohorting, staff were also assigned to a specific building or zone so that when a COVID-19 case was identified, spread of infection was limited to that zone or building. In an attempt to limit COVID-19 introduction to federal prisons, the CSC developed a weekly surveillance report that monitored the epidemiological situation in the local community where each institution was located. The report flagged institutions located in areas where there might be a higher risk of an outbreak.

In the **United Kingdom (England)** a multisectoral approach to managing COVID-19 in prisons was implemented; this involved the Ministry of Justice, Her Majesty's Prison and Probation Service (HMPPS), the Department of Health and Social Care, the National Health Service (NHS) England/NHS Improvement and Public Health England (PHE). Three main interventions were applied to mitigate the risk of introducing COVID-19 into prisons: physical distancing, protecting the most vulnerable populations inside prisons, and compartmentalization of prisons (isolating sick people, shielding the vulnerable and quarantining new arrivals). To ensure physical distancing, visits, training, employment and workshops were stopped completely. People living in prisons with underlying health conditions or those aged 50 years or older were identified as vulnerable groups and placed in protective isolation. HMPPS also compartmentalized each prison by limiting transfers and facilitated single-cell accommodation for each person when possible. To facilitate compartmentalization, HMPPS increased prison capacity by installing temporary single-occupancy cells, decreased the prison population by applying early-release measures, and temporarily released pregnant women and women with children living in prisons.

In **Australia (New South Wales (NSW))** a contingency plan was developed in response to the COVID-19 pandemic by the Justice Health and Forensic Mental Health Network, a body responsible for delivering health care to adults and young people in contact with the forensic mental health and criminal justice systems across community, inpatient and custodial settings in NSW. The plan was in full alignment and collaboration with the NSW Ministry of Health and Corrective Services NSW. As part of the plan, the Network started implementing telehealth services so that staff could provide remote clinical support while working from their offices and at home. Primary care physicians were able to schedule virtual consultations with patients based on requests received from people in prisons and to refer them, if needed, to specialized physicians. For emergency patients, on-duty nurses provided consultations and, when needed, immediate phone advice was sought from the on-call general practitioner.

In **Italy** the Ministry of Justice, in full coordination with the regional health authorities, implemented several mitigation measures to prevent or limit COVID-19 spread into prisons, including a risk-assessment questionnaire and check-up protocol that were implemented outside prison buildings in temporary structures dedicated to the purpose. Wings, cells and hubs were designated for preventive quarantine and contacts and for isolation of suspected and confirmed cases.

The **Republic of Moldova** implemented several emergency measures amid COVID-19 to prevent the introduction of the pandemic into prisons, including halting of visits, activities, transfers and court proceedings. To combat the psychological drawbacks of halting visits and activities, the National Administration of Penitentiaries doubled the weekly frequency of

telephone calls for people in prisons and made videoconferencing communication available. The videoconferencing system was also used in judicial communication, replacing physical presence in courts in compliance with physical distancing measures. A risk assessment was conducted for all people entering prison by screening for COVID-19 signs and symptoms. People living in prisons were encouraged to wear masks when they left their cells and staff had to wear masks when dealing directly with people in prisons. In addition, each prison developed its own tailored contingency plan in line with the national public health plan.

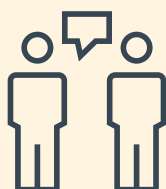


Training and education

Staff training is a central pillar in the context of combating COVID-19 in prisons. WHO's guidance recommends that health-care custodial staff should have essential knowledge of SARS-CoV-2 modes of transmission and symptoms and signs and be trained in hand hygiene, respiratory etiquette, appropriate use of PPE, and environmental prevention measures, including cleaning and disinfection (WHO, 2020e). The guidance also highlights that it is essential that people living in prisons are involved in awareness-raising activities so that they are well informed and can comprehend the restrictions imposed in prisons to combat the COVID-19 pandemic.

In **Ireland** the Irish Prison Service developed a comprehensive training and education package on continual professional development (CPD) for all staff to take every two years. During the COVID-19 pandemic a new chapter was added to the package to ensure that staff accessed basic information on COVID-19. In addition, people living in prisons were educated by their peers on COVID-19-related topics such as handwashing, respiratory etiquette, modes of transmission and how to disinfect their belongings when needed. The peer education programme was a collaborative approach undertaken with the Irish Red Cross that started before the pandemic to improve public health and hygiene in prisons.

In **Spain** the General Secretariat of Penitentiary Institutions developed a multidisciplinary programme aimed at raising self-awareness about the risks of reusing drugs among people living in prisons. The main objectives of the programme included raising awareness among people living in prisons and their families about loss of tolerance to drug use, providing technical support to health-care staff, and enabling a collaborative approach among health and security professionals and professionals from nongovernmental organizations (NGOs) working in prisons. The programme included an awareness-raising campaign targeting people in prisons on the risks associated with loss of drug tolerance and potential overdosing. The campaign also acknowledged the cooperative attitude of people in prisons towards the restrictive measures applied to limit the spread of COVID-19 in prisons. In addition, workshops were conducted to acquaint people living in prisons with available treatment resources and relapse-prevention interventions and to motivate them to use them.



Risk communication

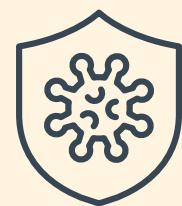
WHO's guidance recommends that countries should tailor key messages on the COVID-19 pandemic and its risks, communicating them in a way that ensures clear understanding among people living in prisons, their families, visitors and prison staff (WHO, 2020e). Messages should include information and advice on preventive measures, hygiene practices, symptoms of infection and measures to be taken if infection is suspected, access to local health care, use of protective face masks and common misinformation about COVID-19. The guidance also suggests that communication tools should take into consideration language barriers and the intellectual disabilities of target groups. Tools could include any relevant means of communication, such as information sheets, flyers, posters, internal videos and radio announcements.

In **Ghana**, recognizing the importance of risk communication, the Ghana Prisons Service formed a rapid response team for COVID-19 with a subcommittee on risk communication at its headquarters and risk-communication teams in all 46 units connected to the prison service. The teams met leaders of people living in prisons to discuss their concerns and gain insight into their understanding of the pandemic and accompanying restrictions. Subsequently, teams were mandated to train these leaders to further cascade information to other people in prisons. Cascading was a pivotal intervention in raising awareness and risk communication across prisons. The information communicated included basic infection prevention and control (IPC) measures taken in prisons, surveillance and risk-assessment measures applied in prisons, and psychosocial support and stigma reduction.

In **Switzerland** Champ-Dollon Prison developed an innovative method to communicate risk to people living in prisons which involved conducting several informal seminars across the corridors of each prison floor, targeting people living on the floors and staff. The seminars were conducted by a physician and a nurse and attended by 10–15 participants. People living in prisons were encouraged to ask questions and share how they felt about the restrictive measures applied during the pandemic. In addition, the prison administration displayed posters in French and English addressing basic protective measures. A video was broadcast on the internal prison television channel showing the prison director and a medical doctor informing people in prisons about the COVID-19 situation immediately after the first case had been reported. Individuals aged 60 and older and/or living with chronic diseases were identified and placed in single cells, transferred to other less crowded prisons or released.

Preventive measures

WHO's guidance emphasizes that the authorities responsible for prison management should ensure that all staff and people living in prisons and other places of detention have comprehensive awareness of COVID-19 prevention strategies, including adherence to hand-hygiene measures, respiratory etiquette, physical distancing, and signs and symptoms of COVID-19 (WHO, 2020e). The guidance also suggests that the authorities should make the required resources available to implement a comprehensive prevention strategy, including use of masks and access to vaccines when they become available.*



In **Canada**, recognizing the importance of applying prevention strategies, the CSC collaborated with the Public Health Agency of Canada (PHAC), local public health departments and civil society to conduct IPC assessments. In addition, the CSC developed, in collaboration with the PHAC, a two-part tool to conduct IPC self-assessments in prisons. Recognizing the importance of agile contact-tracing, the CSC introduced a non-test-based approach, beginning 48 hours prior to onset of symptoms, by which symptomatic staff members and any of their contacts were prevented from entering prisons. The team of trained contact-tracers increased from five to 230 staff members between March and May 2020 to make sure that the contacts of every confirmed case were identified and managed.

In **Italy**, following the diagnosis of the first COVID-19 case in San Vittore Prison in the Lombardy region (the region worst affected by the COVID-19 pandemic), a contact-tracing exercise was conducted to identify people who were in contact with the case. Through this exercise, the role of so-called bridge populations – groups of individuals employed by the prison management who move between different prison buildings and areas – in potentially spreading COVID-19 among people in prisons became apparent.

* During the submission period for good practices to be included in this report (May–September 2020), vaccines were not yet available, so vaccine rollout plans for staff and people living in prisons are not among the practices selected.

In **Slovakia** the Corps of Prison and Court Guards applied several interventions to limit the spread of COVID-19 in prisons, including halting all external work for people living in prisons (work undertaken in external employers' factories or companies) and stopping all visits to people living in prisons. In compensation, it provided them with a free-of-charge one-time 20-minute phone call and access to videoconference communication with their families once per month for 20 minutes per person. The Corps also made it compulsory for people living in prisons to use face masks upon leaving their cells and for prison staff during their shifts.

In **Portugal** the Directorate-General of Reintegration and Prison Services took several preventive measures, including suspending transfers of people living in prisons and allocating a limited number of prisons for new entrants based on the availability of single cells for isolation purposes. The Directorate-General also made wall-mounted alcohol-based gel hand rub available to all visitors and staff, and PPE for all technical staff, including prison guards and health-care professionals. National and regional coordination mechanisms were set in place to liaise with Ministry of Health institutions, including the Directorate-General of Health, the National Institute of Medical Emergency and the National Health Institute Dr Ricardo Jorge. This allowed for efficient monitoring of the epidemiological situation and a speedy decision-making process.



Case management

WHO's guidance recommends that case management should be aligned with updated national guidance for primary care and community settings (WHO, 2020e). It also directs practitioners to use WHO's latest guidance for clinicians involved in the clinical management and care of adult, pregnant and paediatric patients who have or are at risk of severe acute respiratory infection when infection with SARS-CoV-2 is suspected (WHO, 2021a). If single cells are not available, confirmed or suspected COVID-19 cases should be cohorted – placed in the same cell, separated from others – but beds should be at least 1 metre apart. In addition, groups with the same medical reasons for segregation (such as individuals who are older or living with obesity) should be grouped in separate areas. The recommendation is also for dedicated health-care and prison staff to deal exclusively with suspected or confirmed cases.

In **Azerbaijan** COVID-19 cases were managed in accordance with the national COVID-19 management protocol and local guidelines, which were based on international protocols and WHO recommendations. Confirmed COVID-19 cases were admitted to intensive care units for 1–2 weeks and moved to regular wards in the hospital after two consecutive negative COVID-19 polymerase chain reaction (PCR) tests. They stayed there for another two weeks and then returned to their respective prisons. A special medical commission that included civil society representation was formed to ensure access to treatments, including antiviral and antibacterial therapy, immunity stimulants and vitamins.

In **Canada** the CSC established an emergency operations committee (EOC) in coordination with local public health authorities to facilitate communications and leverage public health expertise to support outbreak management inside prisons. Initially, the EOC met virtually on a daily basis to discuss updates on confirmed cases, hospitalizations and those requiring intensive care.

1. Introduction



1.1 Prison population and health in prisons

In 2018 it was estimated that the world prison population was over 11 million, not taking into consideration pretrial detention at police facilities and those incarcerated but not recognized internationally (PRI, 2020b). In the same year, Europe had a total of 1 540 484 people living in prisons, representing a European prison population rate of 106 per 100 000 inhabitants (Aebi & Tiago, 2020). The global prison population has increased by 24% over the last 20 years, with variations across regions and countries. In addition, the female prison population has doubled in the same period (PRI, 2020b).

In contrast to the global trend in prison population, the prison population in Europe has decreased by 21% over the last 20 years (Walmsley, 2018), but a survey conducted by the WHO Regional Office for Europe showed that 23% of countries in the WHO European Region (respondents represented 39 countries) reported prison overcrowding (WHO, 2019). Globally, around 102 countries have a prison occupancy of more than 110% (PRI, 2020b). This increase in prison population and the consequent overcrowding demonstrates, among other things, failure to use alternatives to prison in dealing with nonviolent and petty offences and overuse of pretrial detention, as 46 countries reported that the number of people convicted was lower than those found not guilty (PRI, 2020b).

Strict drug policies remain a major driver of the increased prison population worldwide, with over 2 million people living in prisons serving time for drug-related offences. Among these, 25% are incarcerated for drug possession for personal use (PRI, 2020b).

1.2 Health in prisons in Europe



There are several challenges facing people living in prisons, prison health professionals and prison management in maintaining health and well-being in European prisons. In an effort to identify these challenges, the WHO Regional Office for Europe developed the Health in Prisons European Database, operationalized through a survey that was used to collect data on the health status of people in prison and on the performance of health systems to serve this population between 2014 and 2016. The main results of this assessment were published in 2019 in the *Status report on prison health in the WHO European Region* (WHO, 2019). As well as the overcrowding already mentioned, Member States reported that resources for prevention of infectious diseases were not universally available across European prison health systems, and a number of countries reported that such resources were entirely unavailable (WHO, 2019).



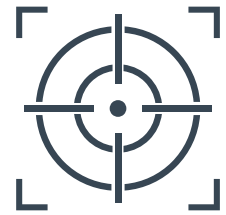
1.3 COVID-19 in prisons

On 31 December 2019 a pneumonia of unknown cause was identified in the city of Wuhan, China, and reported to the WHO China Country Office. In January 2020 the microorganism responsible for the pneumonia was isolated and classified as severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). At the end of January 2020 the outbreak was declared a Public Health Emergency of International Concern, and on 11 February 2020 WHO named the disease developed by this new coronavirus "COVID-19". In March 2020 WHO characterized COVID-19 as a global pandemic (WHO, 2020f).

People living in prisons may be more susceptible and vulnerable in the context of COVID-19 for several reasons. In prisons there is an overrepresentation of the most marginalized communities and of vulnerable populations, including those with poor living conditions and low health status in general. There is also an overrepresentation of people living with multiple chronic conditions that make them more susceptible to more severe forms of COVID-19 infection (Kinner et al., 2020). A high proportion of people living in prisons use drugs and have a higher susceptibility to acquiring infections and face greater risks of complications due to behaviours associated with drug use and procurement (EMCDDA, 2020).

Among people living in prisons there is also an excess prevalence of individuals who have HIV/AIDS, commonly occurring with TB coinfection, and therefore have compromised immunity (Avert, 2021). COVID-19 infections may be introduced into prisons by anyone entering, including visitors and staff, and may be transmitted among people living in prisons, prison staff and visitors. The transfer of people between prisons and staff rotation and cross-deployment between prisons may facilitate infection introduction into prisons (Kinner et al., 2020). In addition, as mentioned above, 23% of countries reported overcrowding in a recent WHO survey (WHO, 2019), which suggests that measures such as physical distancing are difficult or even, in some cases, impossible to implement, further contributing to the spread of infectious diseases.

2. Scope and objectives



2.1 Background

As part of the global response, the WHO Regional Office for Europe developed with partners a package of new materials to support Member States in Europe and across the world in dealing with preparedness, prevention and control of COVID-19 in prisons and other places of detention. The materials are targeted at different audiences, including policy-makers, health-in-prisons practitioners, prison management, people living in prisons, visitors and the public. The package consists of the following documents:

- (1) interim guidance on preparedness, prevention and control of COVID-19 in prisons and other places of detention, issued 15 March 2020 (WHO, 2020e);¹
- (2) a selection of frequently asked questions on prevention and control of COVID-19 in prisons and other places of detention that addresses concerns held by the public and by health-in-prisons practitioners (WHO, 2020a);
- (3) a fact sheet containing COVID-19-related information directed at people living in prisons (WHO, 2020b);
- (4) a fact sheet containing COVID-19-related information directed at visitors to prison (WHO, 2020c); and
- (5) an evaluation checklist, issued 9 April 2020, for use by policy-makers and service providers to assess their level of COVID-19 preparedness and alignment of their response measures with the recommendations included in document (1) (WHO, 2020d).

The interim guidance established a technical roadmap for health-in-prisons practitioners in the context of COVID-19 in prisons and addressed six technical domains:

- human rights and alternatives to incarceration
- preparedness, contingency planning and level of risk
- training and education
- risk communication
- prevention measures
- case management.

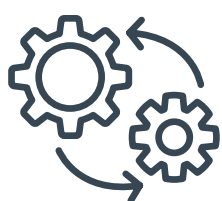
The good practices in managing COVID-19 in prisons and other places of detention described in this report were developed and initiated by countries and regions in light of the interim guidance issued on 15 March 2020. The period for submission of good practices was May–September 2020. The report represents a continuation of the Health in Prisons Programme's efforts to capture and share countries' and regions' experiences in dealing with COVID-19 in prisons.

¹ An updated version of the guidance was issued on 8 February 2021, reflecting more recent understanding of COVID-19 and its prevention and control in prisons and other places of detention (WHO, 2021b). Published after the submission window of this report, it is of course not considered in the good practices described here.

TABLE 1. SELECTION CRITERIA FOR INCLUSION
OF GOOD PRACTICES IN REPORT

Criterion	Description
Relevance ^a	Must address the Sustainable Development Goals (SDGs) identified as core to the Health in Prisons Programme Action Plan (SDG 3 and SDG 10).
Sustainability ^a	Can be implemented and sustained over a long period (including policy decisions) without any massive injection of additional resources.
Efficiency ^a	Must produce results with a reasonable level of resources and time.
Ethical appropriateness	Must respect the rules of ethics for dealing with human population, in particular the Mandela Rules ^b .
Equity/gender	Addresses the needs of vulnerable populations and/or gender in an equitable manner, with a focus on the Bangkok Rules ^c .
Effectiveness	Must work and achieve results that have been measured.
Partnership	Involves satisfactory collaboration between several stakeholders.
Community involvement	Involves participation from the affected communities.
Political commitment	Has support from the relevant national or local authorities.

^a Required. / ^b The Mandela Rules give guidance on all aspects of prison management, from admission and classification to the prohibition of torture and limits on solitary confinement. / ^c The Bangkok Rules, adopted by the United Nations General Assembly on 22 December 2010, are focused on the treatment of female offenders and prisoners.



2.2 Methodology

On 14 May 2020 a call for submission of health-related good practices in COVID-19 preparedness and response was sent to health-in-prisons programme steering and technical group members and to focal points and technical experts across Member States of the WHO European Region (Annex 1). The call proposed technical areas to be addressed by submitters, following the structure of the interim guidance (WHO, 2020e), and specified various selection criteria (**Table 1**). These criteria, tailored to address COVID-19 in prisons and other places of detention, were adopted from *Good practices in the prevention and care of tuberculosis and drug-resistant tuberculosis in correctional facilities*, published by the Joint Tuberculosis, HIV/AIDS and Hepatitis Programme of the WHO Regional Office for Europe in 2018 (WHO, 2018).

The collection of good practices included in this report showcases experiences from countries and regions with different prison systems and epidemiological findings regarding the COVID-19 pandemic.

TABLE 2. DETAILS OF ACCEPTED
COUNTRY SUBMISSIONS

Country	WHO region	Number of practices submitted
Azerbaijan	European	1
Finland	European	1
France	European	1
Ireland	European	1
Italy	European	2
Kazakhstan	European	1
Portugal	European	1
Republic of Moldova	European	1
Slovakia	European	1
Spain	European	1
Switzerland	European	1
United Kingdom (England)	European	1
United Kingdom (Northern Ireland)	European	1
Canada	Americas	6
Ghana	African	1
Australia	Western Pacific	1

The good practices included are the joint work of WHO and the authors listed for each practice. The report is not intended to be exhaustive and does not attempt to include all the good practices and excellent work that countries have implemented in prisons across the globe. Rather, it aims to provide a snapshot to illustrate different approaches that were adopted and adapted to local contexts in the period between the call for submission on 14 May 2020 and the deadline for submission on 1 September 2020. Subsequently, the Health in Prisons Programme continued to work with submitters until October to enhance the quality and clarity of the practices shared.

Over this period WHO received 23 submissions representing 16 countries, 13 of them European (two submissions were received from different parts of the United Kingdom – England and Northern Ireland). Countries whose submissions were accepted are shown in **Table 2**.

To move forward with including the good practices shared, a technical committee was formed to review the submitted practices and select those to be included in the report based on the pre-established selection criteria. The committee was formed of 23 technical experts in the areas of prison health, human rights, public health, infectious diseases and drug dependence. The practices were divided so that each was independently assessed by three committee members using the scoring system set out in **Table 3**. An average of the three scores (from each of the three committee members) for each submission was calculated by the Health in Prisons Programme. In addition, technical committee members provided feedback and comments on the practices they assessed, which were then shared with submitters to further enhance the practices against the selection criteria. Good practices submitted were included in the report if they achieved an average score of 40 or above (out of a possible 70).



2.3 Target audience

The intention of this report is to enable health-care staff, prison management and policy-makers working in prisons and other places of detention to share successful ideas, policy changes, interventions and/or sustainability strategies in the context of COVID-19. The broader aim is to facilitate learning from others' experiences, to create a dialogue among practitioners and to enhance preparedness and response to COVID-19 and other infectious diseases in prisons.

TABLE 3. GOOD PRACTICE SCORING SHEET

Practice title	[title]		
Country/region	[country/region]		
Submitted by	[author(s)]		
Criterion	Description	Submission score	Comments
Relevance ^a	Must address the Sustainable Development Goals (SDGs) identified as core to the Health in Prisons Programme Action Plan (SDG 3 and SDG 10).	.../15	
Sustainability ^a	Can be implemented and sustained over a long period (including policy decisions) without any massive injection of additional resources.	.../5	
Efficiency ^a	Must produce results with a reasonable level of resources and time.	.../15	
Ethical appropriateness	Must respect the rules of ethics for dealing with human population, in particular the Mandela Rules ^b/5	
Equity/gender	Addresses the needs of vulnerable populations and/or gender in an equitable manner, with a focus on the Bangkok Rules ^c/5	
Effectiveness	Must work and achieve results that have been measured.	.../10	
Partnership	Involves satisfactory collaboration between several stakeholders.	.../5	
Community involvement	Involves participation from the affected communities.	.../5	
Political commitment	Has support from the relevant national or local authorities.	.../5	
	Total	.../70	

Decision

1. To be included as submitted
2. To be included with modifications
3. Not to be included

[Decision here]

General comments/modifications required

^a Required.^b The Mandela Rules give guidance on all aspects of prison management, from admission and classification to the prohibition of torture and limits on solitary confinement.^c The Bangkok Rules, adopted by the United Nations General Assembly on 22 December 2010, are focused on the treatment of female offenders and prisoners.



GOOD PRACTICES



3. Human rights and alternatives to incarceration





3.1 Kazakhstan: prevention measures of the penitentiary system in response to COVID-19

Submitted by: Zhanna Nazarova and Olivia Rope, Penal Reform International

3.1.1 Background and context

Kazakhstan's penitentiary system operates under the Ministry of Internal Affairs and has 17 departments, 82 institutions (66 penal colonies and 16 pretrial detention centres), two republican state enterprises (Enbek and Enbek-Oskemen), and 246 probation service departments. As of January 2020, the total prison population was 28 923 individuals, representing 62% of the operational capacity of all facilities; this figure included around 10% women (approximately 3000), 34 elderly persons (aged 63 years and over), and 47 juveniles (aged 18 years and under) – 46 boys and one girl.

Health care in Kazakhstan's prisons remains the responsibility of the penitentiary system and continues to be underfunded (Ministry of Internal Affairs of Kazakhstan, 2020). Although the country's penitentiary institutions are operating below their operational capacity, thereby lowering the risks of an uncontrollable COVID-19 outbreak, there is a need for better health-care provision, which should be made fully independent of the prison administration.

On 16 March 2020, the President of Kazakhstan announced a state of emergency in response to COVID-19, which triggered discussions within the prison and probation services regarding

what emergency preventive measures needed to be taken. On that same day, Penal Reform International (PRI) published a briefing note entitled *Coronavirus: healthcare and human rights of people in prison*, which proved instrumental in helping to design effective measures to respond to COVID-19 and to protect the rights of people in detention in Kazakhstan (PRI, 2020a).



3.1.2 Description of the good practice

PRI provided the Ministry of Internal Affairs, the penitentiary system, the General Prosecutor's Office and the Ombudsman's Office with technical support and advice, which resulted in the development of an internal order and algorithms for the release of persons who had served more than two thirds of their sentences and those who were eligible for parole or reduced sentences. Following the state of emergency order, over 3200 places of detention in the country that fell under the mandate of the National Preventive Mechanism (NPM) – social, sociomedical and penitentiary system institutions, including pretrial detention facilities – were put under quarantine.² Visits were banned, except for independent and state monitoring bodies which retained access under the condition that institutions could provide them with personal protective equipment (PPE), including masks and gloves. Following PRI's recommendation, a call centre was created where relatives, lawyers, and representatives of the NPM and public monitoring commissions (PMCs) could contact people in prisons,³ allowing them to maintain social contact and to benefit from additional consultations on legal and health-related matters and from follow-up discussions after monitoring visits. NPM and PMC members used online meeting tools to provide people in prisons with health-related consultations and access to legal aid and to psychological and medical assistance in emergency situations. Similarly, the visits by relatives and other contacts that had been halted were mitigated by enabling video calls to families and friends – a practice that is set to continue after the quarantine measures end. Over a period of five months (from 15 March to 20 July 2020), 338 994 telephone conversations were facilitated by the penitentiary system, 33 000 of which were from/to women living in prisons; 13 188 video calls (each lasting up to 15 minutes), 1319 of which were from/to women living in prisons; and 3276 video calls (each lasting up to two hours), 328 of which were from/to women living in prisons.

Following recommendations from PRI, the United Nations Subcommittee on the Prevention of Torture, the Ombudsman's Office and other civil society organizations that reduction in detention populations should be accelerated, 407 people living in prisons were released and escorted to their permanent or temporary residence or to a resocialization centre and were provided with masks, gloves and antiseptic spray.⁴ However, in view of the large operational capacity of places of detention and the difficulties in offering protection and monitoring in society after release, the Ministry of Internal Affairs ruled out large-scale temporary release measures.

PRISON POPULATION

January 2020

28 923

TOTAL

approx. 3000

BORN FEMALES

34

ELDERLY PERSONS

47

JUVENILES

(46 BOYS AND ONE GIRL)



CALL CENTRE

15 March–20 July 2020

338 994

TELEPHONE CONVERSATIONS

² An NPM is required to be established when a United Nations Member State ratifies the Optional Protocol to the Convention against Torture (OPCAT); it serves as the national component of the preventive system established by OPCAT. NPMs are mandated to conduct regular monitoring visits to all types of places where persons are deprived of liberty to prevent torture and ill treatment. Currently, the regional groups of NPMs include 114 members from representatives of local NGOs and public associations, Public Monitoring Commission (PMC) members, lawyers, social workers, independent forensic experts and doctors.

³ The PMCs were established in 2005 with a remit to visit all prisons and pretrial detention centres in their region, to interview people living in prisons, to note their complaints and to formulate observations and recommendations for the prison authorities. There are currently 14 regional PMCs composed largely of civil society representatives, human rights activists, journalists, lawyers and academics, who work on a voluntary basis.

⁴ Resocialization centres aim to provide social, medical and other assistance to people in difficult life circumstances who are without a fixed place of residence. They help to reduce recidivism and ensure public hygiene practices are maintained.

Another negative aspect of the quarantine measures implemented as a response to the COVID-19 pandemic was that vocational and training programmes in detention centres, which are essential activities for rehabilitation and mental well-being, were halted. To mitigate the lack of activity and to assist with the response to the crisis that was unfolding outside the prison walls – again, following PRI's recommendations – people living in prisons were encouraged to sew masks and protective equipment for police and prison staff, which allowed them to continue acquiring skills that might be useful after release. Educational activities in the children's colonies were continued without interruption, taking into consideration all relevant precautionary measures.

PRI also played a key role in ensuring that all new measures adopted were communicated transparently to families and friends of people living in prisons, making them aware of what was happening in places of detention throughout lockdown and so avoiding any anxiety or panic. Infographics in Kazakh and Russian, communicating the new measures in place to families and friends of people living in prisons, were created and disseminated online by PRI (PRI, 2020c).

PRI also advocated successfully for livestreaming detailed information on the current situation directly to people in prisons. Additionally, an internal decree for prison staff was created, requiring that they properly inform people living in prisons of their rights, such as the right to request video calls.

Finally, in view of the ongoing need to improve health-care provision in places of detention, PRI is supporting discussions between the Ministry of Health and the Penitentiary Administration with the aim of enhancing the capacity of the prison health system. The Ministry of Health has agreed that health care in prison should be under its responsibility. This would comply with WHO recommendations and allow better provision and improved management of prison health across the country.

3.1.3 Outcome of the good practice

The measures successfully contributed to limiting the spread of COVID-19 in Kazakhstan's penitentiary institutions. As of 16 October 2020, 123 infections of COVID-19 had been confirmed in prisons, representing 4253 COVID-19 infections per million people living in prisons, in comparison to 7747 COVID-19 infections per million in the community. Only one COVID-19-related death had been reported among people living in prisons, representing 35 COVID-19-related deaths per million people living in prisons, in comparison to 116 per million in the community.

In addition, a prison officer who worked in a facility for people serving life sentences tested positive for COVID-19 and was immediately restricted from working and advised to self-isolate at home. Anyone who had had contact with this person was also placed in quarantine to contain further spread of the disease in accordance with WHO technical guidance on quarantine of contacts (WHO, 2021b).

PRI's support in developing and implementing these measures ensured that the human rights of people in places of detention were protected and that they were enabled to cope with

both the restrictive measures in place and a potential outbreak. Increased contact between people living in prisons and their families is expected to continue, which is an important step by authorities towards acknowledging that places of detention are first and foremost places that should promote rehabilitation and that contact with the outside community is key to this and to good mental health. Such measures, as well as better health-care provision, will ensure that the human rights of people living in prisons are better safeguarded.



3.1.4 Sustainability of the good practice

Building on this experience, penitentiary institutions in Kazakhstan will be more resilient and better prepared to respond to similar crises in the future. The flexibility shown by authorities throughout the current crisis, as well as their willingness to collaborate successfully with PRI and other international organizations and with each other, is a strong indication that better practices within places of detention will continue into the future.

Considering the significance of providing good-quality health care across penitentiary systems, not only during the COVID-19 pandemic but also in so-called normal times, authorities are taking action to transfer medical services to the Ministry of Health. This will allow better conditions for health professionals working in places of detention, who currently have fewer privileges than health professionals working elsewhere. Additionally, they will gain clinical independence from their current accountability to penitentiary institution directors, which will ensure higher quality and fairer health-care provision in places of detention.

COVID-19 INFECTIONS

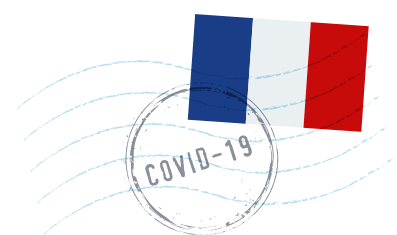
October 2020

0.43%

IN PRISONS

0.77%

IN THE COMMUNITY



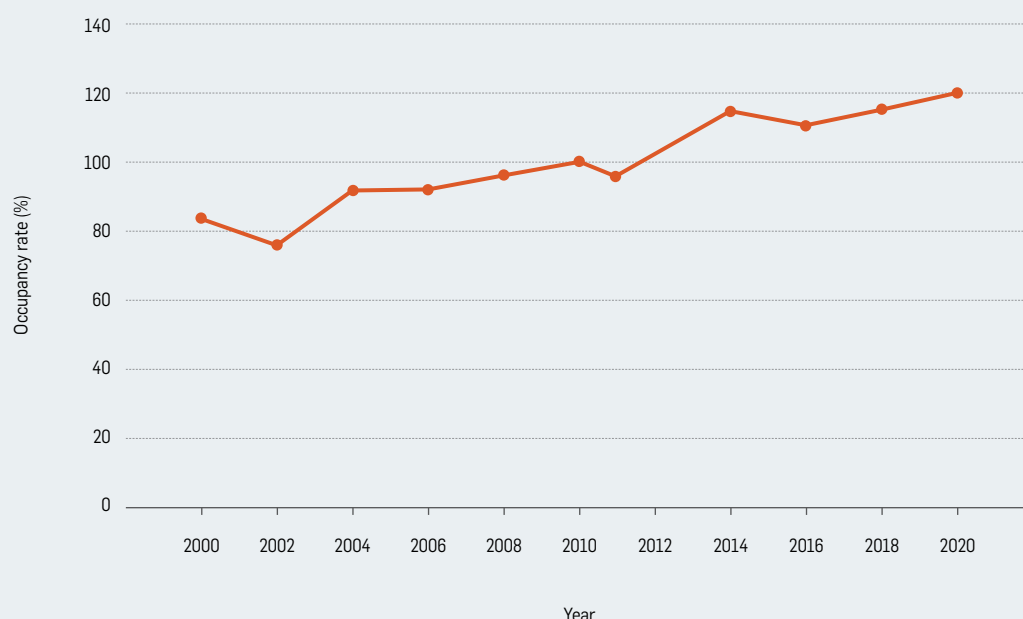
3.2 France: decreasing prison populations during the COVID-19 pandemic

Submitted by: Fadi Meroueh, Director, Health Without Borders, Health Unit, Emergency Department/ Montpellier University Hospital, Villeneuve lès Maguelone Penitentiary Centre, France

3.2.1 Background and context

Prisons in France are managed by the Directorate of Penitentiary Administration, under the Ministry of Justice. Since 1994, health care in prisons has been the responsibility of the Ministry of Health and is equivalent to health care in the community (Crétenot & Liaras, 2013). The official occupational capacity of prisons in France is 61 080 places. In March 2020 the occupancy rate reached 119%, with 72 575 people living in prisons. Of the 188 penitentiary establishments, 144 were overcrowded (Dodman, 2020). Overoccupancy is not a new challenge for French prisons, as occupancy rates have stagnated above 100% over the last eight years (**Fig. 1**) (World Prison Brief, 2020). The overcrowding challenge was highlighted when the European Court of Human Rights ordered the French government to pay fines to 32 people from six prisons, stating that the authorities had not taken sufficient measures to limit prison overcrowding (Dodman, 2020).

FIG. 1. OCCUPANCY RATES IN FRENCH PRISONS, 2000–2020



Source: World Prison Brief (2020)

As of 11 August 2020, France ranked 15th worldwide in relation to COVID-19 infections, with 189 972 confirmed cases and 30 214 COVID-19-related deaths (Public Health France, 2020).



3.2.2 Description of the good practice

As part of the Public Health Emergency Law activated by the French parliament on 22 March 2020, the French authorities set about decreasing the prison population in an effort to limit the spread of the disease behind bars. Arrangements were made for people who had less than two months of their sentence left to serve to be confined at home. In addition, people who were within six months of the end of their sentence were offered community service activities instead of incarceration. These arrangements excluded individuals who were serving sentences for acts of terrorism, domestic violence and violent crimes. Also, a circular was issued requesting postponement of short sentences and suspension of pretrial detention for nonviolent offences (Ouest France News, 2020). The decrease in the prison population was also linked to a decrease in judicial activity, which led to fewer new admissions. Accordingly, the number of people living in French prisons decreased by 13 500 (18.6% of the prison population) between March and May 2020 (Franceinfo, 2020).

Several measures were implemented in French prisons with the aim of preventing COVID-19 from spreading into prisons. These measures were applied in a similar manner to all people living in prisons. The measures included physical distancing, which involved halting all group activities, such as sports, education and professional training, and religious services. Between

**PRISON
POPULATION**

DECREASED
18.6%
between March and May 2020

17 March and 11 May 2020 the authorities suspended all visits to people living in prisons by family members and legal counsellors in order to reduce physical contact, thereby limiting introduction of the infection into prisons. To make up for the suspension of family visits, each person living in prison was awarded €40 credit per month for family calls and a dedicated voicemail system was made available to families. Specific financial help was also granted to people in prisons living under the most precarious conditions.

The authorities strengthened general hygiene measures in prisons, with access to more soap and hand towels. Leaflets and posters giving information about modes of infection and how to protect oneself were made available to people living in prisons and staff.

People newly admitted to prison were required to quarantine for 14 days, instead of the normal period of seven days that was in place prior to COVID-19. Prisons also dedicated single cells for suspected, probable and confirmed cases, and for symptomatic individuals living in prisons (Meyer, 2020). When there was a suspected case, individuals living in the same cell were also placed in isolation until they had been tested for COVID-19. Depending on the result, other people might be tested, but prison management, responding to overall occupancy level, sometimes placed two suspected, confirmed or symptomatic cases together in a single cell. Once or twice daily, medical check-up visits were conducted for each individual who was medically isolated (including suspected, probable or confirmed COVID-19 cases).

The French authorities made sure that continuity of essential medical care was maintained, especially for people with chronic conditions. For example, patients who were dependent on opiate substitution treatment did not have to consult a physician to renew their prescribed doses; instead, nurses delivered doses directly to patients in their cells. This change was made to avoid unnecessary movement of individuals living in prisons and to eliminate any avoidable personal contact. Other services that continued during the pandemic included dentistry and psychiatry, but some health services, including therapeutic support groups for people with drug dependency or a history of sexual violence, were halted as part of the preventive measures for COVID-19 infection.

For people living in prisons, being given the opportunity to watch the news on television made them more aware of the pandemic and the associated measures the whole country had adopted to prevent further spread. This gave them a better understanding of the measures taken inside prisons, including the cessation of visits and group activities and movement restrictions. In addition, health services in prison were available to address any questions from people living in prisons, and specific directives for the prison system were drafted regularly with support from the Ministry of Health and regional health agencies.

3.2.3 Outcome of the good practice

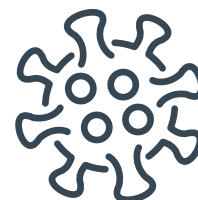
As a result of implementation of these measures, prisons in France tended to be spared the worst effects of COVID-19 in comparison to the general population. As of 14 May 2020, there were 119 reported COVID-19 infections among people living in prisons, equivalent to 1981 infections per million; at the same time, health authorities reported 138 609 COVID-19 infections in the general population, equivalent to 2078 infections per million. Within the same

timeframe, only one COVID-19-related death was reported among people living in prisons, which is equivalent to 17 COVID-19-related deaths per million; by contrast, in the general population 27 029 COVID-19-related deaths were reported, equivalent to 405 COVID-19-related deaths per million. In addition, 300 COVID-19 infections and one COVID-19-related death were recorded among prison staff (Observatoire International des Prisons, 2020a). While the infections per million people in prison and in the general population in May 2020 were quite close, the numbers reflect two different realities: access to testing for suspected cases and contacts of confirmed cases was significantly higher in prison than in the general population, where there were not enough tests available.

3.2.4 Sustainability of the good practice

Most of the measures implemented were appropriate in the context of the pandemic. Several were eased over time as newly reported infections among the public and in prisons started to fall. Family visits, for example, were partially and progressively reauthorized after 11 May 2020. Similarly, all kinds of group activities, including outdoor sports, work and school, started in early June 2020, with strict hygiene measures and appropriate personal distancing observed.

There is growing political pressure in France to seize the opportunity to solve the issue of prison overcrowding permanently. Nearly 1000 public personalities and organizations sent an open letter to the French president on 3 June 2020 asking for sustainable policy change to ensure humane conditions in prisons and to prevent future overcrowding (Observatoire International des Prisons, 2020b). Historically, French prisons have suffered from overcrowding, but in the midst of the COVID-19 pandemic swift decisions ensured the release of 13 500 individuals.



COVID-19 INFECTIONS

Up to May 2020

0.20%

IN PRISONS

0.21%

IN THE COMMUNITY



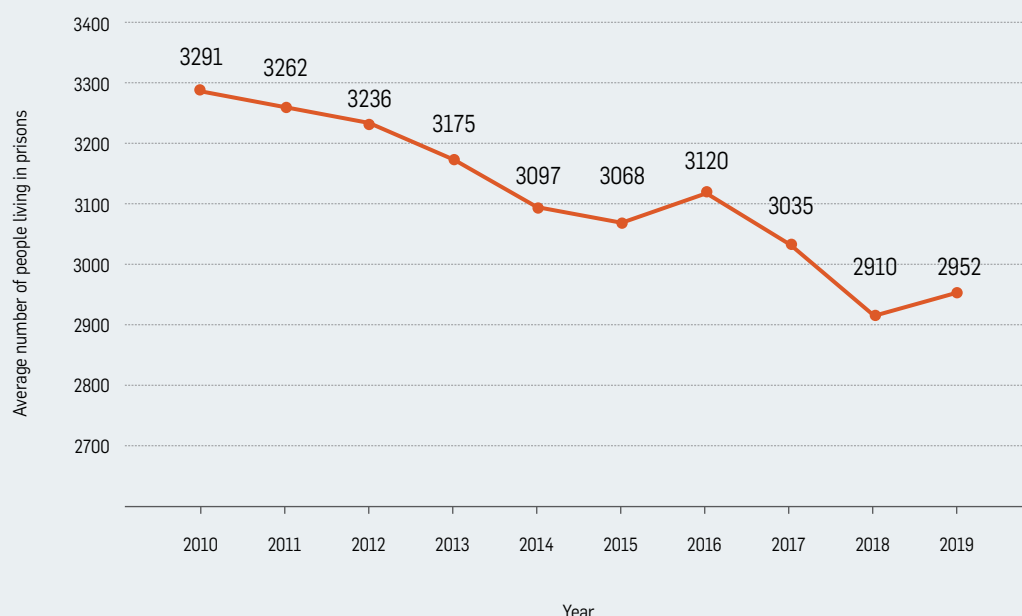
3.3 Finland: comprehensive approach in Finnish community sentences

Submitted by: Jussi Korkeamäki and Hanna Hemminki-Salin, Health Care Services for Prisoners, National Institute for Health and Welfare, Finland

3.3.1 Background and context

The Criminal Sanctions Agency of the Ministry of Justice is responsible for prison management in Finland. Sentences are generally divided into custodial and community sentences. Community sentences include community service and supervised sentences. At the end of 2019, Finland had a total of 14 community sentence offices and 26 prisons. Over the past 10 years, prison populations have been declining; in 2019 there was an average of 2952 people living in prisons (**Fig. 2**) (Criminal Sanctions Agency of Finland, 2019). The Administration of Health Care Services for Prisoners is the mandated entity responsible for health in prisons and operates under the National Institute for Health and Welfare. The Administration also operates in close collaboration with the Criminal Sanctions Agency.

FIG. 2. AVERAGE DAILY NUMBER OF PEOPLE LIVING IN FINNISH PRISONS, 2010–2019



Source: Criminal Sanctions Agency of Finland (2019)

3.3.2 Description of the good practice

In March 2020 the Ministry of Justice issued a decree that postponed enforcement of fines and imprisonment for up to six months between 19 March and 19 June 2020. Accordingly, the Criminal Sanctions Agency postponed any enforcement of short sentences with the aim of reducing the number of short-term individuals entering prisons and thereby reducing the risk of COVID-19 infection among people living in prisons and staff. The decree stated, however, that enforcement of sentences should not be delayed for more than eight months.

As a result, the total prison population decreased by almost 16% (404 individuals were released) between 25 March and 1 June 2020. The decrease was mainly due to the release of 301 sentenced individuals, equivalent to 16.3% of all sentenced individuals.

The number of individuals living in remand prisons decreased by 59 (9.0%); and the number subjected to fine conversion decreased by 44, which equates to 88.0%, during the same period.

As a measure to lessen physical contact in community sentences, plans were changed so that, if possible, work services could be performed from home. Work services might include written assignments, online substance abuse and mental health services assignments, thematic discussions and individual programme lessons with a supervisor by phone or other virtual communication means. It was important that sentenced individuals continued



**PRISON
POPULATION**

DECREASED
16%
between March and June 2020

to receive the support they needed and that, for example, substance abuse rehabilitation was not interrupted during these exceptional circumstances (Criminal Sanctions Agency of Finland, 2020a). In addition, the Criminal Sanctions Agency started to use electronic surveillance and phone location data in controlling community sentences.

In addition to releasing people living in prisons and applying noncustodial measures, in early March 2020 the Criminal Sanctions Agency set up a Contingency and Preparedness Group in the Central Administration Unit to monitor and coordinate measures taken during the COVID-19 pandemic. The Group established communication with the Prison Health Service under the Department of Health and Welfare, which is responsible for monitoring the health status of people living in prisons. The Contingency and Preparedness Group urged the heads of the various units to consider, as far as possible, a range of measures to prevent the spread of infection. The instructions gave the unit heads the authority to hold meetings and transfer people living in prisons from one prison to another only when necessary and on a case-by-case basis. The units already had contingency plans in place and the Contingency and Preparedness Group constantly monitored the situation. For prison staff, the Agency followed the national guidelines issued by the government: all travel abroad was cancelled and workers who had travelled abroad were subjected to a quarantine period of 14 days. Teleworking opportunities were increased as work assignments allowed (Criminal Sanctions Agency of Finland, 2020b). The Group also set guidelines for regional preparedness plans and placement of people living in prisons at higher risk of COVID-19 infection and conducted weekly meetings that served primarily to address enquiries shared by regional preparedness teams.

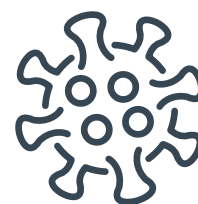
In May 2020 the Criminal Sanctions Agency established another group, which was mandated to regulate and manage the de-escalation of measures taken in the midst of the COVID-19 pandemic. The Post-COVID-19 Working Group included representatives from the Prison Health Service. The Group highlighted the expected increase in the number of people living in prisons due to de-escalating restrictions, which threatened to overstretch the resources of the Prison Health Care Unit. At the termination of the Ministry of Justice decree that postponed enforcement of fines and imprisonment until 19 June 2020, an increase in the number of new arrivals was expected, adding significant pressures to nursing staff responsible for initial health checks-ups on new arrivals in prison. Overall, the Prison Health Care Unit was short of trained health-care staff to accommodate the expected increase in numbers of people living in prisons, especially given the possibility that prison health-care staff might report sick or take annual leave. Moreover, the Prison Health Care Unit was underfunded and lacked financial resources to recruit more staff.

3.3.3 Outcome of the good practice

Although the number of people living in prisons decreased, the number of individuals seeking medical attention did not significantly fall, reflecting the poor health of people living in prisons. The number of initial health check-ups upon arrival in prison did not decrease, especially in remand prisons, as there were general health concerns affecting people living in prisons in the midst of the COVID-19 pandemic.

Increased cooperation between the Prison Health Service and the Criminal Sanctions Agency during the pandemic is considered a positive outcome by both agencies. Cooperation was observed at both central and regional levels. The workloads of the Contingency and Preparedness Group and the Post-COVID-19 Working Group increased significantly in the period between March and July 2020, but more precise definition of roles and responsibilities gradually brought more structure to, and streamlining of, responsibilities.

As of 31 August 2020, no confirmed COVID-19 infections had been found among people living in prisons or staff members, which demonstrates the effectiveness of the measures that were implemented. In the community over the same time period, 8077 COVID-19 infections were reported, representing 1464 infections per million.



COVID-19 INFECTIONS

Up to August 2020

0%

IN PRISONS

0.15%

IN THE COMMUNITY

3.3.4 Sustainability of the good practice

Although it is considered too early to assess the sustainability of the measures taken in prisons (as the pandemic is still not over), one sustainable achievement is the close communication and collaboration between the Prison Health Service and the Criminal Sanctions Agency. As an example, it has been decided by both agencies that the Contingency and Preparedness Group formed during the pandemic will continue to function as an ad-hoc group beyond the pandemic.



AVERAGE DAILY PRISON POPULATION

2019/2020

1516

TOTAL

1442

BORN MALES

74

BORN FEMALES

3.4 United Kingdom (Northern Ireland): health and well-being engagement in the prison population during COVID-19- restricted regimes

Submitted by: Ruth Gray, Clare Connolly and Barry Rooney, South Eastern Health and Social Care Trust, United Kingdom (Northern Ireland)

3.4.1 Background and context

There are three prison sites in the Northern Ireland prison estate: Maghaberry, Magilligan and Hydebank Wood College. The Northern Ireland Prison Service (NIPS) is an agency within the Department of Justice with responsibility for services operation. The South Eastern Health and Social Care Trust (SEHSCT) has had responsibility for delivery of health care in the region's prisons since 2007. A whole-prison approach to the delivery of health care has been adopted, with joint organizational operational strategies developed.⁵ The Healthcare in Prison Team provides multidisciplinary primary care services with integrated mental health and addictions teams.

⁵ A whole-prison approach is a health-promoting prison approach that is safe, secure and reforming, and is underpinned by a commitment to participation, equity, partnership, human rights, respect and decency. It follows an ecological model of public health through understanding health as a holistic concept determined by a complex interaction of environmental, organizational and personal factors, and requires prisons to be committed to supporting the health and well-being of people in prisons and staff through their systems and structures.

The overall average daily prison population recorded in 2019/2020 was 1516, with 1442 males and 74 females living in prisons. The number of annual new entrants into prison in the same year was 5322.

In response to the COVID-19 pandemic, collaboration was established between NIPS, SEHSCT and the Public Health Agency to produce operational arrangements. Accordingly, in April 2020 prisons started quarantining all new entrants for 14 days to minimize the risk of transmission into the wider prison population. In addition, several restrictive measures were instigated across the prisons to minimize the risk of infection. This was aligned with Public Health England guidance for prisons' response to COVID-19.

3.4.2 Description of the good practice

Restrictive measures applied in prisons amid COVID-19 have been found to be detrimental to people's physical and mental health. It is widely recognized that the time of committal into prison is one of difficulty and high risk of self-harm. The Healthcare in Prison Team developed a series of initiatives to support people as they entered prison and began a period of COVID-19 isolation. Collaborative working with NIPS safety and support staff was foundational to the engagement programme. The aim was to mitigate the impact of the restrictions implemented in response to COVID-19, which had a major impact on people's mental health and well-being.

Activities developed include a distraction pack containing puzzles, positive messages, health information and in-cell exercise routines. Weekly quizzes were distributed in prisons, including competitions such as creating self-portraits, creative writing and fantasy football. A regular newsletter was established for each prison with the aim of promoting clear messages when restrictive measures were applied. The *WhatsUp* magazine was codesigned by people in prisons, who contributed to articles, sent positive messages to each other, and acknowledged kindness and generosity among the staff and prison population (Fig. 3).

A summary of the engagement activities used in Northern Ireland prisons is shown in Table 4.

FIG. 3. *WHATSUP* MAGAZINE ADVERTISEMENT IN NORTHERN IRELAND PRISONS



Source: reproduced by permission of South Eastern Health and Social Care, United Kingdom (Northern Ireland)

TABLE 4. ENGAGEMENT ACTIVITIES DEPLOYED IN NORTHERN IRELAND PRISONS DURING THE COVID-19-RESTRICTED REGIME

Activity	Description	Outcome	Metrics	People
Post-quarantine interviews for contacts	One-to-one interviews with people who have been through the quarantine house	Space and time given to share story and be listened to Insight gained into the impact of quarantine on individuals Referrals made to relevant health-care services when needed Feedback provided to health-care teams and NIPS	Post-isolation interview qualitative survey Number of health-care referrals	168
New entrants quarantine engagement sessions	One-to-one sessions with people in preventive isolation to check on their physical and mental well-being	Worries or concerns listened to, support and guidance provided Information on health-care services and how to gain access provided Information on prison routine shared	Number of engagement encounters	472
<i>FAB News</i> newsletter and <i>WhatsUp</i> magazine	Six newsletters delivered across prison sites and placed under each cell door	People in prisons feel more connected to prison news, including health-care services availability People in prisons participating in quizzes and facts within the newsletter and contributing materials to the newsletter	Number of newsletters distributed Number of contributions from people living in prisons	5728
Chat and chew/ banter for breakfast	Social interaction and food-cooking sessions	Facilitated conversation to encourage people in prisons to connect during application of restrictive measures	Number of facilitated sessions	120
Quarantine quiz and bingo	Quiz and bingo during quarantining of new entrants	Interactive activities with people in quarantine	Number of sessions Post-quarantine interview (face to face)	57
Isolation creative writing competition	Competition run across Her Majesty's Prison (HMP) Maghaberry Posters placed on each building	Encouraged reflection on the impact of quarantine that highlights coping strategies Gave people the opportunity to have their experience heard and shared with others	Number of contributions	945
Relaxation and mindfulness groups	Facilitated by drug and alcohol services staff in prisons three days a week	Relieved stress and anxiety Helped develop positive coping strategies	Post-session qualitative survey	100
Distraction packs	Provided structured activities, fun games, mindful colouring, health tips	Relieved stress and boredom Helped develop positive coping strategies	Number of distraction packs distributed Post-quarantine interview qualitative survey	179

The Engagement Team recognized that time spent in quarantine had been linked with negative psychological outcomes, including psychosis, anxiety and depression. Accordingly, a qualitative survey using in-depth interviews was designed to capture the experience of people after completing their period of quarantine. The survey interviews were conducted in the week following release from quarantine and gave people in prisons space to share their stories. All post-quarantine interviews were conducted confidentially, with information displayed anonymously. These experiences were used to shape and improve the care given at this difficult time.

A total of 168 people in prisons shared their experience through this longitudinal survey. Inductive thematic analysis was used to identify a coding set and patterns in the stories. A number of key themes emerged from their experiences, including connection, communication, physical environment and support.

What mattered most to people as they entered prison was contact with their families (Fig. 4). Responding in a timely manner, by April 2020 NIPS had developed a virtual visiting system that alleviated stress on new entrants and their families.

Clear communication about prison life, COVID-19 and the restrictive measures applied was reported as being important to people in prisons. Particular focus was given to the needs of those who were entering prison for the first time during the pandemic. The Engagement Team responded to this need by instigating check-in visits with each person in quarantine. The purpose of the visits was connecting with people, signposting them to health-care services, and formalizing a pathway for mental health support if requested during the period of quarantine.



168 PEOPLE
PARTICIPATED
IN QUALITATIVE SURVEY

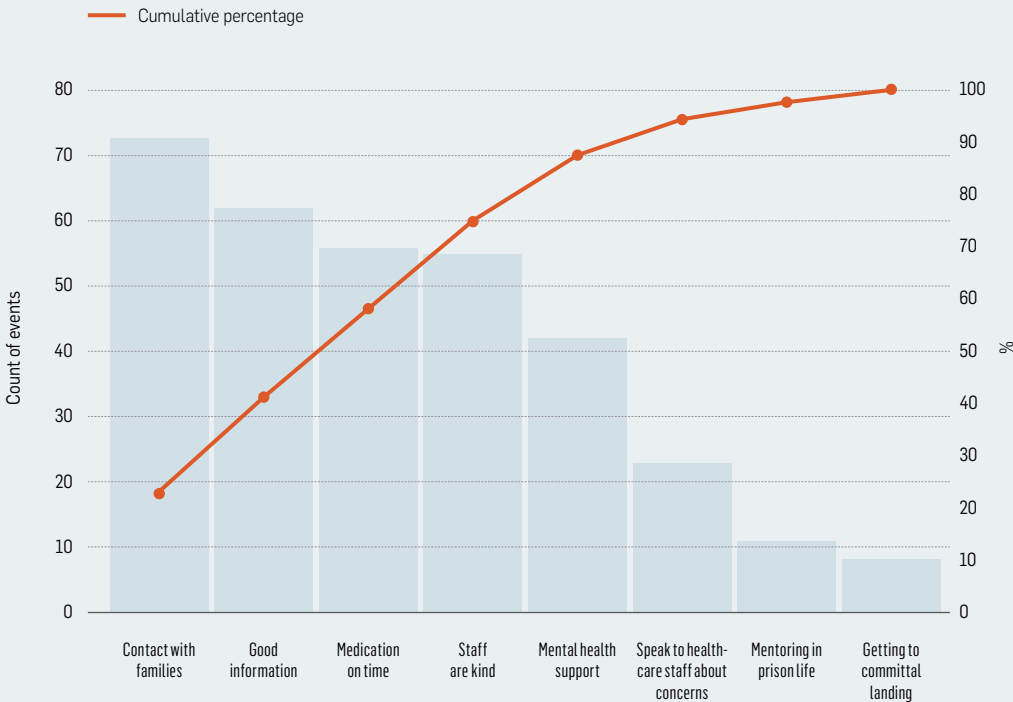


FIG. 4. RANKING OF WHAT MATTERED MOST TO PEOPLE ENTERING PRISONS IN NORTHERN IRELAND

Source: South Eastern Health and Social Care, United Kingdom (Northern Ireland)

3.4.3 Outcome of the good practice

The focus on health and well-being by the Healthcare in Prison Team changed the prisons' culture. The interorganizational partnership approach leveraged limited resources and brought creativity and encouragement to people in prisons and to prison and health-care staff. The engagement work carried out by the Engagement Team became intrinsic to health-care service delivery and incorporated the wider determinants of health into its COVID-19 response. The following quotes were captured during the post-quarantine interviews:



"Priority was given to well-being of the people they care for. Health-care visitor approached the situation with an open mind and did not assume. You don't know what people have been through or what they are feeling and thinking."

"I would have liked more check-ins with health care. I remember you coming to the door, hard to remember. You asked me about support for my mum and did contact her, this has been great for my mum, she is easier to talk to on the phone."

"Distraction pack was useful, would need more, it helped to pass time and keep head focused."

Thematic analysis of the post-quarantine interviews was conducted. The weekly themes were plotted against time to understand the quarantine experience and to highlight issues in a real-time learning loop. Findings were shared with the senior management teams of NIPS and SEHSCT, which enabled focused accountability of care provision from both organizations. The analysis was stratified for gender, prison site and vulnerable populations.

3.4.4 Sustainability of the good practice

A whole-prison approach to the COVID-19 pandemic response was key to the Healthcare in Prison Team working in Northern Ireland's prisons. There was strategic and public health support for the work and collaborative effort across frontline services. A repository of resources was developed for use in a pandemic second surge. The impact of the work was evidenced and analysed, adding to the case for sustainability.

Vital to this ongoing work will be the feedback and codesign of initiatives with people living in prisons. Lived experience is key to relevant and accessible services. Extension of the role of the Engagement Team is being explored by the Healthcare in Prison Commissioning Team, with support from the Department of Health.

4. Preparedness, contingency planning and level of risk





4.1 Canada: modified staffing protocols – rostering and unit-based staffing

Submitted by: Kristina Ma, Olivia Varsaneux, and Madison Van Dalen, Correctional Service of Canada



**AVERAGE
FEDERAL
PRISON
POPULATION**

2019/2020

23 309

PEOPLE IN THE CORRECTIONAL
SERVICE SYSTEM

9377

BEING SUPERVISED IN THE COMMUNITY

13 932

LIVING IN PRISON

4.1.1 Background and context

The Correctional Service of Canada (CSC) is the federal government agency in Canada responsible for administering court-imposed sentences of two years or more. Offenders sentenced to less than two years and youth offenders are managed by provincial/territorial correctional systems. Across five regions in Canada, the CSC manages 43 federal institutions of varying security levels and 14 community correctional centres. Included among these institutions are five regional mental health facilities, five regional women's institutions and five healing lodges, which are sites that foster a traditional healing environment that supports the rehabilitation of indigenous offenders.

In 2019/2020, the CSC was responsible for an average of 23 309 offenders – 13 932 in federal custody and 9377 supervised in the community. CSC sites span the entire country, from large urban centres to remote northern communities, and, as such, serve an incredibly diverse population.

4.1.2 Description of the good practice

As staff can come and go between institutions much more readily than offenders, they are an important source of potential introduction of COVID-19 into CSC institutions. CSC staff tend to work in close quarters with one another, and, in many cases, physical distancing can be challenging because of the complexity of operations and the enclosed infrastructure of correctional institutions. Within the CSC, early contact-tracing efforts revealed that many of the COVID-19 infections among staff were epidemiologically linked and contact-tracers identified a high number of staff close contacts for each case.

In response to the risk of staff potentially infecting one another as well as the people living in prisons, the CSC implemented, wherever possible, a modified rostering and cohorting approach for all staff, which involved creating staff rosters and grouping staff based on their risk of infection. As an example, the CSC implemented among health-care staff a two-team roster approach that required that two staff rosters be established with limited or no overlap between the staff groups to reduce the potential for transmission between groups in the event that one group became affected by COVID-19. Another example of modified staffing protocol was applied among correctional officers, where staff rosters were adapted, wherever possible, to facilitate the cohorting of correctional officers with particular groups of people living in prisons, with limited crossover between different correctional officer groups and people living in prison groups. These were important preventive measures not only to mitigate the risk of COVID-19 transmission, but also to prevent disruptions to service delivery due to staffing shortages resulting from an outbreak occurring among one of the rosters or cohorts.

The CSC also implemented unit-based staffing protocols early in the COVID-19 pandemic. This meant that, wherever possible, staff were assigned to a specific unit/building or – if at an outbreak site – to a specific zone and were not permitted to work anywhere else within the CSC, as an interim measure to prevent the spread of COVID-19 to different areas of the institution. Because many sites house multiple institutions or buildings, unit-based staffing was an important preventive measure, as it reduced the risk of transmission between units, buildings and institutions within a single site.

4.1.3 Outcome of the good practice

Modified staffing procedures offered several positive outcomes in the context of the CSC's COVID-19 response. First, modified staffing procedures helped to mitigate the risk of transmission between teams of staff and work environments, and further mitigated exposure of people in prisons to COVID-19. Secondly, these procedures helped to limit the number of close contacts of potential cases. Lastly, they helped to mitigate disruptions in service delivery due to staffing shortages.

4.1.4 Sustainability of the good practice

Modified rostering and unit-based staffing may not be sustainable in the long term, given the need to cover a multitude of programmes and operations that occur within the correctional context (many of which were scaled back to facilitate the prevention and management of COVID-19). Accordingly, every institution is expected to develop and maintain a plan for modified rostering and unit-based staffing as part of the CSC's IPC preparedness guidelines. This will allow for rapid implementation of modified staffing procedures in the event that the CSC faces another infectious disease outbreak in the future.



4.2 Canada: early warning surveillance based on community transmission

Submitted by: Olivia Varsaneux, Kristina Ma, Joel Collard, and Madison Van Dalen, Correctional Service of Canada

4.2.1 Background and context

For information on the background and context relevant to this good practice, see section 4.1.1 above.

4.2.2 Description of the good practice

Early cases of COVID-19 in CSC institutions were most likely the result of introduction of the virus by staff, as the movement of people living in prisons in and out of CSC institutions was limited and visits were suspended temporarily in response to the COVID-19 pandemic in Canada. Upon further review of the epidemiological data from the early outbreaks, there was a recognition that high levels of transmission in the local community and multiple points of introduction of the virus at a single outbreak site contributed to the challenge of understanding transmission within the CSC, as well as establishing appropriate and timely control measures.

In recognition of the strong link between the amount of community transmission and the potential for COVID-19 introduction in CSC institutions, the CSC developed an early warning surveillance report to supplement the existing outbreak reporting measures. CSC epidemiologists developed a systematic process to collect information on the incidence of COVID-19 cases in the local community, as reported by local public health authorities in each geographic catchment area in which the CSC has an institution. The CSC developed a consistent measure to compare and analyse the level of incidence risk between health regions to make informed and strategic decisions, particularly in the context of early identification of any institutions that might be at higher risk of COVID-19 introduction, based on evidence of elevated community transmission of the virus. The

early warning surveillance report, generated weekly, tracked COVID-19 transmission in the local community over time, flagging institutions located in areas where there might be greater risk of an outbreak.

4.2.3 Outcome of the good practice

This practice helped the CSC by providing a proxy for outbreak risk, which was used to make informed and strategic decisions at national level in response to the COVID-19 pandemic. Specifically, the practice was used to guide a national testing policy for people in prisons and staff and to develop policy related to easing of restrictive measures in the context of operations and programme delivery. Most recently, the practice allowed the CSC to identify a community correctional centre in a geographic location with a large increase in incidence rates, allowing the CSC to communicate the need for increased vigilance and adherence to public health measures to mitigate spread from the community into the centre. Information from this practice was used to brief people at all levels, from ministers and members of Canada's parliament down to the CSC's regional managers of public health and contact-tracing coordinators.

4.2.4 Sustainability of the good practice

Implementing this practice required some initial investment of time from personnel with information management and epidemiological expertise. Once in place, however, the process was systematized and regular data collection, analysis and reporting were sustained with little further investment. Going forward, the benefits of the early warning surveillance report will help to inform the CSC's policy decisions, including informed decision-making on the allocation of resources in the context of COVID-19. The implementation of similar early warning surveillance reports may have utility in the context of surveillance activities undertaken by the CSC for other infectious agents, such as seasonal influenza. Systematically monitoring community transmission may offer a complementary measure in the surveillance, prevention and management of infectious diseases in the CSC.



4.3 United Kingdom (England): partnerships for preparedness and risk mitigation

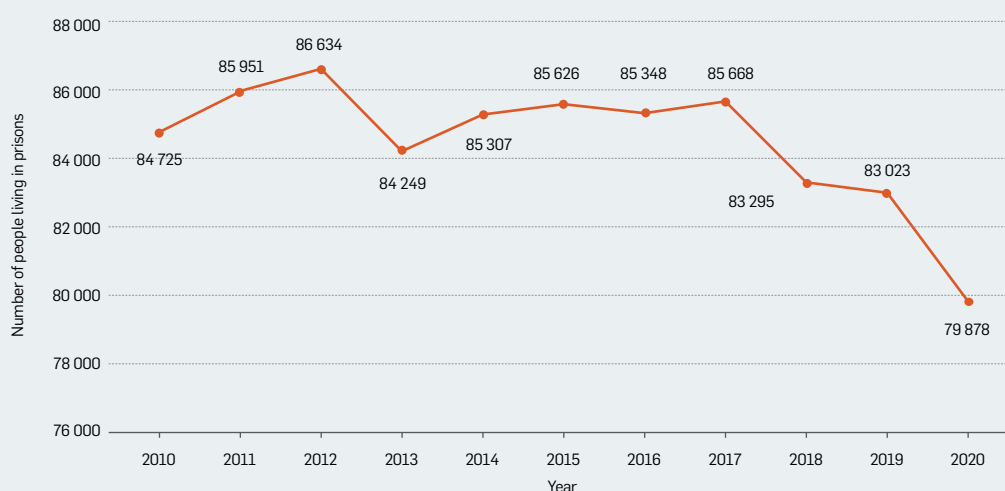
Submitted by: Sunita Stürup-Toft, Alicia Rosello, Éamonn O'Moore, Public Health England/UK Health Security Agency⁶

4.3.1 Background and context

There are 117 prisons in England and Wales. Her Majesty's Prison and Probation Service (HMPPS), under the Ministry of Justice, manages around 90% of establishments (n = 104) and three private companies manage the remaining 10%. The prison population in England and Wales has decreased over the last 10 years (**Fig. 5**), but challenges remain, including overcrowding, increasing numbers of older people living in prisons (over 50 years of age), use of psychoactive substances and traditional drugs inside prisons, staff shortages and high turnover rates, and increased misbehaviour, violence and self-harm rates among individuals living in prisons (Atkins et al., 2019).

The following example is based on practice in prisons in England, which form the majority of the prison estate in England and Wales (112 of 117).

FIG. 5. TOTAL PRISON POPULATION, ENGLAND AND WALES, 2010–2020^a



Source: Ministry of Justice of the United Kingdom (2020)

^a The reported prison population on 5 June is used for 2020.

4.3.2 Description of the good practice

As part of the National Partnership Agreement for Prison Healthcare in England (2018–2021), Public Health England (PHE) provided public health expertise to HMPPS, including on health protection issues (HM Government, 2018). The National Partnership Agreement was a set of priorities and agreed ways of working between the Ministry of Justice, HMPPS, the Department of Health and Social Care, NHS England/NHS Improvement and PHE. The agreement had a range of health priorities, including improving the proactive detection, surveillance and management of infectious diseases in prisons and joint capability to detect and respond to outbreaks and incidents.

PHE published several documents supporting the management of communicable diseases in prisons (PHE, 2021), including a multiagency contingency plan for managing outbreaks in

⁶ Formed on 1 April 2021, the UK Health Security Agency has since that date taken over the functions previously performed by Public Health England.

prisons, which formed the basis of all response work to communicable disease outbreaks in prisons and places of detention (PHE, 2017).

This strong foundation of collaborative working on managing outbreaks in prisons was the basis of managing and controlling COVID-19 in prisons and other detention settings in England. The aim was to protect staff and people in prison but also to lessen the burden on the NHS by reducing the number of those requiring specialized hospital care. One of the major national concerns was the spread of COVID-19 inside overcrowded closed settings such as prisons, with a steep rise of cases creating explosive outbreaks.

PHE advised HMPPS to implement strict measures to prevent or limit the spread of the pandemic inside prisons by applying many of the controls used in the community and adapting them for the prison setting. These measures included applying, as soon as possible, physical distancing, protecting the most vulnerable populations inside prisons, and compartmentalization of prisons (see below), alongside appropriate communication to people in prison to enable them to understand these protective measures for their own health.

Physical distancing was enforced on 24 March 2020 by stopping all visits, training, employment and workshops, and all access to gymnasiums and religious buildings. The measures also included limits on the number of people present outdoors for exercise in the same yard and a two-metre distance that was enforced among people living in prisons and between people living in prisons and staff. Cross-movement of people living in prisons and staff was limited.

On 31 March 2020 HMPPS also activated a compartmentalization strategy, which involved creating units inside prisons to minimize the risk and spread of infection.

- Incursion of infection from the community was minimized by setting up **reverse cohorting units** in which new or transferred individuals were isolated for 14 days.
- Spread of infection from infected prison residents was limited by accommodating suspected or confirmed COVID-19 cases in **protective isolation units**.
- Enhanced protection of clinically extremely vulnerable people was provided by placing them in **shielding units**, with heightened biosecurity level and dedicated staff.⁷
- "Seeding" of infection between prisons was prevented by reducing **inter-prison transfers** as far as possible.

PHE initially advised that single-cell accommodation should ideally be used to prevent transmission of infection, but this would have meant decarceration of up to 15 000 people. Nevertheless, successful implementation of the compartmentalization strategy, physical distancing and population management effectively reduced mixing between people to reduce transmission to a level similar to that likely to be achieved by use of single cells (O'Moore, 2020).

In the first pandemic wave, testing was limited to people meeting clinical case definition and to management of outbreaks, where diagnostic testing of the first few cases was undertaken to confirm the presence of SARS-CoV-2; if confirmed, subsequent cases meeting clinical case definition were classified as probable cases. As of April 2020, there were 17 deaths related to COVID-19 and 382 cumulative confirmed COVID-19 infections among people living in prisons (**Fig. 6**).⁸ These figures, especially those for numbers of people infected, likely underestimate the true prevalence of infection as a result of significant restrictions on testing capacity at the time.

⁷ HMPPS worked with health-care providers and commissioners to identify the most vulnerable individuals, who were defined as people in prison with underlying health conditions or those over 50 years of age.

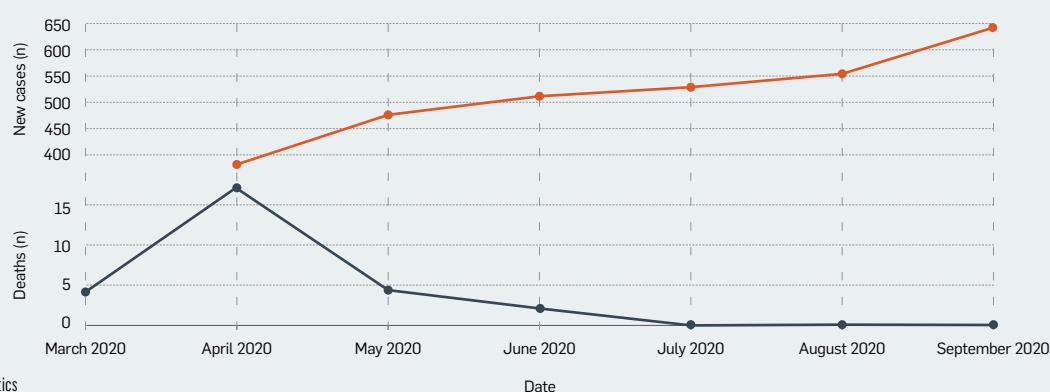
⁸ Data obtained from WHO Minimum Dataset for Prisons Survey submitted by England on 3 July 2020.

4.3.3 Outcome of the good practice

Overall control of the outbreak demonstrates the impact of measures taken by HMPPS and PHE, as outbreaks in prisons were of a limited nature with almost no explosive outbreaks. By July 2020, the frequency and number of new cases were decreasing, as shown by the decline in steepness of cumulative cases (**Fig. 6**), and prisons were reporting evidence of outbreak control.

Modelling has shown that, without implementation of such measures, 80% of new infections in a prison could result in an outbreak of more than five confirmed cases. By implementing the measures, this figure could be reduced to under half (44.3%) of all new infections in a prison resulting in an outbreak of five confirmed cases or more (O'Moore, 2020). These outcomes are, however, based on early assessment of the strategies deployed.

FIG. 6. TOTAL NUMBER OF COVID-19 CASES AND RELATED DEATHS AMONG PEOPLE LIVING IN PRISONS, ENGLAND, MARCH–SEPTEMBER 2020



Source: Official Statistics HMPPS, COVID-19 statistics

4.3.4 Sustainability of the good practice

There are several factors that will influence the sustainability of this practice, emphasizing the relationship of prisons with the community.

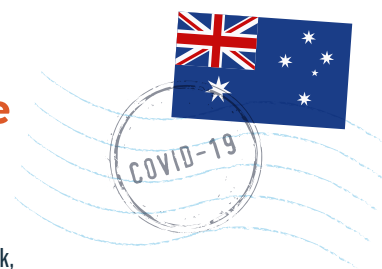
There are considerable pressures on the criminal justice system in managing the backlog of criminal cases and dealing with increasing crime following lifting of lockdown measures in the community. As these are addressed, the population coming into prisons will increase and put pressure on reverse cohorting units. Risk assessment and application of restrictions must be dynamic; as outbreaks are contained in prisons, vigilance is required in lifting measures too soon or without due regard to community transmission caused by the movement of people living in prisons and staff in and out of the prison setting. The impact of COVID-19 on the workforce has been a consistent factor in delivering the current response, and absence due to illness or medical isolation in both custodial and health-care workforces needs daily monitoring. In addition, daily partnership meetings between all actors at local and national levels are needed to assess the sustainability of any actions.

Another area of concern is the impact of restrictive measures on the mental health and well-being of people living in prisons. Being a vulnerable group, people living in prisons have multiple complex health needs and worse health outcomes relative to the general population worldwide, including in relation to mental health and well-being (Hewson et al., 2020). HMPPS has taken several measures to ensure the mental well-being of people living in prisons, including the use of in-cell telephony for half of the prison estate, access to video calls where appropriate, the development of evidence briefings for all staff to help them understand communication issues with people in prison, and the development of distraction packs for use in cells, which include in-cell exercises. This is supported by increased monitoring of mental health in prisons by all staff.



4.4 Australia (New South Wales): increase in prison telehealth consultations during the COVID-19 pandemic

Submitted by: Gary J. Nicholls, Clinical Director, Justice Health and Forensic Mental Health Network, New South Wales, Australia



4.4.1 Background and context

The Justice Health and Forensic Mental Health Network (the Network) delivers health care to adults and young people in contact with the forensic mental health and criminal justice systems across community, inpatient and custodial settings in New South Wales (NSW), Australia. The Network is part of the broader NSW health system and forms a vital component of the NSW public health system through its support for a highly vulnerable patient population whose health needs are often more complex than those found in the wider community. In doing so, it clearly contributes to SDG 10 by reducing inequalities and to SDG 3 by contributing to health and well-being.

In all contexts, the Network works closely with a variety of organizations, including the NSW Ministry of Health, Corrective Services NSW, Youth Justice NSW, local health districts, community-controlled Aboriginal health organizations, NSW Police Force, Department of



PRISON POPULATION

June 2020

12 898

IN NSW

41 060

IN ALL AUSTRALIAN
STATES

Communities and Justice, universities, community groups and advocacy groups. NSW also has four privately run prisons. The vision of the Network is to return healthier patients to their communities. Network values include care, clear communication, honesty, professionalism and respect.

The Network cares for over 30 000 patients annually across more than 100 community, inpatient and custodial settings in metropolitan, regional and rural locations across NSW.

On 30 June 2020 the prison population in NSW was 12 898 (Justice Health and Forensic Mental Health Network, 2020b), while the population in all Australian states was 41 060 (Australian Bureau of Statistics, 2020). Several new prisons have been built in recent years across NSW.

4.4.2 Description of the good practice

The Network developed a contingency plan in response to the COVID-19 pandemic. In full alignment and collaboration with the NSW Ministry of Health, the Network developed local COVID-19 guidelines to protect patients and staff and to prevent a prison outbreak (Justice Health and Forensic Mental Health Network, 2020a).

Planning involved communication and collaborations with stakeholders across NSW corrective services and other health agencies, including those working in private prisons. Regular meetings were held with all relevant stakeholders to ensure that guidelines were consistent across the state. The Network response team included executives and clinical leaders in medicine and nursing who received expert advice from state-wide and local public health teams. Daily updates and planning meetings were held across the Network. Meetings became virtual rather than face-to-face to allow physical distancing.

The Network and stakeholders developed responses to prevent pandemic spread from the community to prisons. These included sentinel PCR testing for COVID-19, a 14-day quarantining for all new entrants prior to mixing with the wider prison population, temperature testing of all staff and people living in prisons each time they arrived at a prison, reduced movements between NSW prisons, physical distancing, and increased cleaning and handwashing to prevent infection. Appropriate PPE was used according to the level of risk and regular COVID-19 testing was undertaken as per NSW Health guidelines (NSW Government, 2021).

People living in NSW prisons were updated regularly on NSW Health and Network guidelines created to respond to the COVID-19 pandemic. Accordingly, they collaborated to reduce the risk of pandemic spread in prisons through involvement in health promotion activities and increased cleaning frequency of their accommodation cells.

Face-to-face visits for people living in prisons were stopped to prevent pandemic spread into prisons. The Network subsequently made available secured electronic tablet communication for family and legal visits (Fitzgerald, 2020). People living in some prisons could also access secure tablets loaded with applications, including news and entertainment, education, health

information and mental health support. Further rollout of these secure tablets across the state could provide new opportunities to support people living in prisons and improve their mental and physical health.

The Network fast-tracked equipment and staff training for remote telehealth services so that staff could provide remote clinical support from offices and home computers if isolated and working from home. Network staff adapted quickly to the situation and were set up to work remotely within two weeks of the plans. Clinicians were able to case-manage patients considered to be at risk or of concern through video and telephone conferences, supported by a centralized clinical management team. Plans were further developed for teleconferencing with experts in emergency medicine, infectious diseases and respiratory medicine, should it be required. Nursing staff assessed and triaged requests received from people living in prisons to see primary care physicians, and appointments were made centrally with the support of the primary care administration team. Emergency patients were consulted by the attending nursing staff and immediate telephone advice was sought from the on-call general practitioner service 24 hours a day. Video teleconference clinics were booked as needed across NSW. Electronic health records enabled remote access to patient documents and investigation results and supported remote multidisciplinary patient reviews. The Network also collaborated with the Prince of Wales Hospital, Sydney, to further improve access to specialist services that were suitable for remote access. The Network did not halt face-to-face medical consultations for people in prisons, but rather embraced a hybrid clinic model with both face-to-face and telehealth clinics, depending on clinical need and staff availability. Patients were supportive of the partial move to telehealth services and provided their consent.

The Network also increased mental health clinic availability with telehealth clinics. Specialist mental health nurses worked closely with medical staff to support case management of patients with anxiety and depression, as well as those with more severe psychiatric disorders.

Development of telehealth clinics had multiple benefits, including more timely access to clinics for patients while reducing the need for secure transfers, thereby reducing the financial and human resources required. In addition, telehealth services allowed provision of medical consultations for people housed in more remote prisons across the state.

4.4.3 Outcome of the good practice

State-wide access to primary care general practitioner consultations was maintained and improved during the pandemic period. The number of Network telehealth consultations increased by 62% between 2019 and 2020, and there was a 44% reduction in patient waiting times to see primary care clinicians (Justice Health and Forensic Mental Health Network, 2020b). Feedback from people in prisons highlighted their contentment with the ability of the telehealth model to better manage and follow up anxiety and depression.



TELEHEALTH CONSULTATION

between 2019 and 2020

INCREASED
62%



COVID-19 INFECTIONS

Up to December 2020

ONLY 1
INFECTION

As of 16 December 2020, only one COVID-19 infection had been confirmed in NSW prisons, representing 77 COVID-19 infections per million people living in prisons, compared to 539 COVID-19 infections per million in the community. No COVID-19-related death had been reported among people living in prisons, whereas seven COVID-19-related deaths per million were reported in the community.

Increased use of teleconferencing at the Network and across NSW Health further supported clinical multidisciplinary teamwork and multiagency collaboration. The Network was able to continue to work effectively with stakeholders across the state despite the pandemic. Recent projects included policy to improve support for oncology and palliative care patients in prisons and for transgender and gender-diverse people living in prisons.

4.4.4 Sustainability of the good practice

Development of telehealth services is sustainable and expandable. Increased telehealth provision, particularly in primary care, is highlighted as one of the positive new practices emerging from the COVID-19 pandemic. Telehealth has resolved some access problems related to a relatively low number of medical staff supporting many Network health centres across the large landmass of NSW. Successful implementation of telehealth services across the Network can provide effective long-term changes to models of care, particularly given the long travel distances within NSW. While there will always be a need for face-to-face care and to examine patients in person, telehealth can be an effective mode of care to see many patients when supported by an onsite clinical nurse. It can be particularly useful for initial triage of patients. Essential observations and examinations are documented by the nurse locally in the electronic record and reported to the doctor during the consultation. Further telehealth services with hospital specialists are being planned. Hospital telehealth clinics for people who live in prisons could greatly improve access to specialist advice for patients across the state, while reducing the need for time-consuming, costly and complicated security transfers to hospitals. Avoiding the significant travel times between rural prisons and Sydney is also beneficial for patients by reducing the stress of moving between prisons unless clinically necessary.

The Network is implementing an electronic prescribing system in 2021 that will further support remote medical care for people living in NSW prisons. The electronic prescribing system will support improved medication management and quality use of medicines for the prison population.



4.5 Italy: prevention and risk mitigation measures in Italian prisons

Submitted by: Roberto Monarca, Health Unit, Maximum Security Prison Viterbo, and Lara Tavoschi, University of Pisa, Italy



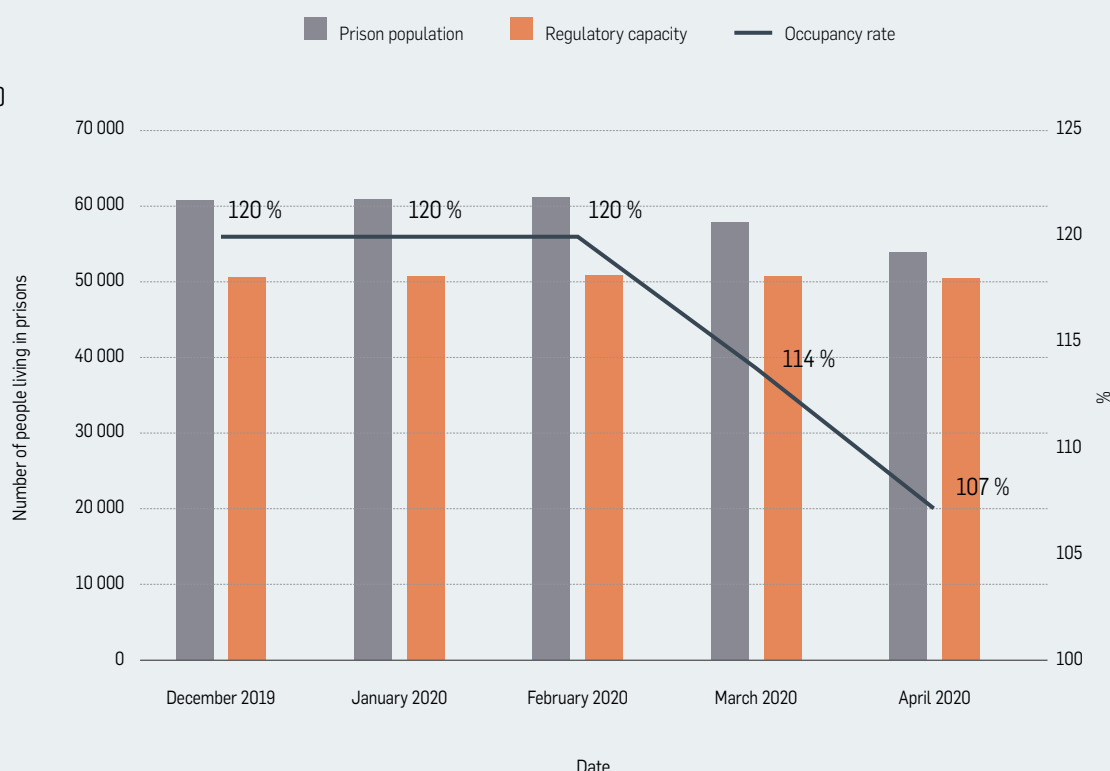
4.5.1 Background and context

Since 2008, health care in prisons has been managed by the National Health Service through its regional health authorities to guarantee equity between health care provided to people living in prisons and the community. In 2018 a new penitentiary law was issued to reform the Italian prison system, with a focus on health-care access, improving quality of health care provided in prison, reintegration and education services. Italian prisons, however, are often faced with several health-care-related challenges, such as staff shortages and unavailability of state-of-the-art preventive, diagnostic and treatment capabilities.

From the beginning of the COVID-19 pandemic, Italy experienced a high incidence rate, with northern regions, particularly Lombardy, Veneto, Piemonte and Emilia-Romagna, at the epicentre of the epidemic in the country.

Prisons were settings of higher risk for COVID-19 infections, as confined conditions, exacerbated by overcrowding, are among the biggest challenges for controlling infection spread.

FIG. 7. OCCUPANCY RATES
IN ITALIAN PRISONS,
DECEMBER 2019–APRIL 2020



Source: Ministry of Justice of Italy (2021)

On 29 February 2020, at the beginning of the pandemic, Italy had a prison population of 61 230, representing an occupancy rate of 120%. The Italian government moved fast to authorize judges to release people living in prisons who had less than 18 months to serve, conditionally under house arrest. This had contributed to a steep decrease in prison overcrowding by the end of April 2020, with an occupancy rate of 107%, as the number of people in prisons decreased to 53 904 (Fig. 7).

4.5.2 Description of the good practice

In the early stages of the COVID-19 pandemic, rapid scale-up of IPC measures was implemented in close coordination with relevant health authorities. Triage and syndromic screening were set up for all individuals entering prison premises, including staff, visitors and incoming new entrants. Dedicated areas for screening were identified, and in 77% of prisons (151/197) temporary structures were put in place. Collection of biological samples and testing were ensured as per standard community protocols. Areas for preventive isolation were designated for contacts of cases to be quarantined, while areas for medical isolation were designated for suspected and confirmed cases and provided with adequate protective measures to minimize the within-prison transmission risk and manage mild cases. Areas included dedicated wings, single detention rooms and a COVID-19 prison hub. Severe cases were transferred to tertiary hospitals. The Civil Protection Agency also contributed to ensuring that the prison system was ready for the response against COVID-19 by setting up external triage areas and by providing PPE. This was particularly useful in the early

stage of the national emergency. Despite all efforts, however, availability of diagnostics and coverage of testing was largely suboptimal in the initial period. This gap was relevant for custodial staff, as most of those filling in sick leave requests in February and March 2020 went largely undiagnosed.

The Ministry of Justice issued several organizational recommendations and imposed stringent limits on admission to prison premises in early March 2020. Access was restricted to essential staff and visitors were banned from entering prisons (Ministry of Justice of Italy, 2020). These measures were deemed necessary to minimize COVID-19 introduction risks and were swiftly implemented.

Several mitigation measures were put in place by the Ministry of Justice, in collaboration with regional health authorities responsible for provision of health care in prisons, to prevent and detect cases of COVID-19 behind bars. The measures were stated in a circular, *Operational indications for the prevention of coronavirus infection in prisons*, and included detailed recommendations that were implemented across the country:

- for new entrants, either from the community or from other prisons, each prison created a separate area or room to allow for initial examination by the prison physician, appropriately equipped with PPE;
- a sanitary isolation cell was arranged in a special section already identified by prison management for any individual in prison identified as a suspected case;
- an adequate number of disinfectant dispensers were installed and PPE was made available for all staff handling people in isolation;
- people living in prisons were put into medical isolation once they had reported symptoms and signs of COVID-19, as indicated by the prison physician (according to national guidelines, the physician might choose to test an individual in prison for COVID-19 and act accordingly: if the individual tested positive, the physician and prison management made the decision either to keep them in isolation within the prison or transfer them to hospital; if the individual tested negative, they were kept in isolation until the physician had cleared them to go back to their cell after the quarantine period was over); and
- transfers of people living in prisons from and to the most affected regions in Italy were suspended, except for urgent health or security reasons and after all health precautions, including testing of the individual prior to transfer, had been taken.

The introduction of measures as an alternative to incarceration were effective in decreasing the level of overcrowding, although occupancy remained above prisons' operational capacities. The measures nevertheless contributed to reducing cell occupancy rates and made additional space available for medical isolation.

COVID-19 spread within the prison system was monitored constantly by the Ministry of Justice, with data on the number of suspected, probable and confirmed cases among prison staff and people living in prisons collected regularly, alongside data on the number of samples tested. The data were not made public for security reasons.

4.5.3 Outcome of the good practice

The prison system in Italy was part of the wider national response to the pandemic from the start. The management of health-care services in prison by regional health authorities ensured that adequate and rapid responses were set up in prison institutions, while the Ministry of Justice was timely in issuing guidance and enforcing actions to reduce the spread of the pandemic into prisons and to mitigate overcrowding.

Available data at this stage suggest that the introduction of IPC measures had a positive impact on the spread of COVID-19 into and within the Italian prison system. As of 22 April 2020, in Lombardy, one of the hardest-hit regions, 19 COVID-19 infections had been reported among people in prisons, representing 2591 infections per million; and in Emilia-Romagna, another very badly affected region, 14 COVID-19 infections had been reported among people in prisons, representing 4551 infections per million. These levels were much lower than those observed in the general community, with 6838 infections per million in Lombardy and 5246 in Emilia-Romagna. Only one COVID-19-related death was reported in the two regions among people living in prisons. A complete assessment of the impact will be possible only at the end of the emergency, when data collected by the Ministry of Justice are made available (Tavoschi et al., 2020).



COVID-19 INFECTIONS

Up to April 2020, Lombardy

0.26%

IN PRISONS

0.68%

IN THE COMMUNITY

While COVID-19 cases in prison were unavoidable, heightened attention, along with stringent and comprehensive measures, had to be sustained as countrywide lockdown measures were gradually relaxed and virus circulation increased. The COVID-19 pandemic emphasizes the principle that prison health is public health and is needed to protect the well-being of people in prison, uphold equity, and avoid serious organizational, security and safety dangers resulting from outbreaks occurring in this setting.

4.5.4 Sustainability of the good practice

The COVID-19 response in Italian prisons was timely and integrated into the wider national prevention and control measures adopted. Health and justice institutions in Italy share responsibility for the prison health system, and this set-up proved successful in this emergency situation.

The pandemic response intensified communication between health and justice institutions and tightened collaboration. A degree of heterogeneity was, however, observed, largely related to decentralization (at regional level) of health-care services in Italy. A stronger role for national health institutions might be needed in the future, not only to ensure standard levels of service provision in emergency situations across the country, but also to monitor quality of care and burden of disease in prison settings, possibly integrating epidemiological surveillance within broader national efforts.



4.6 Republic of Moldova: collaborative approach to preventive measures in prisons during the COVID-19 pandemic

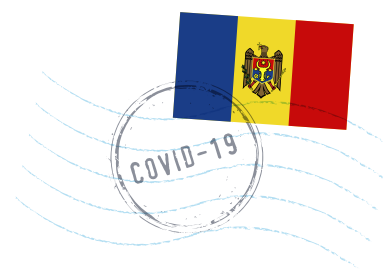
Submitted by: Vlad Busmachi, Institutional Management Directorate, National Administration of Penitentiaries, Ministry of Justice, Republic of Moldova

4.6.1 Background and context

The prison system of the Republic of Moldova is a re-education institution in which the state ensures observance of human rights and implementation of national and international laws. The specific role of prisons is to enforce custodial measures and sentences in such a way as to increase public safety and prevent recidivism.

Currently, the prison system consists of the National Administration of Penitentiaries; 17 prisons, including one female and one juvenile prison; and specialized institutions, such as the training centre and a special intervention unit named "Pantera".

As of 1 June 2020, there were 6597 people living in the prison institutions, of which 5523 were sentenced individuals and 1074 were in pretrial detention. Among all people living in prisons (n = 6597), there were 396 born females and 65 juveniles. Both the women's penitentiary and the prison hospital have specialized units for mothers and children.



PRISON POPULATION

Up to June 2020

6597
TOTAL

396
BORN FEMALES

65
JUVENILES

In response to the COVID-19 pandemic and to limit its spread, the Republic of Moldova declared a national state of emergency from 17 March to 15 May 2020.

4.6.2 Description of the good practice

As part of the national state of emergency, the prison system of the Republic of Moldova implemented several emergency measures to prevent introduction of the pandemic behind bars. These measures involved reducing certain rights and were aimed at protecting people living in prisons from COVID-19; these limitations were replaced with other benefits where possible. The measures included:

- implementing quarantine standard operating procedures in all penitentiary institutions;
- halting all prison activities, court proceedings and individual transfers except for those within medical institutions in emergency cases;
- conducting risk assessments by screening for signs and symptoms, including temperature measurement, for all people entering the penitentiaries;
- ensuring that people living in prisons wore face masks when they left their cells and that staff wore face masks when dealing directly with people living in prisons;
- ensuring use of disinfectants at the entrance to penitentiaries;
- developing contingency action plans tailored to each prison for approval from the headquarters of the National Administration of Penitentiaries;
- suspending hearings at the headquarters of the National Administration of Penitentiaries and subordinate institutions;
- maintaining contact for people in prisons with the outside world by replacing physical meetings with videoconferencing systems and software platforms accepted by the penitentiary institution, and doubling the frequency of access to telephone calls for each person living in prison;
- creating a systematic approach to information dissemination among people in prisons regarding the COVID-19 pandemic, associated risks, vulnerable groups and the preventive behaviour necessary to limit infection;
- using teleconferencing in judicial communications instead of requiring the physical presence of people deprived of their liberty, allowing compliance with physical distancing and limiting direct interactions between people; and
- supplying people in prisons and prison staff with the necessary consumables and PPE, including masks, gloves, disinfectant and quartz lamps (the consumables and PPE were centrally procured, then distributed to prisons, and the Administration of Penitentiaries also received in-kind donations from development partners).

Management of COVID-19 suspected cases among people living in prisons was taken forward according to the guidance provided by the Ministry of Health (Pînzaru, Gherciu & Russu-Deleu, 2020), WHO and the United Nations Office on Drugs and Crime (UNODC) (UNODC, 2020). After evaluation of the measures applied with respect to suspected cases by a Ministry of Health and National Agency of Public Health joint committee, recommendations were made on the designation of a centre located at the penitentiary hospital for isolation of COVID-19 confirmed cases. In addition, the recommendations suggested that asymptomatic and mild cases of COVID-19 should be treated in the penitentiary hospital, while more severe forms would be treated in national health service hospitals.

On 13 May 2020, UNODC, WHO, the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Office of the United Nations High Commissioner for Human Rights (OHCHR) published a joint statement on COVID-19 in prisons and other closed settings that stated

that overcrowding in detention facilities was an insurmountable obstacle to preventing, controlling or responding to the pandemic (UNODC et al., 2020). This statement suggested that addressing overcrowding in a quick and firm way was essential to reducing the risk of spread of COVID-19 in prisons and other places of detention.

In response to the statement, the National Administration of Penitentiaries initiated a procedure for drafting an amnesty law to depopulate the penitentiary institutions in the context of the COVID-19 pandemic, by launching an appeal to the Prosecutor General to examine the applicability of preventive measures and noncustodial sentences, including temporary or early release from detention, amnesty, pardon, house arrest, commutation of sentences, suspension of prosecution and postponement of sentences.

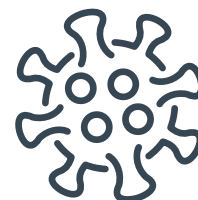
4.6.3 Outcome of the good practice

As of 1 June 2020, two suspected COVID-19 cases had been isolated among people living in prisons, although both tested negative for COVID-19. One confirmed COVID-19 case – a person wearing an electronic monitoring bracelet – was reported and treated at a public hospital. There were no confirmed COVID-19 infections among people living in prisons reported in all institutions under the Administration of Penitentiaries. This showed that the measures implemented were effective in keeping the pandemic from spreading behind bars, especially when considering the 8251 infections reported in the general community during the same timeframe.

4.6.4 Sustainability of the good practice

The National Administration of Penitentiaries mainstreamed the distribution of PPE and disinfectants to all prison institutions into its standard procedures to guarantee the sustainability of the measures that had been implemented. Maintaining these measures, even after the COVID-19 pandemic, will limit the spread of other communicable diseases. In addition, as an activity within the Prevention of COVID-19 in Penitentiaries Project, 120 staff members were trained with the support of the Institute of Criminal Reforms, the Dignity Institute and the Swedish Embassy in the Republic of Moldova.

Top management of the National Administration of Penitentiaries joined a national fundraising campaign to combat COVID-19. The campaign was launched by the Government of the Republic of Moldova by having all government employees donate one day's salary to the cause. The campaign was supported by national donors, including the Promo-LEX Association,⁹ Rusca (a state enterprise) and Memoria, a rehabilitation centre for torture victims.¹⁰ Contributors to the campaign mobilized and donated disposable sanitary masks and antiseptic and disinfectant products. This collaborative approach between the government and civil society organizations guaranteed the sustainability of resources needed to address COVID-19 inside prisons. The national response to COVID-19 in prisons was also technically supported by the UNODC country office in the Republic of Moldova, the United Nations Committee Against Torture and the European Council for the Prevention of Torture. The budget of the Administration of Penitentiaries was revised to meet prison needs to combat COVID-19.



COVID-19
INFECTIONS

Up to June 2020

NO CONFIRMED
INFECTIONS

⁹ The Promo-LEX Association is an NGO that aims to develop democracy in the Republic of Moldova by promoting and defending human rights, monitoring democratic processes and strengthening civil society.

¹⁰ Memoria is a nonprofit, apolitical and independent institution in the Republic of Moldova, providing comprehensive rehabilitation for victims of torture and inhuman and/or degrading treatment in the country.

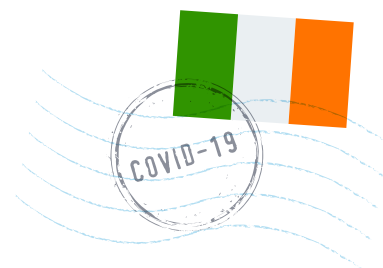


5. Training and education



5.1 Ireland: training and education support for COVID-19 preparedness

Submitted by: John Devlin, Emmett Conroy, Liam Phillips, Elaine Dunne, Philip Kennedy, Padraig Carty, Tom Malone, Mark Farrelly and Darren McDonnell, Irish Prison Service, Ireland



5.1.1 Background and context

The Irish Prison Service (IPS) is responsible for the safe and secure custody of persons sentenced to prison, held on remand or held on immigration matters in Ireland. Its vision is to provide a safer community through excellence in a prison service built on respect for human dignity.

The Irish prison system comprises 12 institutions: 10 closed institutions, two of which cater for both females and males and one of which is exclusively female; and two open centres that operate with minimal internal and perimeter security.

As of 31 August 2020, the total number of people living in prisons was 3687, which is significantly less than the figure of 4068 in the second half of 2019 (Table 5).



PRISON POPULATION

2019
4068

2020
3687

TABLE 5. TOTAL NUMBER OF PEOPLE LIVING IN PRISONS IN IRELAND, 31 AUGUST 2020, BY GENDER

Category	Number	Capacity	Operational capacity used (%)
Born male	3553	4201	84.6
Born female	134	174	77.0

The IPS is responsible for providing opportunities for people living in prisons to engage in a meaningful way to reduce the likelihood of their reoffending and for assisting them to reintegrate into their communities. Health-care services are focused on primary care, but there is provision for in-reach forensic mental health services and access to specialist medical services as required. Monitoring of the IPS occurs at several levels, including through the Committee for the Prevention of Torture, the Inspector of Prisons and the Irish Penal Reform Trust.

5.1.2 Description of the good practice

It was recognized that prisons were a vulnerable setting during the current COVID-19 crisis, with the potential for outbreaks that could overwhelm health-care capacity both inside and outside prisons. Accordingly, the IPS established several measures to reduce the risk of introduction of COVID-19 into prisons, while being mindful of the impact of these measures on the mental and psychological well-being of people living in prisons. The measures included risk assessment of all persons entering prisons, cessation of family visits, making PPE available, shielding all immunosuppressed and elderly people and those living with underlying health conditions,¹¹ isolating suspected cases, quarantining new entrants, and installing video-call facilities for legal aid and family visits.

In addition, the IPS focused on training and educating staff and people living in prisons in the context of COVID-19 through a range of mechanisms.

- In 2017 a comprehensive training and education package on continual professional development (CPD) was devised for all IPS staff. Staff must attend this programme once every two years. After two tuberculosis outbreaks in prisons in 2018, the IPS developed a comprehensive infection control module for inclusion in the CPD delivered in all prisons. Following the emergence of COVID-19, a specific module that incorporated use and removal of PPE and provided staff with an understanding of COVID-19 was designed and delivered to all staff across the IPS.
- The Red Cross Community Based Health (CBH) in Prisons Programme was first introduced to the IPS in 2009. This is a Red Cross initiative that qualifies and empowers people living in prisons to look at the overall health and well-being of the prison as a community, incorporating a whole-prison approach. The CBH enables people living in

¹¹ Shielding involves placing these individuals in temporary isolation to reduce their likelihood of contracting the virus.

prisons to become special-status Red Cross volunteers and then peer educators. It is a unique approach that raises overall public health and hygiene awareness in prisons through peer education. The initiative is a collaboration between the IPS, the Education and Training Board, and the Irish Red Cross.

In the context of COVID-19, the Red Cross CBH in Prisons Programme granted people living in prisons access to the developed and tailored comprehensive infection control training and education module mentioned above. The volunteer individuals living in prisons immediately started educating the rest of the prison population through peer education on how COVID-19 can spread and the vulnerability of prison settings. This education incorporated basic infection control interventions such as handwashing and respiratory etiquette and stressed the importance of environmental cleaning of cells, shared facilities and all surfaces across prisons. Information was shared on the unique nature of the prison setting and how it lends itself to the transmission of pathogens. The role of peer-to-peer educators encouraged people living in prisons to willingly embrace the regime change caused by COVID-19, realizing that it was for their own safety and benefit. The programme was key to securing buy-in from people living in prisons of all levels.

- Another key initiative that proved invaluable was the contact-tracing model devised in collaboration with the Quality Improvement Team of the Irish Health Service (Health Service Executive). The key difference between contact-tracing in the public health model and the IPS model concerned the onset of contact-tracing. In prisons, the onset was immediate (within the prison) on identification of symptoms. As it could take several days for a test result to be returned (2–6 days), contacts of probable cases were immediately quarantined. This collaboration was uniquely tailored to the IPS. A train-the-trainer programme was devised through the Irish Prison Service College to train staff on contact-tracing procedures, using tutors and health-care staff from the college.¹² This information was then disseminated to each prison, ensuring that there was a contact-tracing team available seven days a week in each institution.

The IPS also utilized several mechanisms for risk communication. The most up-to-date COVID-19-relevant information was disseminated to people living in prisons and staff through different communication platforms. These platforms included audiovisual, newsletter, email and posters, with special emphasis on handwashing technique, cough etiquette, physical distancing and measures to take when feeling unwell. For prison staff, risk communication included a do-not-attend policy if there were any symptoms of COVID-19 or if a staff member developed symptoms while on duty, and a policy of mask-wearing and leaving immediately was implemented. These policies were communicated and emphasized using the IPS information platform (IRIS), emails and audiovisuals.

The IPS also shielded vulnerable groups living in prisons, such as those with chronic medical conditions and/or immunosuppressed people, in response to COVID-19. After vulnerable

¹² The Irish Prison Service College is an IPS support unit responsible for the planning, coordination, design, delivery, evaluation and recording of all learning and development activities for the organization's staff.

individuals had been identified, they were housed in one area of the prison where there was a clear understanding of the key messages on how to combat COVID-19. Filtering facepiece 2 (FFP2) masks were made available for this group, and they were instructed on their proper use and disposal.



COVID-19 INFECTIONS

Up to October 2020

0.11%

IN PRISONS

1.01%

IN THE COMMUNITY

5.1.3 Outcome of the good practice

As of 19 October 2020, there were four reported COVID-19 infections among people living in all Irish prisons; this represented 1088 infections per million, much lower than the 10 118 infections per million observed in the general community in the same timeframe. The four individuals were identified as community-acquired cases who were diagnosed while they were in the 14-day quarantine period upon arrival in prison. All people living in prisons were tested on the sixth day of their quarantine period. Without these control measures in place, these asymptomatic people living in prisons might have caused an outbreak within the prison. This shows the value of ongoing peer education and continuous communication of control measures in ensuring compliance among the prison population. The measures implemented enabled both staff and people living in prisons to come together with one main objective: managing the COVID-19 pandemic effectively.

5.1.4 Sustainability of the good practice

The measures outlined above are considered complementary and in accord with public health principles of prevention and early detection of COVID-19 infections. The collaborative approach to training and education with the Irish Red Cross and the Irish Health Service has potential for further development and sustainability.

The absence of COVID-19 outbreaks reduced reliance on restricted regimes and meant that fewer periods of isolation for people living in prisons were necessary, with the potential for easing of restrictions across prisons when the numbers of community cases allowed. The sustainability of these processes was key to managing COVID-19. The practice of quarantining new entrants showed its worth in identifying the four infections. In sustaining these initiatives, the IPS was confident that it could contain any potential outbreaks that might occur among this vulnerable clientele.

With the country experiencing a second surge in COVID-19, the IPS took the decision on 6 October 2020 to implement the preventive measures again, including stoppage of family visits. With the support of Red Cross volunteers who supported education and information-sharing, it was anticipated that this would lead to a broader understanding of these measures and controls. This would benefit not just people living in prisons, their families and IPS staff, but also the public health of the community, as prison health is public health.



5.2 Spain: educational programme to prevent overdosing and loss of drug tolerance among people using drugs in prisons

Submitted by: Carmen Martínez Aznar, General Secretariat of Penitentiary Institutions, Spain

5.2.1 Background and context

The penitentiary system in Spain is managed by the General Secretariat of Penitentiary Institutions, Ministry of the Interior. As of 5 June 2020, the General Secretariat managed 84 penitentiary centres, including 69 prisons, two penitentiary psychiatric hospitals and 13 social integration centres, with a total prison population of 47 775 (3524 women and 44 251 men).

Data collected through the Spanish Survey on Health and Drug Use among Prisoners for 2016 indicated that three quarters of people living in prisons had used drugs in the month prior to their prison entry (Government Delegation for the National Plan on Drugs, 2016). Accordingly, interventions addressing drug dependence and programmes aimed at preventing and controlling drug supply and demand inside prisons are prioritized in prisons, including harm reduction and overdose prevention programmes.



PRISON POPULATION

June 2020

47 775
TOTAL

44 251
BORN MALES

3524
BORN FEMALES

At the beginning of the COVID-19 pandemic, the General Secretariat implemented several restrictive measures to prevent the spread of infection behind bars. Measures included suspending physical external communications, suspending permissions for transfers of people living in prisons, and suspending visits of family members and external partners. As a result of these measures, decreases in drug use, drug overdoses and overdose-related deaths were observed. The number of overdoses during the first half of 2020 fell by 15.9% compared to the same period in 2019, putting the half-yearly rate at 2.33 per 1000 people living in prisons, adjusted for population in each period. In the same period, there was a 19.9% drop in the number of individuals living in prisons requiring detoxification, a 44.9% drop in syringe exchanges, and a 61.7% drop in the distribution of aluminium foil, which is used to smoke and inhale various drugs. There was also a decrease of 30.2% in health education programmes and an increase of 25.9% in the number of individuals living in prisons enrolled in the overdose prevention programme (n = 276 newly admitted individuals). This clear decrease in consumption resulted in loss of drug tolerance, which could result in erroneous judgement of dose if individuals were to reinitiate drug use.

5.2.2 Description of the good practice

As part of the measures taken to address drug use in prisons during the COVID-19 restrictions, the General Secretariat convened a working group coordinated by the Vice Directorate-General of Penitentiary Health. The group included representatives of doctors and nurses, both those who work centrally in the Vice Directorate-General of Penitentiary Health and those who work in prisons. The group served as a mechanism to monitor the situation regarding drug consumption, proposing ways of dealing with the risks associated with drug use and easing the possible effects of the restrictive measures on people living in prisons who use drugs.

Based on the concern over loss of tolerance, the working group initiated a multidisciplinary programme aimed at increasing the self-awareness of people living in prisons of the risks of restarting drug use. The programme included interventions aimed at all people living in prisons and delivered by penitentiary health professionals, security staff, treatment departments and civil society NGOs that work in prisons.

The programme was launched on 28 May 2020 and implemented in all 84 Spanish penitentiary institutions, including women's prisons. The main objectives of the programme were to raise awareness among people living in prisons and their families of harmful practices and loss of tolerance to drug use, to provide technical support to health-care and other professionals, and to open up multidimensional discussion and collaboration among health, security and NGO professionals.

To raise awareness among people living in prisons and their families, several interventions were carried out by prison professionals in the areas of health and security and NGO partners working in prisons. Interventions were planned in two phases: a first phase during de-escalation of the restrictive measures applied amid COVID-19; and a second phase during the period of normalization.

- **Health promotion.** The campaign began with developing and disseminating educational posters and other means of communication. In addition, people living in prisons were provided with brief health education sessions by prison health staff, supported by dissemination of information and educational flyers and stickers. The health education sessions and supporting information and educational materials thanked them for their positive attitude during the application of COVID-19 restrictive measures and raised awareness of the risks associated with loss of drug tolerance in the event of restarting use of unprescribed drugs (**Fig. 8**).
- **Treatment.** Informative workshops were conducted to acquaint people living in prisons with available treatment resources and relapse-prevention interventions and to motivate them to make use of them. In addition, work was taken forward with the families of people living in prisons and leisure activities were promoted.
- **Security.** Staff participated in disseminating the programme information and educational materials and focused more on controlling drug trafficking in prisons to decrease supply.

The programme was presented through videoconference to all NGOs working in prisons in the context of drug use, addiction and mental illness. The aim for NGO involvement was mainly to work with more at-risk individuals living in prisons and their families, especially those who did not adhere to the programme. Another collaborative working group was set up, including penitentiary staff and NGO professionals, to prepare work with family members and people living in prisons during the period of de-escalation of COVID-19 measures in prisons.



FIG. 8. LEAFLETS MADE AVAILABLE TO PEOPLE LIVING IN SPANISH PRISONS ADDRESSING LOSS OF TOLERANCE TO UNPRESCRIBED DRUGS

Source: reproduced by permission of the Vice Directorate-General of Penitentiary Health of the Spanish General Secretariat of Penitentiary Institutions

FIG. 9. THE ANIMATED HEALTH PROFESSIONAL CHARACTER NAMED GESCO CREATED BY THE WORKING GROUP UNDER THE VICE DIRECTORATE-GENERAL OF PENITENTIARY HEALTH



Source: reproduced by permission of the Vice Directorate-General of Penitentiary Health of the Spanish General Secretariat of Penitentiary Institutions

To provide technical support to health-care and other professionals, the working group under the Vice Directorate-General of Penitentiary Health created an animated health professional character named GESCO and a document as a text search using image-recognition techniques (Fig. 9). The GESCO document included all the information on COVID-19 communicated to prisons from the start of the pandemic in January 2020. It also included all links to the restrictive measures adopted during the pandemic and the de-escalation measures taken by the General Secretariat of Penitentiary Institutions, the Ministry of Health, international institutions such as WHO and scientific societies, and scientific articles related to COVID-19, COVID-19 health information and diagnostic tests, laboratory technical videos, radiological images, treatment schemes and overdose prevention videos.

5.2.3 Outcome of the good practice

The objective of the programme was to take advantage of the restrictive measures applied in prisons during the COVID-19 pandemic to reduce the number of overdosing events and related deaths and to secure an increase in the number of individuals living in prisons enrolled in drug prevention and treatment intervention programmes.

Accordingly, the number of overdoses during the first half of 2020 fell by 15.9% compared to the same period in 2019, putting the half-yearly rate at 2.33 per 1000 people living in prisons, adjusted for population in each period. The same period saw a 19.9% drop in the number of people living in prisons requiring detoxification, a 44.9% drop in syringe exchanges, and a 61.7% drop in the distribution of aluminium foil. There was also a decrease of 30.2% in health education programmes and an increase of 25.9% in the number of people living in prisons included in the overdose prevention programme for the first time (n = 276 new admissions).



NUMBER OF OVERDOSES

during the first half of 2020

DECREASED
15.9%

5.2.4 Sustainability of the good practice

The General Secretariat implemented several strategies to ensure programme sustainability; among these was the decision that the programme implemented by the General Secretariat should involve all professional disciplines and all penitentiary centres. In addition, the programme was integrated as a priority intervention with drug-dependent individuals living in prisons.

The involvement of, and coordination between, the General Secretariat, health promotion staff, treatment staff, security and NGO professionals enhanced the chances of continuity. Sharing the GESCO document on the General Secretariat website ensured ease of retrieval and promoted usage among health prison staff.

6. Risk communication





6.1 Ghana: strategic risk-communication interventions in the management of COVID-19 in the Ghana Prisons Service

Submitted by: Isaac Kofi Egyiri and Lawrence Kofi Acheampong, Ghana Prisons Service, Ghana

6.1.1 Background and context

The Ghana Prisons Service is a security agency under the Ministry of the Interior mandated by the 1992 Constitution of Ghana to provide safe custody, welfare and, when practicable, reformation and rehabilitation. The service is a key stakeholder in achieving overall security and public safety and is an important player in the criminal justice system of Ghana.

With a presence in all regions of Ghana, the prison service is made up of 43 prison establishments, one senior correctional centre, one prison officers' training school and an administrative headquarters in Cantonments, Accra. As of 31 August 2020, the total prison population in Ghana was 15 528, consisting of 1.2% born females and 98.8% born males; of these, 7.2% were foreigners and 0.9% juveniles.

To maintain standards as set forth in SDG 3 ("Ensure healthy lives and promote well-being for all at all ages"), society has a compelling responsibility to ensure that all vulnerable

groups receive good-quality health care and treatment during ill health. Accordingly, the prison service has not only succeeded in establishing a new health directorate but has also registered the Prison Health System under the Ghana Association of Quasi Government Health Institutions, which is one of the agencies under the Ministry of Health.



6.1.2 Description of the good practice

Risk communication is an integral component of public health risk management. It is focused on dialogue with those affected and concerned and strives to ensure communication strategies are evidence-based. After publication of the detailed COVID-19-related hygiene protocol and its implementation in all prisons in the country, the Ghana Prisons Service, seeing the significance of risk communication as an important public health intervention in prisons, formed a rapid response team for COVID-19 with a subcommittee on risk communication. The formation of this subcommittee at the prisons headquarters was complemented by the formation of risk-communication teams in all 43 prisons. All members of the respective teams underwent a train-the-trainer programme delivered by the regional health directorates, with support from their district/municipal health directorate and the Ghana Psychological Association and with sponsorship from the COVID-19 private-sector fund. The teams were made up of health professionals, psychologists, communication experts, chaplains and the operational officers in charge of the various prisons. The teams were to spearhead the effective dissemination of preventive, security and safety information in the context of COVID-19 to reduce the already heightened tensions posed by the pandemic. The information disseminated comprised three themes:

- medical aetiology, transmission, prevention and disease surveillance system in prisons
- information risk assessment and dissemination in prisons
- psychosocial and stigma reduction among officers, people living in prisons and relevant prison stakeholders.

After formation of the risk-communication teams in the various prisons, the risk-communication subcommittee of the rapid response team performed virtual onsite monitoring visits and provided practical training on case management approaches at selected volatile prisons based on a risk assessment.

The risk-communication teams initially met with various leaders representing people living in prisons and discussed their concerns and level of apprehension with respect to the pandemic. Subsequently, the teams were tasked to train these leaders. This leadership training was a pivotal strategy to promote COVID-19 information, including handwashing techniques, respiratory etiquette and physical distancing, among people living in prisons. The consistent promotion of evidence-based measures applied in prisons by the trained leadership to people living in prisons was complementary to the training activities delivered by the local risk-communication teams. This was to ensure peer-to-peer evidence-based information sharing.

PRISON POPULATION

August 2020

15 528

TOTAL

98.8%

BORN MALES

1.20%

BORN FEMALES

7.20%

FOREIGNERS

0.90%

JUVENILES



COVID-19 INFECTIONS

Up to August 2020

0.10%

IN PRISONS

0.15%

IN THE COMMUNITY

The risk-communication strategy was implemented in all seven female prisons, all male prisons and the juvenile detention centre. Special attention was given to COVID-19-vulnerable groups, including older people living in prisons (aged 55 and over), people living with immunocompromising conditions such as diabetes mellitus and hypertension, and people living with disability. Vulnerable groups were given supplementary rations when practicable and were prioritized whenever medical face masks were distributed. The Prisons Service tailoring shops sewed nonmedical face masks for each person living in prisons in Ghana.

6.1.3 Outcome of the good practice

This intervention heightened the culture of hygiene in all prisons in Ghana and gave all health professionals and prison staff and their dependants the opportunity to learn and enhance their knowledge of infectious disease prevention in public health emergencies. The pragmatic nature of the policies put in place meant that outbreaks of the virus were prevented in all prisons in the country. As of August 2020, the Ghana Prisons Service had recorded 15 COVID-19 infections among new entrants to prisons; these people were quarantined and treated, and all recovered. This represented a rate of 966 infections per million, which was less than the 1453 infections per million found in the outside community. No older people living in prisons tested positive for COVID-19.

6.1.4 Sustainability of the good practice

Promoting prison health is seen as helping to build a healthier society. This important contribution reduced health inequalities and aided the successful resettlement of people living in prisons after their release, as it allowed them to gain knowledge and skills related to COVID-19.

The risk-communication teams at the various prisons will continue to embark on various education and risk assessments for all communicable diseases and help with dissemination of evidence-based information on prison-associated conditions to ameliorate any disease outbreaks. The teams will send quarterly reports to the rapid response team at headquarters to support sustainable policy initiatives and a weekly checklist for all protocols to ensure monitoring and evaluation. This has also been added to the monthly report submitted to headquarters.

Risk communication was an important intervention in prisons' public health crisis management that ameliorated any negative impact this pandemic could have created. As well as this major intervention and the preventive protocols that were introduced, other complementary strategic policies were also implemented, such as granting amnesty to over 1600 people living in prisons, facilitation of the noncustodial sentencing bill in parliament, implementation of robust preparedness and contingency plans to prevent and manage cases, and enhanced contact-tracing and case-management protocols.



6.2 Switzerland: risk communication at Champ-Dollon Prison

Submitted by: Hans Wolff, Komal Chacowry, Stéphanie Baggio, Anne-Claire Bréchet and Laurent Gétaz, Division of Prison Health, Geneva University Hospitals and University of Geneva, and Martin Von Mural, Champ-Dollon Prison, Geneva, Switzerland



6.2.1 Background and context

As a federal state consisting of 26 separate cantons, Switzerland has 26 different systems of health-care provision in prisons. There are more than 100 prisons across all the cantons, with an overall capacity of 7390 places. The capacity varies widely from prison to prison, with the largest able to host 398 people and the smallest only 10. In May 2020, the prison occupancy level across Switzerland was 93.5%, with 6906 people living in prisons.

Prison health in Switzerland faces several challenges, the main ones being the different prison systems in place across the 26 cantons, scarce resources, overcrowding and lack of qualified health-care providers. Opened in 1977, Champ-Dollon Prison in the Geneva canton is the largest prison, with an operational capacity of 398 places. It has suffered from overcrowding over the past 10 years.



**PRISON
POPULATION**

May 2020

6906

TOTAL

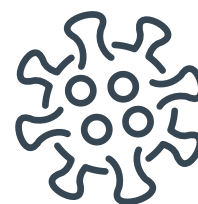
6.2.2 Description of the good practice

Several preventive measures were applied to limit and control COVID-19 introduction in prisons, including the following initiatives.

- A special area of Champ-Dollon Prison was reserved for all new entrants to undergo 14 days of quarantine.
- Everyone entering the prison, including prison staff each time they re-entered the prison, visitors, lawyers and people living in prisons when they were outside their cells, was obliged to wear a protective face mask and undergo a temperature check.
- The prison conducted an intensive COVID-19 risk-communication education programme that targeted people living in prisons and staff. The programme was implemented in a very informal way across the corridors of each prison floor, consisting of two sessions and targeting all individuals and staff located on that floor. Each session was conducted by a physician and a nurse and was attended by 10–15 participants. Fifty such sessions were conducted in the prison. The topics that were covered included symptoms and complications of COVID-19, modes of transmission, the current epidemiological situation in the outside community and in the prison, and how to protect oneself by adopting the requisite handwashing technique and applying physical distancing of at least 1 metre. At the end of each session, people living in prisons were encouraged to report any symptom for clinical evaluation and, if necessary, to have a nasopharyngeal swab. All questions raised were addressed by the instructors. Question-and-answer sessions made it possible to observe how people in prisons felt about the restrictive measures. Overall, they were found to acknowledge that constraints were necessary and to accept the measures implemented.
- Posters in French and English, which had been developed by the cantonal health authorities and addressed basic protective measures, were displayed on each prison floor, targeting both people living in prisons and staff.
- Cleaning of all surfaces and door handles was conducted several times per day.
- In total, 8.5% (54/634) of people living in prisons were identified as vulnerable, meaning that they had chronic diseases and/or were aged 60 or over and hence were at high risk of complications from COVID-19; they were informed individually by their doctor about risks related to COVID-19 and necessary protective measures. Those with COVID-19 vulnerabilities were placed in single cells, sent to less overcrowded prisons or released. Those transferred to other prisons or released accounted for 30% of people in prison with a health vulnerability identified.
- Routine nasal smear screening of all symptomatic people living in prisons and prison staff was conducted. Medical staff continued to test all those who had suspected symptoms, not only those at risk or presenting with serious manifestations.
- When the first case was identified among people living in prisons in March 2020, a video recorded by the prison director and a medical doctor informing all people about the situation was broadcast on the internal television channel. The situation status and reminders of health recommendations were provided in French, English and Spanish.
- Workshops were closed, but individual sports activities and visits were maintained, following installation of plexiglass screens. Compensatory measures were taken, with twice as many telephone calls permitted and consultation with lawyers carried out via

voice over internet protocol (VoIP). Free-of-charge telephone calls during this period of restrictions helped to alleviate stress experienced by people living in prisons.

- To mitigate and anticipate the deleterious impact of restrictive measures on the mental health and psychological well-being of people living in prisons, access to consultations with psychiatrists was granted to those who needed it, including at night and over weekends.



6.2.3 Outcome of the good practice

On 21 March 2020 the first confirmed case of COVID-19 infection was reported in the prison. The individual concerned had been transferred from the Frambois Prison at the time of its closure and was probably infected there by a prison officer. At that time, Champ-Dollon Prison received five people from Frambois Prison. Each was placed separately in quarantine and all precautionary measures were taken during the transfer. Two of the five contact individuals tested positive and were then followed clinically by members of the medical staff on a daily basis. In addition to the two initial contacts, one person living in prison developed influenza signs and tested positive for COVID-19 in April. He was placed in medical isolation and recovered without complications. No secondary cases were detected despite testing of all people with influenza signs. In August 2020 an outbreak occurred that was linked to two people living in prison who were positive and working in the kitchen. A total of 120 identified contacts living in prisons were quarantined and clinically monitored. Samples were collected and tested for all contacts. Of these, four tested positive for COVID-19, including two asymptomatic individuals.

From March to September 2020, 285 nasopharyngeal smears were screened, 165 (57.9%) of which were collected from people with symptoms suggestive of COVID-19 and 120 (42.1%) from people who had been in contact with confirmed cases during the outbreak in August. Seven cases tested positive among the 285 tested individuals.

The measures that were applied controlled the spread of the pandemic inside the prison. Cooperation and communication channels between the prison government and health-care services were reviewed and improved.

By the end of May 2020, six COVID-19 infections among people living in prisons had been reported at national level; this represents a rate of 869 infections per million. In addition, 40 COVID-19 infections among prison staff (out of 3000) were reported, none of whom needed hospital care. This is considered significantly lower than the incidence rate of 3609 infections per million observed in the general population in the same timeframe.

6.2.4 Sustainability of the good practice

Management of epidemics in prison settings was assessed and subsequently improved in such a way that risk communication remains an integral part of preparedness and response for a potential COVID-19 resurgence or another epidemic. Medical screening standard procedures were also updated and improved.

Communication channels via VoIP applications were implemented and highly appreciated by all partners. Cooperation and communication between all stakeholders were also improved.

COVID-19 INFECTIONS

Up to May 2020

0.09%

IN PRISONS

0.36%

IN THE COMMUNITY

A large, stylized number '7' in a light orange color, positioned on the left side of the slide. It has a thick, blocky appearance with a slight shadow effect.

7. Prevention measures



7.1 Canada: infection prevention and control assessments at all Correctional Service of Canada sites



Submitted by: Kristina Ma, Olivia Varsaneux, Joel Collard, and Madison Van Dalen, Correctional Service of Canada

7.1.1 Background and context

For information on the background and context relevant to this good practice, see section 4.1.1 above.

7.1.2 Description of the good practice

There was early recognition by the CSC that the closed setting of the correctional environment, similar to long-term care homes and cruise ships, presented challenges for containing COVID-19 once introduced into the environment. This recognition highlighted the important role that robust IPC measures play in the prevention and containment of COVID-19. To strengthen existing IPC policies and practices in response to the pandemic, the CSC sought

support from external experts in public health and IPC. This led to the establishment of IPC and environmental and occupational health (EOH) assessments for all CSC sites to identify areas where IPC and EOH practices could be strengthened, as well as areas where improvement and support, or training and mentorship, were needed.

To address this need, the CSC worked closely with the Public Health Agency of Canada (PHAC), local public health departments, the Canadian Red Cross and community experts to conduct IPC assessments at all 43 institutions (spread across 39 locations or sites) and, where feasible, additional EOH assessments. Institutions were graded according to the level of risk; institutions with an outbreak and those located where surrounding communities had a high prevalence of COVID-19 cases were prioritized.

The CSC worked closely with the PHAC to develop a self-assessment tool related to IPC standards and practices to help individual sites identify strengths and limitations in the existing measures being taken to prevent and control COVID-19. The tool is divided into two parts: Part A is an institutional profile to collect basic information about the institution to establish an understanding of each environment; and Part B is the self-assessment tool, which assists institutions in reviewing site-specific policies, procedures and practices in relation to IPC and COVID-19 in the federal correctional context. Part B includes assessments around administrative control measures, engineering control measures, COVID-19-specific recommendations, and surveillance and outbreak management. External IPC experts used this self-assessment tool and their on-site assessments to understand how the CSC's IPC policies were being implemented at site level to identify areas where the CSC could strengthen IPC practice and provide more support or resources.

7.1.3 Outcome of the good practice

An important outcome of the implementation of IPC assessments was that it allowed the CSC to harness the IPC and EOH expertise of the PHAC and other community experts. This helped the CSC to strengthen existing IPC policies and procedures and to build internal IPC capacity for the future. The IPC and EOH assessments made it possible to better understand existing practices at individual sites to identify site-specific needs and areas for improvement, and the policies that needed to be developed at regional and national levels to support and strengthen IPC across the country. In conjunction with these assessments, all CSC IPC policies were reviewed by the PHAC, to ensure that they were consistent with the PHAC's IPC guidance and recommendations and all available evidence on COVID-19.

7.1.4 Sustainability of the good practice

These assessments have contributed to several long-term changes for the CSC. The auditing process identified the need to develop enhanced IPC capacity internally; as such, the CSC is in the planning stage of developing IPC committees at regional and national levels, as well as IPC team leads at each site. There is strong interest in the organization in supporting IPC

team leads to undertake IPC-specific training through accredited training programmes. The IPC committees will be chaired jointly by health services and operations staff to facilitate mutual commitment to excellence in IPC. The audits identified the need for environmental management plans specific to each institution – these will be developed in collaboration with IPC and EOH experts and reviewed at routine intervals. The CSC also intends to maintain strong relationships with PHAC and community experts to continue routine auditing by external experts as standard practice.

7.2 Canada: robust contact-tracing

Submitted by: Olivia Varsaneux, Kristina Ma, and Madison Van Dalen, Correctional Service of Canada



7.2.1 Background and context

For information on the background and context relevant to this good practice, see section 4.1.1 above.

7.2.2 Description of the good practice

In the closed environment of a correctional setting, COVID-19 was likely to be introduced via the community. With the temporary suspension of visitors and programmes due to COVID-19, prison staff were an important potential source of introduction and spread of the virus. To promote the health and safety of people living in prisons and employees, it was imperative to monitor the health status, travel history and exposure criteria of all staff members as a method of source control to prevent COVID-19 from entering the sites.

In most local public health authorities, contact-tracing commenced upon receipt of a positive COVID-19 test result. The CSC recognized the risks of COVID-19 introduction and transmission if a staff member came into close contact with a case and entered an institution for work while potentially being an asymptomatic or presymptomatic carrier of the virus. Given that transmission could occur rapidly among staff working closely together (assigned to the same posts, eating lunch together) and that viral transmission would be difficult to contain in closed environments, the CSC initiated a non-test-based approach for contact-tracing beginning 48 hours prior to onset of symptoms (or, if an asymptomatic positive case, beginning on the day of the test). This allowed the organization to be proactive in blocking entry of any symptomatic staff member, as well as any contact of that staff member, into CSC sites and thereby reducing the introduction of COVID-19 within the sites.

Once a new case or symptomatic individual was identified among CSC staff, contact-tracing began immediately. Time was of the essence, as it was necessary to identify contacts prior to their next shift to prevent any potential transmitter from entering the institution. On average, a tracing event took 3–4 hours from receipt of the potential contact list to completion of the tracing. It is important to note that the CSC contact-traced only the workplace contacts

of staff (such as people living in prisons and other staff) – it did not trace family contacts or contacts outside the workplace. The CSC also undertook a contact-tracing exercise for cases among people living in prisons.

The main challenge in implementing this contact-tracing practice was the staffing requirement, as COVID-19 continued to spread and more and more contact-tracing was required. The initial team was restricted to five contact-tracers from CSC National Headquarters on 31 March 2020 and grew rapidly into an intricate web of contact-tracers led by the National Contact Tracing Unit lead. Further members of the team included regional contact-tracing leads, contact-tracing event leads, data-quality managers, data-entry clerks and contact-tracers for each region. The CSC developed guidelines and hosted training sessions for all contact-tracers. An online database was created to establish a comprehensive surveillance system for tracking cases and their contacts, and return-to-work information. As of 21 May 2020, 230 CSC staff members had been trained as contact-tracers and 392 contact-tracing events had been completed. Through identification of contacts, human resource challenges and staffing shortages grew significantly, with infection spread to several staff members who worked closely together. The CSC worked with local public health authorities to follow protocols and guidelines. All staff members identified as close contacts, symptomatic individuals or positive cases were instructed to contact local public health services for follow-up.

7.2.3 Outcome of the good practice

Implementation of this thorough and responsive contact-tracing protocol prevented many potentially transmissible staff from entering CSC sites, thereby reducing the spread of COVID-19 among staff and people in prisons. The contact-tracing process provided an opportunity to inform staff identified as contacts to reach out to local public health authorities for information and testing, facilitating early detection of COVID-19 illness. By identifying these individuals through contact-tracing at the CSC and recommending their prophylactic isolation, the health of family and friends of staff and the communities in which they live may have been protected. There was a decreasing trend in the number of contacts identified per tracing event from the start of contact-tracing as a result of the implementation of IPC measures in the sites, including diligent and thorough contact-tracing.

7.2.4 Sustainability of the good practice

This response to COVID-19 created new roles for CSC staff and provided extensive training that will be valuable in future if COVID-19 resurges or other outbreak situations occur. The guidelines, training materials and data-tracking systems developed for COVID-19 contact-tracing will be archived for future use to facilitate the sustainability of this practice. Contact-tracing caused changes in the policies surrounding self-isolation of staff and return to work. It also enabled local public health services potentially to provide testing to contacts prior to symptom onset. This early detection and the proactive method of keeping potentially transmissible staff members out of the workplace are practices that will be beneficial in protecting CSC staff and people in prisons, as well the communities surrounding the sites, during infectious disease outbreaks.



7.3 Italy: outbreak investigation and containment of COVID-19 in the San Vittore Prison, Milan

Submitted by: Ruggero Giuliani,^{13,14} Cristina Cairone,¹⁴ Teresa Sebastiani,^{13,14} Laura Ciaffi,¹⁵ Raffaella Bartolotti,¹⁴ Giorgia Cocca^{13,14} and Roberto Ranieri^{13,14,16}



7.3.1 Background and context

Lombardy was the region in Italy most affected by the COVID-19 pandemic. In Milan, the regional capital of Lombardy, 24 320 COVID-19 confirmed infections had been recorded in the community as of 28 June 2020.

Lombardy has 18 detention centres, hosting a population of 8500 people living in prisons and 4580 custodial officers.

At the beginning of the pandemic, the Ministry of Justice, the Ministry of Health and the Regional Health Authority issued a number of recommendations, mainly concerning the



**PRISON
POPULATION**

Lombardy, 2020

8500
TOTAL

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¹⁶ Welfare General Directorate, Lombardy Regional Health Authority, Milan, Italy

suspension of family visits and a limit on the number of people entering prisons daily to work, including social workers, lawyers, magistrates and volunteers. Admission to detention centres, though limited, did not restrict the entrance of essential health-care workers and security officers to preserve good functioning and sustain service provision. The recommendations also included release of low-risk offenders and promotion of house arrest as an alternative to incarceration. Further measures that were implemented included imposing quarantine restrictions on all new entrants and undertaking nasopharyngeal swabs.

The following describes measures implemented to contain the pandemic in the San Vittore Prison in Milan, which has an operational capacity of 850 but on average houses 900–1000 people (106–118% occupancy rate).

7.3.2 Description of the good practice

Following diagnosis of the first confirmed infection, an outbreak investigation was conducted by the health personnel of the prison, coordinated by infectious disease specialists who were experienced in epidemic management. The focus of the investigation was as follows.

- Contact-tracing was carried out according to the WHO definition of contact adapted to the penitentiary context (WHO, 2020e). All COVID-19 positive cases gave verbal consent to being interviewed and reported their contacts over the previous seven days. In addition to individuals sharing the same cell, tracing extended to all contacts reported, such as individuals who encountered the positive case during out-of-cell time (exchanging cigarettes, shaking hands, etc.), and security officers.
- Case-mapping and plotting of cases in spatial distribution was carried out to identify outbreak spots.
- All interviews were performed by a physician trained in contact-tracing. Data were initially recorded in narrative form, including analysis of people's social behaviour and characteristics. All information was then registered in an internally developed database. Through contact-tracing and interviewing contacts, all movements and activities were tracked and recorded in the same database. Identified contacts were notified, and isolation measures and the diagnostic timeline were explained to them. Diagnostic tests were performed on a voluntary basis.
- Extensive testing using the PCR technique on a nasopharyngeal swab was conducted for all contacts, including people living in prisons and prison staff. A total of 933 tests were performed among people living in prisons, custodial staff and health personnel.
- All measures were applied equally to males and females living in prisons.

Through contact-tracing and behavioural analysis of prison populations, the role of bridge populations – groups of individuals who move across different prison buildings and areas – in potentially introducing COVID-19 into prisons from outside and thereby spreading it between different groups of people was clear. By interviewing case contacts, a group of working individuals living in prisons who move frequently between different areas of the prison was identified. This group is employed by prison management to provide services such as catering, shopping, cooking, cleaning and maintenance. Accordingly, this group moves

between various parts of the prison premises (floors, sections and blocks) or outside the buildings and plays a role in the social links between people living in prisons, performing such tasks as transferring messages and objects, exchanging goods and cigarettes, and dispensing meals. The group was systematically tested for COVID-19 and two members were found to be positive. By tracing their contacts, another 22 people living in prisons were tested, leading to the identification of three asymptomatic cases. By mapping the spatial location of the cases in the prison buildings, transmission by proximity in adjacent cells was observed, not just among people living in the same cell.

Finally, through analysis of the behaviour of people living in prisons and contact-tracing, clusters of outbreaks were observed among people living in prisons coming from the same regions and speaking the same language.

Through this exercise, a bundle of measures to contain the outbreak was implemented, including:

- extending clinical surveillance and testing to the group of working individuals who moved frequently inside prisons and to people living in cells adjacent to the primary cases;
- limiting the movements of the working group, especially in an outbreak area;
- training the working group and custodial staff on personal protection measures and hygiene etiquette;
- reinforcing surveillance and testing among people living in prisons who shared the same language or came from the same geographical region;
- conducting contact-tracing exercises by staff members who were familiar with the detention centre environment to analyse the data in the environmental context;
- creating a task force composed of health personnel (doctors and nurses) to work on contact-tracing, epidemiological data collection, the surveillance system and strategies for infection containment; and
- creating a basic database of sociodemographic characteristics, virology test results, symptoms and date of onset, clinical outcomes, movement inside prison, and the location of people living in prison (as well as staff) who were reported to be confirmed, probable or suspected cases of COVID-19; this database could be shared with other detention centres, allowing homogenous compilation of data and subsequent data analysis.

7.3.3 Outcome of the good practice

Despite these measures, 88 COVID-19 infections were confirmed among people in prisons from the beginning of the pandemic until 24 June 2020. While this represents 10 353 infections per million, it is much lower than the rate observed in the general community of Milan, which was 17 988 infections per million. Five of the confirmed cases were transferred to hospitals and two died in intensive care units, which represents 235 COVID-19-related deaths per million. As of 16 July 2020, no new additional infections had been confirmed.

The inclusive and transparent approach to handling the pandemic in the prison led to good collaboration between correctional staff and people living in prisons, with no critical violent events or protests during the period in which the restrictive measures were applied.



COVID-19 INFECTIONS

Up to June 2020, Milan

1.04%

IN PRISONS

1.80%

IN THE COMMUNITY

The successful containment of the epidemic spurred regional judicial authorities to organize a webinar to share this experience with the management teams of other detention centres. During the two-hour webinar, the San Vittore management team and Médecins Sans Frontières (MSF) representatives presented their experiences of the outbreak investigation and preventive measures taken.

7.3.4 Sustainability of the good practice

There was close collaboration between MSF and the prison management with respect to building capacity among prison staff to equip them with the relevant knowledge to implement the measures and sustain the practices. While all measures were implemented by prison staff, training was managed and delivered by MSF. Multiple one-hour training sessions were delivered to custodial staff on COVID-19 modes of transmission, preventive measures, and use and removal of PPE. In total, 29 training sessions were conducted, targeting 243 officers. In addition, 13 sessions targeting 104 working individuals living in prisons were conducted on environmental hygiene and personal protection.

This model of collaboration between prison management and an NGO, which includes sharing roles and involves people living in prisons, guarantees sustainability, as it is an investment in building alliances in the community with the involvement of relevant stakeholders, including people living in prisons and staff. This model can be reproduced in the management of other epidemics or health issues affecting prisons.



7.4 Slovakia: prevention measures in Slovak prisons amid COVID-19

Submitted by: Corps of Prison and Court Guards, Slovakia



7.4.1 Background and context

The Corps of Prison and Court Guards (the Corps) is an armed security corps that is mandated to manage and secure all detention centres in Slovakia, including pretrial detention places, prisons and psychiatric penitentiary facilities. The Corps is also mandated to ensure order and provide security in judicial and prosecution premises. It comprises a general directorate and 18 prison facilities, including a prison hospital and a juvenile prison.

The General Directorate and prisons are independent government organizations, established by the Ministry of Justice of Slovakia. The General Directorate governs and controls all prison facilities. The Corps is headed by a director-general who is appointed by, and reports directly to, the Minister of Justice. As of 10 June 2020, the operational capacity of the Corps' prisons was 11 625 places; the total prison population was 10 486, representing an occupancy level of 90.2%.



**PRISON
POPULATION**

June 2020

10 486

TOTAL

7.4.2 Description of the good practice

The first case of COVID-19 in Slovakia was confirmed on 6 March 2020. The government swiftly declared a national emergency situation on 12 March and enacted a state of emergency on 16 March, which was to extend until 13 June 2020.

In parallel with the national response, the Corps adopted various preventive measures to halt the spread of COVID-19 behind bars. These measures followed the recommendations of the Central Crisis Staff,¹⁷ measures and guidance issued by the Public Health Authority, and guidance offered by the Crisis Staff of the Ministry of Justice. The measures were updated regularly according to the development of the situation in the country and included the following.

- The ability of people living in prisons to work in external locations was suspended gradually from 9 March 2020,¹⁸ as a consequence of the location of the work in a zone with a high COVID-19 incidence rate, lack of PPE or lack of work opportunities for people living in prisons. In March the total number of people living in prisons who missed their scheduled external work opportunity was 343; this increased to 1017 in April but fell to 818 in May.
- Visits to people living in prisons were suspended from 6 March 2020. To compensate for this, the Corps made available a free-of-charge one-time 20-minute phone call per person living in prison. In addition, the requirement of people living in prisons to pay their outstanding claims (such as child alimony) or to purchase phone credit was cancelled to ease contact with their families, and they were allowed to use the phone more often. From 15 May, the Corps provided handheld electronic tablets that people living in prisons could use to conduct virtual visits with their families via free communications applications. Even though people living in prisons have no legal right to conduct virtual visits, an exception was made based on the restrictive measures that had been imposed. Calls were conducted once a month for 20 minutes per person living in prison. Juveniles and people living in open prisons were allowed to conduct virtual visits once a week for 20 minutes. A maximum of five people from the person's family could be present on each call and the call was monitored by a prison officer. Those younger than 15 years could have more than five people joining the call.
- Following gradual national easing of restrictive measures, de-escalation of measures took place in prisons, with restoration of prison visits from 1 July 2020. Visitors were required to comply with the preventive and risk-assessment measures that had been applied, including measurement of body temperature, wearing of face masks and use of hand disinfectant. Visits were limited to one hour and a maximum of three people, including children, per person living in prison. Visits were conducted without physical contact with the people living in prisons as visitors were separated from them by plexiglass. In addition, video visits were available as an alternative to the restricted standard visit introduced from July.
- In response to the lack of PPE during the pandemic, people living in prisons were involved in the production of face masks, which were distributed to prison staff, people living in prison and state agencies. Production started on 27 February 2020 after procurement of the necessary materials. Several workshops were redesignated from producing clothing to producing face masks. On 5 March 2020 serial production of face masks began in

¹⁷ The Central Crisis Staff was established by the government to coordinate state administration bodies, local authorities and other bodies designated to handle a crisis. It is chaired by the Minister of the Interior.

¹⁸ "External locations" are workshops/workstations placed in external employers' factories or companies.

two prisons, and gradually production spread to another five prisons. The face masks were distributed primarily to all prisons and other Ministry of Justice institutions, such as courts, prosecution services, the Judicial Council and the Centre of Legal Aid. Face masks produced in prisons were also provided to law enforcement authorities, judges, lawyers and other people providing legal assistance who entered prisons to perform service activities. As demand decreased, production ended on 22 May, by which time a total of 295 263 face masks had been produced.

- Compulsory use of face masks was introduced for people living in prisons when they left their cells or rooms; this included time spent during escorts, using the phone in corridors, and at work. Wearing face masks was compulsory when individuals took their walk time out of their cells, with a limit on the number of people who could walk or shop from the prison grocery at the same time. Wearing of face masks was also compulsory for prison staff during their shifts.
- Educational, cultural and awareness-raising activities conducted by external providers, including use of the library, reading room and fitness facilities, were stopped.
- Compulsory quarantine for 14 days for all new entrants to any prison facility was enacted, as were measurement of body temperature before entering prison for staff and people living in prisons, restriction of mass escorts between prison facilities, and prohibition of mass catering.
- The Corps dedicated facilities that were used for events and training and for prison staff members' family vacations to make space available for COVID-19-related isolation. For people living in prisons, the Corps dedicated the prison hospital in Trenčín as a central hub to which all confirmed COVID-19 cases were transferred from Slovak prisons.
- Restrictive measures increased tensions between people living in prisons and prison staff, so it was necessary to support the mental well-being of people living in prisons by explaining the purpose of the imposed restrictive measures and keeping communication channels open. Basic information regarding COVID-19 was communicated to people living in prisons through information leaflets placed on prison noticeboards. Information included how to wash hands, how to observe physical distancing, and symptoms and possible complications of COVID-19. In addition, information was disseminated through case managers during their personal interviews with people living in prisons.¹⁹

From 10 June 2020 the preventive measures that had been applied were gradually discontinued, but the Corps management continued to follow the epidemiological situation in the country.

7.4.3 Outcome of the good practice

As a result of implementation of these measures, prisons tended to be spared the worst of COVID-19 compared to the outside community. Since the beginning of the pandemic, as of 10 June 2020, only one confirmed infection had been reported among people living in prisons, which represents 95 infections per million. At the same time, health authorities reported 1541 COVID-19 infections in the general population, representing 282 infections per million. No cases were reported among prison staff. A total of 96 people living in prisons and 33 prison staff were tested between the beginning of the pandemic and the end of May 2020. According to national guidelines, only people with symptoms suggesting infection and contacts of confirmed or suspected cases should be tested.

¹⁹ A case manager is a prison staff member who is responsible for following up on treatment activities and education with people living in prisons.



**COVID-19
INFECTIONS**

Up to June 2020

**ONLY 1
INFECTION**

In light of the favourable epidemiological situation in the country, the Corps gradually eased the previously imposed preventive measures.

7.4.4 Sustainability of the good practice

Some of the measures applied during the pandemic that proved beneficial to the overall health of people living in prisons will be sustained, including:

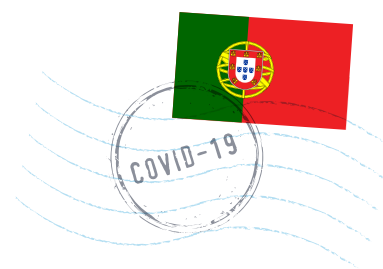
- increased numbers of nurses in prisons to address the shortage of staff that existed prior to the pandemic but was more noticeable during the pandemic; and
- creation of a legal framework for possible use of members of the armed forces in the event of a sudden decrease in prison staff that might be caused by a pandemic or any other emergency.

The pandemic triggered procurement of several equipment items that ensured that IPC measures were implemented efficiently. These included germicidal ultraviolet-C emitters that were installed in prisons where large group gatherings occurred (such as prison entry areas, visiting rooms, mass catering premises and meeting rooms). Prison hospitals were equipped with necessary materials, including vital-signs monitors and oxygen therapy equipment. Hardware that enabled virtual visits with families for people living in prisons and supported the conduct of nonphysical staff business meetings and at-distance court proceedings was also procured.



7.5 Portugal: prevention and preparedness in Portuguese prisons

Submitted by: Rui M. Ramos Morgado, Directorate-General of Reintegration and Prison Services, Porto Prison, Portugal



7.5.1 Background and context

The Directorate-General of Reintegration and Prison Services is the body responsible for managing prisons in Portugal, under the Ministry of Justice. Portugal has 49 prisons and special prisons for individuals who need special care, such as women, young or sick people. People living in prisons have the right, by law, to access the National Health Service to ensure equal health provisions to those guaranteed to all citizens (Dores, Pontes & Loureiro, 2013).

With a prison population of around 12 900, a significant number of whom are elderly people living with chronic and infectious diseases and mental health problems, and an occupancy rate of almost 98.6%, prisons in Portugal are facing several challenges (European Prison Observatory, 2020).



**PRISON
POPULATION**

2020

12 900

TOTAL

7.5.2 Description of the good practice

Before the first case of COVID-19 in Portugal, specific contingency plans for the prison system were set in place to prevent, limit and control disease transmission in prisons. The Directorate-General of Reintegration and Prison Services took several preventive measures, including suspending the transfer of people living in prisons and limiting the number of prisons for new entrant receptions based on their ability to offer single-cell isolation to ensure 14-day quarantine for all new entrants. Additional single cells were prepared in case there was a need for medical isolation of suspected cases, and regular temperature checking and questioning about symptoms were conducted. Physical distancing, hand hygiene and respiratory etiquette were strongly recommended through training, regular verbal reminders by prison officers, and visual reminders through leaflets and posters. General hygiene measures, such as regular cleaning of surfaces and installation of wall-mounted alcohol-based gel for all visitors and staff, were reinforced. PPE usage became mandatory, and it was distributed among all technical staff, including prison guards and health-care professionals, on a regular basis and according to risk profile. Self-monitoring of symptoms was also requested. Visits were suspended temporarily and compensatory phone calls and videoconferencing were facilitated. Some activities inside prisons were stopped, but recreational activities and sports were maintained, alongside occupational activities such as cooking, cleaning and agricultural work (in some prisons). The same measures were adopted in female prisons.

The Directorate-General of Reintegration and Prison Services cooperated continuously with Ministry of Health institutions, including the Directorate-General of Health, health authorities, the National Institute of Medical Emergency and the National Health Institute Dr Ricardo Jorge, especially on management of COVID-19 suspected cases and contact-tracing activities. The Directorate-General of Health provided regional focal points to facilitate coordination between the health and prison systems. A specific protocol was set up with the National Institute of Medical Emergency and the National Health Institute Dr Ricardo Jorge to screen prison staff.

In coordination with the armed forces, prison nursing wards were prepared to receive confirmed cases and function as isolation areas in the event that the number of cases increased rapidly (**Fig. 11**).

Coordination of the partnerships was set up at national level between the Ministry of Health and the Ministry of Justice, although implementation, follow-up and monitoring were decentralized to regions to allow speedy decisions and adjustments.



COVID-19 INFECTIONS

Up to May 2020

0.04%

IN PRISONS

0.31%

IN THE COMMUNITY

7.5.3 Outcome of the good practice

As of 30 May 2020, 20 COVID-19 infections had been diagnosed in Portuguese prisons, including 15 among prison staff and five among people living in prisons. This represents 388 cases per million, much lower than that observed in the general population (3107



infections per million). There was also one confirmed case in a youth detention facility. The five individuals diagnosed with COVID-19 were isolated in single cells and did not contact other people, as they were diagnosed during the quarantine period for new entrants. All reported cases were asymptomatic. As female prisons in Portugal are, in comparative terms, better equipped, less densely populated and have better isolation capacity than their male counterparts, the adopted measures succeeded in preventing any COVID-19 infections among women living in prisons.

7.5.4 Sustainability of the good practice

Overall preventive measures will be maintained in Portuguese prisons, as returning to normality will require ongoing and consistent application of the basic hygiene measures implemented. However, there will be some difficulty in maintaining control over preventing introduction of the pandemic from outside prisons. Additional funding may be required in coming budget reviews to cover the cost of consumables used, especially PPE. Periods of observation for new entrants before introduction to the rest of the prison population will nevertheless be maintained as good practice, with overall positive consequences in infection control.

FIG. 11. COVID-19 WARDS IN PORTUGUESE PRISONS



8. Case management



8.1 Azerbaijan: COVID-19 case management in Azerbaijani prisons

Submitted by: Famil Mammadov, Musallim Amiraslanov, Natavan Alikhanova and Fakhriyya Huseynova,
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8.1.1. Background and context

The penitentiary system of Azerbaijan manages 39 facilities that include three pretrial detention facilities, one prison, 16 colonies of different security regimes, and 19 correctional facilities of different types. Health care in the penitentiary system is provided through 20 medical wards in detention facilities with a capacity of 900 beds; the Central Penitentiary Hospital with seven wards, four units and a capacity of 400 beds; and a specialized treatment institution for tuberculosis cases that has 18 wards, 24 units and a capacity of 900 beds. Medical services for people living in prisons and staff of the penitentiary system and the Ministry of Justice are managed by the Main Medical Department of the Ministry of Justice.

The first case of COVID-19 in Azerbaijan was reported on 28 February 2020 and special quarantine measures were announced on 24 March 2020.

At the end of March, a 33-year-old person living in prison who had renal failure tested positive for COVID-19. The person was being treated at the Central Penitentiary Hospital

and visiting another civil medical facility for haemodialysis in accordance with the treatment schedule. A week later, more COVID-19 positive cases were reported among his contacts.

8.1.2 Description of the good practice

The Azerbaijani government established the Task Force under the Cabinet of Ministers (TFCM) to deal with the pandemic nationally, shortly before the pandemic was declared by WHO. The Main Medical Department of the Ministry of Justice relied on TFCM guidance and instructions and WHO's guidance on preparedness, prevention and control of COVID-19 in prisons and other places of detention to prevent and manage COVID-19 behind bars (WHO, 2020e).

To detect COVID-19 infection among the prison population early, a mobile team that included six physicians, two paramedics and two drivers was established to cover all penitentiary facilities and the entire prison population. The team was mandated to collect samples from suspected COVID-19 cases among people living in prisons and to ensure their delivery to Ministry of Health laboratories for confirmation. The specialized tuberculosis treatment institution allocated four wards equipped with ventilation systems, adaptive support ventilation, oxygen stocks and necessary premises for isolation and medicines for treatment of COVID-19 patients. Wards were allocated in all medical units of the penitentiary facilities to isolate suspected COVID-19 cases. Isolation and treatment of COVID-19 cases were taken forward in accordance with the national protocol for COVID-19 management and local guidelines, which were based on international protocols and WHO recommendations and adapted by the Head of the Disease Control and Prevention Department of the Management Union of Medical Territorial Units (TABIB). Confirmed COVID-19 cases were placed in the intensive care unit for 1–2 weeks. Following two consistent COVID-19 negative laboratory test results, they were then transferred within 24 hours to other departments for subsequent medical follow-up for another two weeks. One month after the first negative laboratory test result, they were transferred back to their penitentiaries.

Of the 39 facilities managed by the penitentiary system, COVID-19 infection was reported among new entrants at three pretrial detention centres, one prison, one treatment facility and five colonies. On diagnosis, a COVID-19 treatment regimen was initiated by the Special Medical Commission, which includes representatives of the civil sector, to ensure that treatment regimens were established that were tailored to the needs of each patient and their further monitoring. The regimens included antiviral therapy and antibacterial, immunity-stimulating and vitamin therapies. Greater attention was paid to treating confirmed COVID-19 cases who were also living with chronic diseases.

The first COVID-19 case among people living in prisons spread the infection to nine people (aged 33–64) of 13 who shared the same ward at the Central Penitentiary Hospital. Eight of these cases were detected a week later, while the diagnosis of the ninth patient was confirmed 10 days later. The disease coursed asymptomatically in eight of the 10 confirmed cases, including the first confirmed, while the other two patients were diagnosed with viral

pneumonia. Of the 10 cases, three were living with hepatitis C virus, one had renal failure and two were living with cardiac diseases.

Several COVID-19 cases were reported among staff and medical workers. It was difficult to determine the source of infection for most staff, but it was ascertained that one medical officer who worked in the mobile team responsible for sampling and two medical staff members who cared for COVID-19 cases among people living in prisons were among the spreaders.

Several preventive, risk-mitigation, educational and risk-communication activities that were developed are also worth describing.

- The penitentiary service increased supplies and technical support to the Main Medical Department of the Ministry of Justice, ensuring disinfectants, medicines and PPE stocks were available in a timely manner.
- All new entrants and the contacts of confirmed or suspected COVID-19 cases in prisons were placed in quarantine.
- To minimize the risk of introducing COVID-19 into prisons, contacts with civilian visitors to penitentiary facilities were reduced, as was the number of packages sent to people living in prisons. To combat the psychological effects of visit limitation and to maintain the mental well-being of people living in prisons, psychological support sessions were made available.
- On 6 April 2020 a presidential decree was issued to decrease the prison population. By 31 August 2020, 176 people living in prisons aged over 65 who were in need of special care because of their age and health status had been released in the context of the COVID-19 pandemic; 1374 people living in prisons had been released on parole; 326 had been transferred to settlement-type colonies; nine had been released because of serious illness; 460 people living in pretrial detention centres had been released; and 24% of confirmed COVID-19 cases among people living in prisons had been released on parole and, in compliance with anti-epidemic standards, transferred to civil sector institutions. After release or removal to the civil sector, further treatment was provided and recorded in the national database.
- As a risk-assessment procedure, all staff members and visitors were required to pass through a temperature-screening point at the entrance to any penitentiary facility. The entry point was equipped with disinfecting devices. Vehicles were also disinfected upon entry to any facility. Ultraviolet lamps were installed in overcrowded places. All people living in prisons had daily temperature screening and a chest X-ray if required. The safe disposal of used PPE was continuously enforced and monitored.
- From the onset of the pandemic, the WHO Collaborating Centre on Prevention and Control of Tuberculosis in Prisons, in collaboration with the specialized treatment institution, regularly held relevant training for medical staff and cascaded awareness events for nonmedical personnel. Doctors and psychologists working in prisons raised awareness of the disease among people living in prisons. In addition, posters were developed explaining hygiene rules and antiviral protection measures across all penitentiary facilities.

8.1.3 Outcome of the good practice

From the beginning of the pandemic until 31 August 2020, no COVID-19-related deaths were reported among people living in prisons in Azerbaijan. The average age of COVID-19 cases was almost 39, with the following underlying diseases: HIV in 1.5%, diabetes mellitus in 5.0%, hepatitis C virus in 25.0%, hepatitis B virus in 1.5%, cerebrovascular diseases in 5.0%, and renal failure in 1.5%. There were no reported COVID-19 cases among people living in prisons with active tuberculosis, but two COVID-19 cases acquired tuberculosis. Eighteen percent of reported COVID-19 cases were in pretrial detention centres. Among the reported cases, 85.0% were asymptomatic or had low-grade fever, 10.0% showed mild symptoms, and only 5.0% developed a severe course of the disease. Symptoms included loss of taste (7.7%), dry cough (32.8%), fever (13.1%), and asthma attacks (4.1%). As of 31 August 2020, 79% of cases had recovered and 21% were still on treatment. All conditionally released individuals with COVID-19 were referred to treatment facilities in the community.

8.1.4 Sustainability of the good practice

The measures taken amid COVID-19 were funded from the core Ministry of Justice budget and by the Global Fund to Fight AIDS, Tuberculosis and Malaria. In addition, all activities implemented were included in the 2021 Ministry of Justice budget and funded in part by the Global Fund's project, which was launched in 2021. Management of COVID-19 among people living in prisons was carried out by medical professionals involved in the Tuberculosis National Programme, without prejudice to the latter. This grants sustainability to the measures taken.



8.2 Canada: establishing an emergency operations committee to coordinate outbreak management response

Submitted by: Olivia Varsaneux, Kristina Ma, and Madison Van Dalen, Correctional Service of Canada

8.2.1 Background and context

For information on the background and context relevant to this good practice, see section 4.1.1 above.

8.2.2 Description of the good practice

In the context of outbreak management, the CSC collaborated closely with local public health authorities (LPHAs) in the catchment areas where CSC institutions or community correctional centres were located. COVID-19 is a notifiable disease in Canada and the LPHAs

are responsible for surveillance of COVID-19 cases in their local communities. At one of the early outbreak sites in Canada, the CSC learned that an important aspect of effective and efficient outbreak management was the establishment of procedures for communications and data flow with LPHAs. The CSC and the LPHAs established an emergency operations committee (EOC) to facilitate improved communications and to harness public health expertise to support outbreak management decisions at the affected site.

The EOC met by teleconference and was chaired jointly by the CSC and the relevant LPHA. The CSC had representation from health services management at national, regional and site levels, as well as representation from the regional physician lead and correctional operations. The LPHA had representation from a medical health officer, a hospital lead/medical director, IPC experts and a public health lead for the local community within which the outbreak site was situated. Each teleconference began with a set agenda and ended with a roundtable discussion of any emerging issues that needed to be addressed. The agenda included the following.

- **Situation update.** The CSC's Regional Public Health Manager provided an update on the outbreak, including the current number of COVID-19 confirmed cases and pending testing results at the institution. The LPHA provided an update on hospitalizations and the proportion of hospitalized COVID-19 cases among people living in prisons who required transfer to intensive care.
- **Status report.** The CSC's regional health and operations representatives provided updates on the implementation of LPHA recommendations, such as IPC measures and testing implementation. The CSC also shared any operational concerns, including staffing shortages. The LPHA provided recommendations and/or established plans to provide additional support to the CSC where needed, such as assistance with testing, training and education, and addressing staffing concerns. The CSC and the LPHA also established information- or data-sharing procedures required for the outbreak response – for example, sharing of employee information for the purposes of contact-tracing or the CSC's epidemiological summaries related to the specific outbreak site, and any forms or formal documentation required by the LPHA. The EOC also provided an opportunity to discuss any communication items, including media requests and requests for information by local or provincial governments.

Initially, EOC teleconference calls occurred daily. However, as the outbreak began to resolve and more cases transitioned from active to recovered, the call frequency gradually decreased.

8.2.3 Outcome of the good practice

Establishing an EOC was effective in supporting a more coordinated and efficient outbreak response. This was of particular use within the Canadian correctional context, where outbreak management required communication and collaboration not only among stakeholders at all levels of the CSC (local, regional and national) but also among many local and provincial public health partners. The EOC established a common time and place for stakeholders to come together to discuss outbreak management decisions and responses. The EOC led to the implementation of more robust IPC practices, facilitated by site visits from the LPHA to

the CSC outbreak site and the LPHA's support in training staff in IPC measures for COVID-19. The EOC ultimately improved the overall outbreak management response and contributed to the containment of the outbreak.

8.2.4 Sustainability of the good practice

As a result of the success of the EOC at the outbreak site described above, a similar model was proposed for other COVID-19 outbreak sites and in the planning of future outbreak committees as a preparedness measure for sites that might be affected by COVID-19 in the future. Strengthened IPC practices, including staff training on infection control in the COVID-19 context, will help to prevent and contain a future resurgence of COVID-19 or other outbreaks going forward.

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Annex 1

CALL FOR SHARING “GOOD PRACTICES – COVID-19 IN PRISONS”

Date: 14 May 2020

Dear members of the WHO Health in Prison Network

We hope everything is well with you and your families in the challenging time of the pandemic.

As a continuation of the WHO Health in Prison Programme efforts to capture and share countries' experiences regarding COVID-19 in prisons, we are in the process of developing a report on “Good Practices – Managing COVID-19 in Prisons” that will document good practices in several areas including:

- (1) human rights and alternatives to incarceration amid COVID-19
- (2) preparedness, contingency planning and level of risk
- (3) training and education
- (4) risk communication
- (5) prevention measures
- (6) case management.

The purpose of the report is to document the excellent work being developed in this particular setting and to share knowledge and lessons learned that could be utilized in Europe and globally, building on the guidance *Preparedness, prevention and control of COVID-19 in prisons and other places of detention*, launched in March 2020.

Call for sharing of good practices, deadline 15 June 2020

We are inviting you to share a “good practice” experience to be included in this report. The good practice could be variable, covering one prison, several prisons, or a nationwide practice covering all prisons.

The document should follow the following structure.

1. Background and context: tell us about the prison system in the country, including governance, number of establishments, total official prison capacity and total prison population **(200 words maximum)**.
2. The good practice: under one or more of the seven areas mentioned above, tell us about the good practice to mitigate the risks posed by COVID-19 in prisons and how it was implemented. What was the COVID-19 pandemic burden in prisons (until [date]: number diagnosed, hospital transfers, suspected cases, etc.), what was the main challenge, how was the decision of “the practice” taken, and how was it implemented? (Examples: health in prisons sustainability, PPE supply, staff training and shortages, case-management challenges (including creation of partnerships), noncustodial measures imposed, decreasing overcrowding, allocation of resources, visiting and legal counselling modifications) **(750 words maximum)**.

3. Outcome of the good practice: tell us how implementation of the good practice affected outcomes in the short term **(150 words maximum)**.
4. Sustainability of the good practice: where applicable, tell us if implementation of the good practice will be sustainable and if it has created a change in policy or governance **(150 words maximum)**.

The call is open to all stakeholders and partners, including national health authorities, ministries of internal affairs, ministries of justice, or any other relevant responsible governmental, partner and nongovernmental organizations working in this area.

The practices will be compiled and evaluated against the selection criteria listed in the table below, and we will be supporting you to assure the quality and conditions of the practices shared. To be able to finalize this in due time, we ask that **any proposal is submitted before 15 June 2020**.

Again, thank you so much for your collaboration and dedication to enhance health in prisons.

Regards

Selection criteria for good practice inclusion

Criterion	Description
Relevance ^a	Must address the Sustainable Development Goals (SDGs) identified as core to the Health in Prisons Programme Action Plan (SDG 3 and SDG 10).
Sustainability ^a	Can be implemented and sustained over a long period (including policy decisions) without any massive injection of additional resources.
Efficiency ^a	Must produce results with a reasonable level of resources and time.
Ethical appropriateness	Must respect the rules of ethics for dealing with human population, in particular the Mandela Rules ^b .
Equity/gender	Addresses the needs of vulnerable populations and/or gender in an equitable manner, with a focus on the Bangkok Rules ^c .
Effectiveness	Must work and achieve results that have been measured.
Partnership	Involves satisfactory collaboration between several stakeholders.
Community involvement	Involves participation from the affected communities.
Political commitment	Has support from the relevant national or local authorities.

^a Required.

^b The Mandela Rules give guidance on all aspects of prison management, from admission and classification to the prohibition of torture and limits on solitary confinement.

^c The Bangkok Rules, adopted by the United Nations General Assembly on 22 December 2010, are focused on the treatment of female offenders and prisoners.

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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