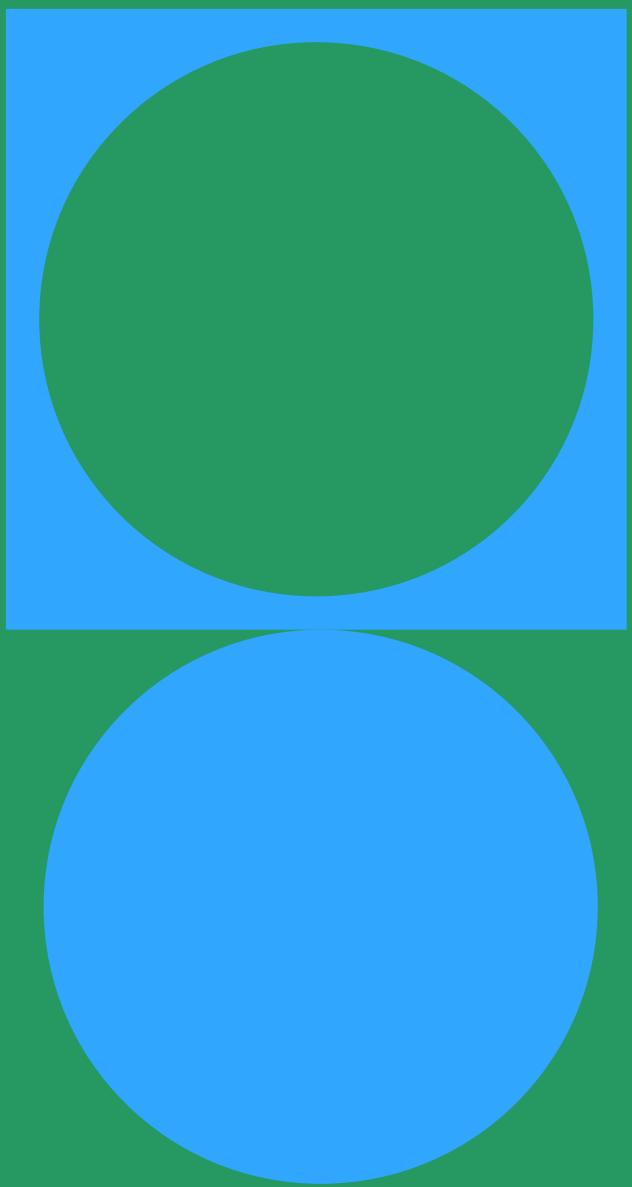
PRISONS AFTER COVID-19: BEYOND EMERGENCY MEASURES



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HARM REDUCTION INTERNATIONAL

Prisons after COVID-19: Beyond emergency measures.

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HARM REDUCTION INTERNATIONAL

Harm Reduction International (HRI) is a leading non-governmental organisation dedicated to reducing the negative health, social and legal impacts of drug use and drug policy. We promote the rights of people who use drugs and their communities through research and advocacy to help achieve a world where drug policies and laws contribute to healthier, safer societies.

The organisation is an NGO with Special Consultative Status with the Economic and Social Council of the United Nations.

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1.

INTRODUCTION

1. INTRODUCTION

Since the COVID-19 outbreak in January 2020 and the declaration of the pandemic in March 2020,[1] governments have been responding to this unprecedented crisis and the challenge of preventing and controlling the spread of COVID-19 by invoking emergency executive powers and adopting exceptional measures.[2] In many cases, this has led to an expansion of law enforcement powers and the introduction of highly restrictive measures which have had a particularly negative impact on vulnerable populations by exposing them to significantly greater health risks and human rights abuses.[3]

People deprived of their liberty have been disproportionately impacted by the COVID-19 pandemic. In the last few years, COVID-19 has spread through prisons and other closed settings at higher rates than in the broader community.[4] Prisons are high-risk environments for the transmission of COVID-19 and other communicable diseases because of their often poor and overcrowded conditions which favour the spread of diseases, and because of inadequate prison health services due to decades of neglect and underinvestment.

Furthermore, people deprived of their liberty have been found to be at significantly increased risk from COVID-19 compared to the broader population.[5] Members of vulnerable and marginalised groups, such as people who use drugs, are overrepresented in prison settings.[6] Many of the factors that make these groups more likely to be incarcerated, including poverty, discrimination and drug use, also mean they tend to carry a disproportionately high burden of disease and ill-health.[7] This places them at higher risk of becoming seriously ill if they contract COVID-19. Despite limited data on COVID-19 prevalence among people who use drugs, evidence indicates that this population, particularly people who inject or smoke drugs, face a greater risk of infection and adverse outcomes from COVID-19 compared to the general population. This is associated with pulmonary and respiratory complications, and a compromised immune system as a consequence of prolonged drug consumption, among other health issues.[8] Additionally, the prevalence of HIV, viral hepatitis and tuberculosis is higher among people who inject drugs, increasing their risk of experiencing complications from COVID-19.[9]

Prison populations have also been among the most impacted by the strict measures taken to control the spread of COVID-19, including extended lockdowns and preventive quarantine. These and other extreme measures have been found on several occasions to be disproportionate, arbitrary, abusive and ineffective in controlling the spread of the virus in closed settings.[10] Their impact on conditions of detention and the enjoyment of fundamental human rights, including the right to health, have given rise to concerns that they could, in some cases, amount to torture and ill-treatment.[11]

Three years into the pandemic, many States have now gradually moved away from emergency responses to COVID-19 and are beginning to focus on recovery and long-term plans and measures, such as the modernisation of health services and implementation of telemedicine, and economic recovery plans, among others. While most States have eased restrictions[12] and communities are learning to live with an ongoing pandemic, questions remain as to whether prisons have adapted to this new recovery phase and what actions, if any, are being taken to protect the health and rights of people in detention, particularly for those most vulnerable, going forward. With this report, Harm Reduction International (HRI) aims to contribute to the research on responses to COVID-19 in prisons and their impact on the health and rights of people deprived of their liberty.

Overall, this report shows that people living in prisons in fifteen countries surveyed (Benin, Burkina Faso, Canada, France, Ghana, Indonesia, Italy, Mexico, Kenya, Kyrgyzstan, Mauritius, Moldova, Nepal, Switzerland, and the UK) were and continue to be deeply affected by the COVID-19 pandemic and the disproportionate measures taken to address it in prisons. Rather than improving the health and safety of people in prison, preventive measures have negatively impacted the provision of health and harm reduction services in prisons, and have made people in detention more vulnerable to health and human rights harms. While some important adaptations and minor reforms have been adopted to help protect the rights and health of people living in prisons, in many prisons it is back to "business as usual", symbolising a missed opportunity for positive structural changes.

At the same time, prisons in some countries continue to impose disproportionate and harmful prevention measures such as preventive quarantine and limitations on visits, justifying and normalising them as a form of COVID-19 risk management. While this report focuses on the provision of health and harm reduction services to help protect the health and rights of people deprived of their liberty during the COVID-19 pandemic and beyond, it is acknowledged that considerable structural changes are required to improve preparedness for future health and other emergencies in prisons. In this regard, as recognised by the United Nations System, decarceration and the decriminalisation of drug-related activities are recognised as the best way to reduce prison overcrowding and ensure the safety and rights of people deprived of their liberty, and should therefore be the ultimate goal. As stated in the 2021 United Nations System Common Position on Incarceration, "[a]ddressing the challenges associated with incarceration, including its overuse, should be a key part of the effort to "build back better"."

The report begins with an overview of key international standards relating to the right to health of people in detention, especially in the context of the COVID-19 pandemic. It then reviews the availability and accessibility of health and harm reduction services in prisons prior to the pandemic, followed by a look at the various measures implemented to curb the spread of COVID-19 in prisons in the fifteen countries studied and the impact of these measures on the provision of services. The report then considers some of the failures and successes of the measures taken to start moving away from emergency responses to COVID-19 and towards more structural and sustainable approaches. The report concludes with a critical analysis of the findings in the context of the international standards reviewed. The findings and analysis contribute to HRI's ongoing work to promote the health and rights of people in detention, while also informing initiatives to strengthen pandemic prevention, preparedness, and response, with specific reference to closed settings.

2.

METHODOLOGY AND LIMITATIONS

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Due to the embedded nature of the authors' positionalities[13] and tacit knowledge[14] in the research process, we acknowledge our outsider and privileged position as members of an international organisation that advocates for the rights of people who use drugs and people in detention, but does not provide services or have permanent contact with people in detention, and the impact this has on our approach to this work and the methodology chosen.

Considering our role as an international organisation, time and resource constraints, and the complexities of getting first-hand information from people in detention, this research applied a mixed methodology by analysing primary data collected from an online survey and follow-up interviews, complemented with a comprehensive desk review of secondary data.

HRI has been monitoring the impact of the COVID-19 pandemic in prisons since 2020, identifying a need to delve into the effects of the pandemic on people who use drugs in prisons and people incarcerated for drug offences. For that reason, an initial mapping of research on COVID-19 in prisons was conducted by HRI to determine if there were areas that required more research that aligned with HRI's objectives. Consequently, an online consultation was carried out with key organisations, including Centro Justicia y Sociedad (Chile), AMICA Legal (Australia), AKSI Keadilan (Indonesia), FLAG (Philippines), Fair Trials (international), and World Organisation Against Torture (International), as well as other individual legal practitioners, to share ideas and insights. Based on this preliminary discussion, HRI decided to focus this research on how the provision of health and harm reduction services was affected by measures taken to control the spread of the pandemic and whether any structural changes were implemented to guarantee access to health care in prisons moving forward.

Next, an online survey was developed to gather qualitative data to supplement the desk-based research. The survey consisted of 22 questions, carefully crafted to provide an understanding of the preventive measures adopted, as well as the availability and accessibility of pre- and post-pandemic health and harm reduction services in prison. The survey focused on the provision of opioid agonist therapy (OAT); needle and syringe programmes (NSPs); human immunodeficiency virus (HIV), tuberculosis (TB), and viral hepatitis treatment and care; drug education and overdose management programmes; and contraceptive methods. The decision to focus on these services in particular was taken due to their relevance for the prison population, particularly for people with a history of drug use, and the general shortage of these services in prison settings, as well as HRI's focus and expertise. A decision was taken to omit questions about the availability and accessibility of COVID-19 vaccines in prisons, as research had already been undertaken by HRI on this issue.[15] In retrospect however, this was a missed opportunity and the information gap this generates is acknowledged. The survey was translated into English, French and Spanish. It was shared with 97 local organisations, practitioners and academics from 50 countries that have specialist knowledge of prisons, important contact with people in detention, and/or deliver health services in prisons in their countries.

The timeframe for the survey was three weeks, between 18 August and 12 September 2022, with follow-up questions to participants between 1 and 21 December 2022. The completion rate was 40%, with 29 completed responses out of 69 partially completed surveys. Although completed responses were received from 16 countries, two responses were excluded from the analysis as they provided general information about a region of the world and did not meet the criteria of a country response. Overall, we analysed data from fifteen countries: Benin, Burkina Faso, Canada, France, Ghana, Indonesia, Italy, Kenya, Kyrgyzstan, Mauritius, Mexico, Moldova, Nepal, Switzerland, and the UK.

As the COVID-19 pandemic impacted each country and prison in distinct ways, with outbreaks experienced during different periods, the survey was designed to be flexible, without asking for specific dates. Instead, the instrument divided the questions into two main parts: before and after the COVID-19 outbreak in a particular prison or prison system, allowing participants to provide more detailed information about how the COVID-19 pandemic evolved in their specific country or prison. The

set of questions aimed to collect information regarding the prison population's access to health services before and after the pandemic, focusing on harm reduction services, HIV, TB, Hep C and contraceptive methods. Therefore, restrictions or adaptations related to access to justice, such as online hearings or prison decongestion measures, were not considered.

The survey did have some limitations. In addition to the low completion rate already mentioned, some contradictory and incomplete answers were received. Steps were taken to clarify and ask for elaboration through follow-up interviews with participants and complementary secondary research. In cases where contradictory data could not be resolved, they were excluded from the analysis. Additionally, survey responses did not allow for a comparative analysis of the impact of COVID-19 on the provision of health and harm reduction services for male, female, trans and non-binary prison populations.

Following the identification of countries to include in the analysis, comprehensive desk-based research was conducted to verify and complement the data obtained through the survey. An extensive review of civil society reports, government reports, prison body reports, academic articles, news reports, regional and international jurisprudence, prison monitoring body reports and UN documents, was undertaken.

Finally, an overview of international standards and guidelines relating to the right to health of people deprived of liberty was undertaken in order to firmly ground this research and any conversations around access to health care in prisons and conditions of detention in the legally binding nature of international human rights law. This particular section was based on previous work undertaken by HRI, and supplemented with more recent available data and analysis to update the information and consider the context of COVID-19.

While great efforts were taken to ensure accuracy and completeness, mistakes and oversights are possible. Any errors found within this report are solely the responsibility of HRI and notification of these are always most welcome.

3.

INTERNATIONAL STANDARDS AND GUIDELINES – A BRIEF OVERVIEW

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International human rights law protects the rights of every human being, including people deprived of their liberty. Therefore, apart from the limitations that are unavoidable in a closed environment, people in detention retain all their human rights; their right to health is in no way diminished by their detention.

In fact, the increased degree of vulnerability of people in detention caused by their incarceration triggers a related heightened duty of care on the part of the State to protect their lives, as well as their physical and mental health. Specific obligations for protecting the health of people deprived of their liberty derive from their inherent dignity and value as human beings, as well as their rights to life, to health and to be free from torture and ill-treatment. The following section briefly outlines some of the key international standards and guidelines delineating how States must respect, protect and fulfil the right to health of people in detention, and demonstrates how interrelated these are with the absolute prohibition of torture and ill-treatment, particularly in the context of the COVID-19 pandemic.

3.1 THE OBLIGATION TO ENSURE ADEQUATE PROVISION OF HEALTH CARE WITHOUT DISCRIMINATION

Article 12 of the International Covenant on Economic, Social and Cultural Rights is the cornerstone protection of the right to health. It recognises everyone's right to the highest attainable standard of physical and mental health, regardless of their legal status. One of the core obligations of the right to health is ensuring adequate provision of health care (health facilities, goods and services necessary for medical treatment and care) on a non-discriminatory basis, especially for vulnerable groups including people deprived of liberty.[16] This obligation also engages the right to life and the prohibition of torture and ill-treatment, and is emphasised in many standards relating to the treatment of people in detention and public health guidelines.[17]

International standards make clear that States have an obligation to ensure that health care for people in prison is adequate, timely, available and accessible to all without discrimination and without cost.[18] Health care must also be at least the same standard that is available in the broader community,[19] which is known as the "principle of equivalence". The World Health Organization (WHO) has confirmed that the prevention and management of the pandemic in closed settings should guarantee that people in prisons enjoy the same standards of health care that are available in the broader community, without discrimination on the grounds of their legal status.[20] This means, among other things, that they should be supported to have the same access to safe water, sanitation and hygiene, and infection control and prevention measures that are available to general population.[21]

Increasingly, human rights experts are urging the aim to be one of equivalence of objectives and results, rather than equivalence of care.[22] In the context of COVID-19 responses, this would involve a higher standard of care for people in detention, which would be

"The World Health Organization (WHO) has confirmed that the prevention and management of the pandemic in closed settings should guarantee that people in prisons enjoy the same standards of health care that are available in the broader community, without discrimination on the grounds of their legal status."

necessary to address their disproportionate burden of COVID-19 related risk and ill-health. Crucially, States may not invoke the lack of financial resources or other logistical problems to reduce or shirk the responsibility to provide adequate health care to prisoners.[23] This is particularly important in the context of the COVID-19 pandemic and other public health emergencies, when limited resources must be (re) distributed.

A critical element of the obligation to provide adequate health care is for health services to be closely linked to the general health services of the State,[24] and in a way that ensures continuity of treatment and care as people move between prisons and the broader community, including for infectious diseases and drug dependence.[25] As provided in the International Guidelines on Human Rights and Drug Policy, States should "organise...drug-related and other health care services in close parallel with general public health administration, taking into account the specific nature of individuals' detention, and design services to ensure the continuity of harm reduction, drug treatment, and access to essential medicines through transitions of entering and exiting the detention facility, as well as transfer between institutions."[26] In the weeks following the outbreak of COVID-19, key UN bodies reminded States that they were required to "[enhance] prevention and control measures in closed settings as well as [increase] access to quality health services, including uninterrupted access to the prevention and treatment of HIV, TB, hepatitis and opioid dependence".[27]

3.2 THE OBLIGATION TO ENSURE PREVENTIVE HEALTH SERVICES, INCLUDING COVID-19 VACCINES AND HARM REDUCTION SERVICES

The provision of health care in prison is not limited to the treatment of sick people; the right to health also imposes an obligation on States to prevent and combat the spread of diseases in prisons by ensuring preventive health services.[28] Failure to ensure effective methods of prevention can further amount to a violation of the prohibition of torture and ill-treatment, and may also include violations of the right to life and the right to liberty and security of the person.[29] This legally binding obligation is also reflected in prison health standards[30] and guidelines,[31] World Medical Association declarations,[32] as well as non-binding resolutions of the Council of Europe[33] and Parliamentary Assembly.[34] Since the COVID-19 pandemic was declared, many human rights, public health and prison health experts and authorities have specifically released statements and provided guidance on the prevention and control of COVID-19 in prison settings.[35]

Evidence confirms that vaccinating people in prisons is a key public health measure to prevent the spread of COVID-19 both inside and outside of prisons,[36] and numerous calls have been made for prisons to be prioritised in the roll-out of COVID-19 vaccines.[37] Nevertheless, prisons continue to be left behind in vaccination efforts. Research by Harm Reduction International and Penal Reform International found that the process of including people detained and working in prisons as an at-risk or priority group in national vaccination plans has been controversial, leading to piecemeal and often insufficient implementation.[38] As of September 2021, available figures indicate that only 20 countries had provided at least 80% of their prison population with at least one dose of the vaccine, while a further 86 countries had vaccinated less than 10% of their prison population.[39] In some countries, people in prison have been intentionally left behind in the roll out, despite vaccines being available.[40] It is worth mentioning that other measures, such as prison decongestion or decarceration, have been recognised and recommended as being effective in preventing the spread of COVID-19 in prisons by greatly reducing the number of people in prison.

Similarly, there is unequivocal evidence confirming that one of the most effective ways of reducing the incidence of HIV and viral hepatitis in prisons, while also protecting rights and limiting suffering, is through the provision of harm reduction services such as OAT and NSPs.[41] This has been endorsed by numerous human rights[42] and public health authorities.[43] Indeed, the provision of harm reduction services for people who use drugs is now recognised as a component of the right to health and constitutes a legal obligation under international human rights law, which States must progressively realise.[44] Nevertheless, globally OAT is only currently available in at least one prison in 59 countries, while NSPs are currently only available in at least one prison in 10 countries.[45]

3.3 THE OBLIGATION TO PROVIDE ESSENTIAL MEDICINES

Another core obligation stemming from the right to health which also engages the right to prevent torture and ill-treatment is the provision of essential medicines.[46] According to the World Health Organization Essential Medicine Programme, essential medicines are those that satisfy the priority health care needs of the population and should be available at all times, in appropriate dosage forms, with assured quality, and at an affordable price.[47] The WHO's Model List of Essential Medicines includes methadone and buprenorphine, drugs commonly used to treat opioid dependence. These and other drugs on the list, such as morphine, interferon alpha and antiretroviral drugs, are also essential for the treatment of COVID-19, HIV, HCV and TB, and for pain management and relief. The obligation to provide essential medicines is non-derogable and must be discharged on a non-discriminatory basis, meaning that it can never be limited and must be fulfilled in prisons. The former Special Rapporteur on the right to health and the Human Rights Committee have both confirmed that there is an obligation on States to ensure that people who use drugs deprived of their liberty are provided with, among other things, essential medicines, and that pain and suffering of people in detention associated with withdrawal symptoms could amount to ill-treatment,[48] as found by the European Court of Human Rights in *McGLinchey and Others v UK*[49] and *Wenner v Germany*.[50]

3.4 THE OBLIGATION TO ENSURE ACCESS TO UNDERLYING DETERMINANTS OF HEALTH

As clearly exposed by the COVID-19 pandemic, the health status and outcomes of individuals and communities are not only influenced by individual genetics and lifestyle choices, but also by a broad range of structural, social, economic, environmental and political factors. These are known as the underlying determinants of health. Disparities in the underlying determinants of health disproportionately affect marginalised and vulnerable populations, including people deprived of their liberty, making them more prone to poor health and wellbeing. These disparities are amplified during times of crisis, such as the COVID-19 pandemic.

In the context of prisons, the underlying determinants of health have an enormous impact on the prison population's health and wellbeing.[51] They include, but are not limited to: adequate living and working conditions, nutritious food, fresh air, clean water and adequate sanitation, health education, non-discrimination, and active and informed participation in decisions affecting their health. Prison authorities have an obligation to ensure that people deprived of liberty have the best chance to be as healthy as possible by doing everything they can to provide access to these and other underlying determinants of health. This obligation derives predominantly from right to health[52] and the freedom from torture and ill-treatment,[53] and is also recognised in the Standard Minimum Rules for the Treatment of Prisoners (Nelson Mandela Rules).[54] The application of COVID-19 prevention and control measures in prisons have had a considerable impact on the underlying determinants of health for people in detention, including on adequate living conditions. The Nelson Mandela Rules confirms that "[i]n no circumstances may restrictions…amount to torture or other cruel, inhuman or degrading treatment or punishment."[55] They further prohibit the practice of indefinite and prolonged solitary confinement, as well as the interdiction of family contact.[56]

4.

FINDINGS

4.1 HEALTH AND HARM REDUCTION SERVICES IN PRISONS PRE-PANDEMIC

Despite the acute need for health and harm reduction services in prisons from both a health and human rights perspective, these are generally weak, underfunded and difficult to access – if they are available at all.[57] This section provides a brief overview of the availability and accessibility of services in prisons in the fifteen countries assessed in this study prior to March 2020, when emergency measures were adopted to address the spread of COVID-19.

AVAILABILITY OF SERVICES

Before the pandemic, the health services reviewed were provided at some level in all fifteen countries assessed. As demonstrated by the table below, HIV testing and treatment had the highest coverage of all services analysed, reportedly being available in at least one prison in all countries analysed. Conversely, NSPs and overdose prevention management (including the provision of naloxone) were the two least available services. Generally speaking, the provision of essential health and harm reduction services was inadequate prior to the COVID-19 pandemic.

Pre-pandemic availability in at least one prison

Service	
HIV testing and treatment	**All countries** Benin, Burkina Faso, Canada, France, Ghana, Indonesia, Italy, Kenya, Kyrgyzstan, Mauritius, Mexico, Moldova, Nepal, Switzerland, the UK
Testing for viral hepatitis	**11 countries** Benin, Canada, France, Ghana, Indonesia, Italy, Kenya, Kyrgyzstan, Moldova, Switzerland, the UK
Treatment for viral hepatitis	**8 countries** Benin, Canada, France, Italy, Kyrgyzstan, Moldova, Switzerland, the UK
TB testing	**12 countries** Burkina Faso, Canada, France, Ghana, Indonesia, Italy, Kenya, Kyrgyzstan, Mauritius, Moldova, Nepal, Switzerland
TB treatment	**12 countries** Benin, Burkina Faso, France, Ghana, Italy, Kenya, Kyrgyzstan, Mauritius, Moldova, Nepal, Switzerland, the UK
OAT	**10 countries** Canada, France, Indonesia, Italy, Kenya, Kyrgyzstan, Mauritius, Moldova, Switzerland, the UK
NSPs	**5 countries** Canada, France, Kyrgyzstan, Moldova, Switzerland
Drug education programmes	**10 countries** France, Indonesia, Italy, Kenya, Mauritius, Mexico, Moldova, Nepal, Switzerland, the UK
Overdose management programmes	**2 countries** Canada Moldova
Contraceptives	**6 countries** Canada, France, Ghana, Mexico, Moldova, Switzerland

ACCESSIBILITY OF SERVICES

The fact that a service is available does not automatically mean it is accessible, and this is even more true in prison settings. While all survey respondents reported that access to prison health and harm reduction services was not conditional on good conduct or time in prison, or limited to specific groups of people in detention, numerous other serious barriers to access were reported, while more were identified through secondary research.

One of the most common barriers identified by survey respondents was a lack of information about the service: only eight countries (France, Italy, Kenya, Mauritius, Moldova, Nepal, Switzerland, and the UK) were reported to provide any kind of information about the availability of health and harm reduction services to people in detention.

In other countries, services were available in some prisons but not others, resulting in an unequal provision of healthcare that was likely arbitrary and disconnected from health needs. In Canada, for example, NSPs were only available in 25% of federal prisons, and in no territorial or provincial prisons. Furthermore, in the nine federal prisons where this service was available, access was (and continues to be) contingent on the approval of prison health and security staff, indicating that there may be some discretion and/or arbitrariness in its provision, in addition to concerns about confidentiality. Naloxone was primarily accessible to prison health care staff and sometimes to correctional staff. In other countries, the availability of particular services was not consistent. In Ghana, for example, the provision of health services was irregular. It was reported that while it was possible for sick individuals to receive health services from prison authorities if certain conditions were met, they were and continue to be mostly delivered haphazardly by non-governmental organisations. Indeed, and as will become clear in the following section, the services provided by NGOs are sometimes the only ones available to people in detention.

Lack of confidentiality was another obstacle to accessing health services in many countries. When confidentiality is not respected, people deprived of their liberty can face discrimination and reprisals, among other consequences, which often results in a decrease in the uptake and continued use of health services. At the same time, perceived lack of confidentiality makes people reluctant to access health services in the first place. In Benin, people in detention had to be accompanied to health services by prison security guards. In Italy, prison officers could be present during medical examinations and consultations.[58] In Mauritius, ARV treatment for HIV had been provided in public (including in the prison courtyard), reinforcing discrimination and discouraging adherence to treatment.[59]

In some countries, resource shortages were a serious barrier to service accessibility. In Benin, shortages of medicine and medical equipment were found by the UN Subcommittee on Prevention of Torture (SPT) to have resulted in a decrease in medical consultations and treatment seeking behaviour.[60] In Indonesia, one respondent indicated that prison health services for people who use drugs or living with HIV in prison were overstretched and could not meet demands because of prison overcrowding. In the UK, longstanding austerity measures have resulted in serious health staff shortages, which have hampered the delivery of health services and increased waiting times for people in detention to access treatments.[61]

In Moldova, it was reported that although there were no legal or administrative barriers to service accessibility in prisons, a prison subculture which fosters inter-prisoner violence, played a major role in limiting access to health services for some people in detention.[62] The European Committee for the Prevention of Torture (CPT) has highlighted that this subculture is a major barrier to accessing and staying on OAT in particular.[63] People in prisons who enrol in OAT are frequently subject to isolation, resulting in many of them stopping OAT upon entry into prison.[64] Other barriers identified included the scarcity of medical staff, confidentiality issues, limited access to independent medical examinations, a lack of medication and funding for prison health, which forces people in detention to pay out of pocket for medicine, including for TB.[65]

In the UK, while OAT was generally available to all those who needed or wanted it in prisons, the CPT reported in 2018 that challenges in accessing records from community services and external medical practitioners often hindered the continuity of OAT when arriving to prison. In four different prisons visited, for example, people in detention receiving OAT in the community who entered prisons on a Friday were unable to access treatment again until after the weekend. Instead, they might be prescribed a drug for withdrawal symptoms, but the CPT noted that in several cases patients had suffered considerably from withdrawal symptoms.[66]

4.2 RESPONSES TO COVID-19 IN PRISONS AND THEIR IMPACT ON THE PROVISION OF HEALTH AND HARM REDUCTION SERVICES

The following section looks at the various measures implemented to curb the spread of COVID-19 in prisons and the impact these had on the provision of health and harm reduction services in prisons in the fifteen countries surveyed.

Although the implementation of mask and hand washing requirements was not reported by many respondents (only Burkina Faso and Mauritius), this is likely an oversight as these measures, which are both relatively easy to implement and impactful in terms of curbing the spread of COVID-19 in prison settings, are widely noted in the literature. Conversely, the implementation of physical distancing measures, despite being difficult to achieve in prison settings, was reported in all countries apart from Benin and Ghana. While social distancing was likely attempted in these two countries as well, overcrowding likely made it impossible. Indeed, the prison service in Ghana confirmed that it was almost impossible to implement social distancing protocols due to the congested nature of the country's prisons.[67]

Lockdowns were reportedly implemented in prisons at the beginning of the COVID-19 pandemic and at various other times during the pandemic in all countries surveyed apart from Ghana and Mauritius,[68] with people in most countries confined to their cells for sometimes 23 or 24 hours a day, and a full suspension of regular activities in most prisons, including work, school, leisure and physical activities.[69] In many countries, these lockdowns were prolonged, indefinite and occurred on multiple occasions. In the UK, a survey of over 1,400 people in detention found that 85% reported being locked in their cells for more than 23 hours a day often for months at a time, with access to all regular activities largely suspended.[70] Another review of three UK prisons in June 2020 further found that prison authorities recognised that 23 hour per day lockdowns were unsustainable and felt they had sufficient staff to contain the spread of COVID-19, but believed they had no autonomy to increase time out of cell and could offer no reassurance about when the restrictions would ease.[71]

Infection control through the use of quarantine for all new detainees, as well as those returning after a short leave or being transferred, was only reported in Benin, Burkina Faso and Italy, but research reveals that other countries surveyed have also implemented this policy in one or more prisons, including - but probably not limited to - Canada, France, Switzerland and the UK.[72] In Canada, for example, extensive quarantine for prevention purposes was reported in federal prisons, as well as in at least six of the country's 13 provinces and territories, sometimes lasting up to 24 days.[73] Prisons in the province of Quebec imposed a mandatory quarantine on new arrivals, including for those who were fully vaccinated.[74] Quarantine took place in a small cell for 23 hours a day, for 14 days straight, with no visits from medical professionals and reportedly nothing provided to help pass the time.[75] Despite their intention to limit the spread of COVID-19, Quebec's prisons still experienced several outbreaks.[76] In the province of Manitoba, all youth admitted since the beginning of the pandemic have been required to quarantine for 14 days as a public health measure in conditions that mimic solitary confinement: youth reported having only 15 to 30 minutes of free time per day, as well as limited and inconsistent access to educational, mental health, and cultural supports.[77] In France, health rules implemented in response to COVID-19 impose 10 to 14 days of isolation each time detainees return from a leave of absence, or after a family visit or outpatient medical treatment. As a result, the French chief prison inspector has reported that some people in detention have refused outpatient medical treatment, despite all the risks this presents to their health.[78]

The suspension of visits was reported in all countries, which prevented not only family and friends from coming into prisons, but external services as well, including harm reduction and other health service providers. In Burkina Faso, Canada, France, Ghana, Indonesia, Kenya, Mauritius, Moldova, and the UK, it was reported that entry into prisons for external service providers was either prohibited or extremely restricted at some point during the pandemic. As prisons in many countries rely on NGOs and other external providers to deliver essential services, this had a significant impact on the availability of health and harm reduction services. In Burkina Faso, for example, this reportedly had a particularly negative effect on the provision of screening and treatment services as these were often performed by NGOs. In Benin and Ghana, visit restrictions greatly reduced the frequency of medical services provided by NGOs, including sensitisation campaigns. In Canada, all external service provider visits were suspended during earlier waves of the pandemic. In the province of Nova Scotia, people in detention further reported that they did not have access to a physician during the pandemic, that their drug-related or mental health care was discontinued, and that their

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medical procedures were indefinitely postponed.[79] In Kenya, limitations on visits had a particular impact on the provision of psychotherapy and human rights sessions for people in prisons, as well as on the availability of medical supplies usually provided by families and external organisations.[80] In some countries, restrictions on prison visits were implemented unevenly among prisons, with some groups experiencing tighter controls. In Indonesia, for example, visits were limited in the majority of prisons, but women's prisons reportedly experienced the highest restrictions.[81]

In France, many NGOs that provided voluntary health and social services in prisons suspended or greatly reduced their prison-based activities during lockdowns, including four out of the five specialised centres for "addictions counselling" (CSAPA) which support people who use drugs or with a history of sexual violence.[82] In Italy, all external service providers working in prisons reduced their activities from the end of February 2020, including those for people who use drugs, which reportedly led to a reduction in counselling, as well as testing and treatment for infectious diseases such as hepatitis C. Even after the strict lockdown period, interventions by external providers in Italian prisons remained limited, which reportedly impacted the diagnosis of drug-related health issues and the granting of alternative measures.[83]

In Mexico, there were reportedly limited services for people in prison living with HIV, while sexual and reproductive health services – specifically, contraceptives and abortion treatment – and drug education programmes were suspended. In Nepal, while HIV treatment continued, HIV and TB testing, as well as viral load testing and care for other opportunistic infections were reportedly abruptly ceased. Similarly, in Kyrgyzstan, treatment and testing for tuberculosis and viral hepatitis were reportedly suspended, as was the provision of OAT.[84] In Benin, restrictions reportedly impacted the regularity, quantity or durability of health service provision in prisons, while a suspension of drug education programmes was reported in Indonesia. Furthermore, disruptions of and/or suspensions in the transfer of individuals to hospitals for specialist appointments and care reportedly occurred in Mexico and Moldova, while longer waiting times for people deprived of liberty for external specialist services were reported in Italy.

Like in the broader community, the redeployment of resources and staff to support COVID-related health services disrupted other critical health services in prisons. Shortages of essential medicines and medical products in prisons were reported in Benin, Burkina Faso, Canada,[85] Indonesia, Kenya, Mauritius, Mexico and Nepal. In Mexico, these shortages were blamed on the deprioritisation of prison settings, with all available resources deployed to contain the spread of the virus in the broader community. The shortage of medical personnel in France, Indonesia and Italy reportedly disrupted and/or limited the availability and accessibility of medical services in prisons. Benin, Kenya and Mauritius reported not only the shortage of essential medicines but also limited access to Personal Protective Equipment (PPE) to combat the spread of the virus. Respondents in Benin further reported a shortage of products essential for maintaining personal hygiene, such as soap, feminine hygiene products, toilet paper, mattresses, blankets, and clothes.

Despite the many restrictions in place, some health and harm reduction services continued to be available to people in prison during the pandemic. Canada, France, Italy, Kenya, Mauritius, Moldova, Switzerland and the UK all reportedly continued to provide OAT, as well as HIV and HCV testing and treatment in at least one prison. Canada,

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France, Moldova, and Switzerland reportedly continued to provide access to NSPs in at least one prison, while France, Kenya, Mauritius, Moldova, Switzerland, and the UK continued to provide drug education programmes in at least one prison. Of course, as already highlighted throughout this section, some of these services did experience interruptions in their provision or became more difficult to access because of the prevention measures that were implemented.[86] In Moldova, for example, the provision of OAT was suspended in two prisons because authorities reportedly distributed the medication among themselves, and interruptions in the availability of antiretrovirals were also reported. In Canada, while the Correctional Service of Canada maintained that the "Prison Needle Exchange Program" (PNEP) continued in the prisons where it was already being provided, its promised rollout remained suspended for a long time.[87] However, even before the lockdown, many - if not most - people in prison who inject drugs were not accessing the programme because of its inherently flawed nature.[88] While it has been difficult to gather reliable data on PNEP uptake during the pandemic, civil society maintains it is safe to assume that numbers remain very low due to significant restrictions on programming that occurred at the onset of the pandemic, on top of the confidentiality concerns and other barriers to access.[89]

The prevention and containment measures reviewed in this section were implemented to protect people living and working in prisons from COVID-19-related sickness and death and probably helped to achieve that specific goal in some ways. It is clear, however, that these measures also had the effect of reducing the already limited availability and accessibility of key health and harm reduction services in prisons. It is worth also noting that the prolonged nature of the more restrictive measures – such as extended lockdowns, preventive quarantine and visit limitations – resulted in the severe isolation of people in detention, which had a particularly deleterious impact on their already fragile mental health and wellbeing.[90] In Italy, for example, suicides in prisons jumped to a 10-year high, largely due to restrictions on outside contacts which have not yet been fully reversed.[91] In the UK, a survey of over 1,400 people in detention recorded the "widespread trauma" inflicted on them as a result of extended isolation, with accounts of self-harm, suicide, suicidal thoughts, extensive despair and spiralling anxiety.[92] These measures also had far reaching human rights implications for people deprived of their liberty in the countries surveyed, including on their right to health and the prohibition of torture and ill-treatment. As pointed out by the Joint Committee on Human Rights in relation to the human rights implications of the UK government's response to COVID-19, legitimate questions remain as to whether the severe measures imposed in prisons were proportionate and whether lives could have been protected by other, less restrictive means.[93] This issue will be analysed in section V.

4.3 AFTER THE PANDEMIC: BEYOND EMERGENCY MEASURES

While most States are gradually moving away from emergency responses to, and management of, COVID-19, and beginning to focus on recovery and long-term plans and measures, the situation in prisons is not generally as promising. The following section explores some of the failures and achievements of moving beyond emergency measures in prisons in the fifteen countries surveyed.

While most of the countries had lifted the majority of COVID-19 restrictions in the broader community at the time of the survey and appeared to be following general guidance on preventing and managing the virus in closed settings, prisons in some countries continued to implement incredibly restrictive measures years into the pandemic, and in some cases still have some measures in place at the time of writing, raising questions as to their exceptional or temporary nature. In many countries, lockdowns continued to be imposed in prisons long after they were lifted in the broader community. In the UK, for example, the survey of 1,400 people in detention found

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In Canada, preventive quarantine for as much as 23 hours per day and lasting up to 24 days was used for an extended period of time and remains in place in at least some prisons in the country,[96] while prison in-reach[97] and visits remain suspended in some institutions.[98] Preventive quarantine also continued to be applied for extended periods for all new individuals and people transferred from other closed settings in France, and likely in more countries too.

In most countries, while visits have resumed, they are very different from what they used to be. Not only are they often less frequent, but they also remain much more restricted than before the pandemic. With masks, physical distancing, and the actual separation of people, some visitors have expressed that they do not want to visit their imprisoned relatives in these conditions.[99] In at least four prisons in Mexico, the number of visits have been permanently reduced.[100] In France, a resumption of visiting hours brought with it the implementation of a reinforced isolation policy.[101]

In some prisons, the impact of COVID-19 restrictions on the availability and accessibility of health and harm reduction services are still being felt, even if strict measures have been lifted. In Mexico, for example, medicine shortages continue to be a problem and the quality of health services reportedly remains subpar. In Nepal, prison overcrowding continues to render the less restrictive and most effective prevention measures, such as physical distancing and mask wearing, completely ineffective. In Italy, interventions by external providers reportedly remain limited and many activities have struggled to resume in some prisons, which has had a negative impact on the diagnosis of drug-related health issues and the granting of alternative measures.[102]

There have been some examples of good practice in the countries surveyed, whereby prison authorities have successfully adopted more moderate prevention and containment approaches (either immediately or in time), or implemented mitigating measures to help protect mental health and wellbeing. The urgency of the crisis has also provided a rare impetus for the development of some important innovations and minor reforms that merit highlighting.

In the Lombardi region of Italy, for example, as of November 2022 all prisons had lifted previous COVID-19 restrictions and replaced them with more reasonable prevention strategies, such as swabbing new or transferred individuals, the use of protective equipment in health care areas, five-day quarantine for positive cases and ten-day health surveillance for close contact cases. Visits had also resumed for families and external service providers, treatment for COVID-19 and other diseases was guaranteed, and telecardiology and teleradiology services were being implemented in the major institutions.

In Switzerland, the prevention strategies implemented in prisons were less extreme than in the other countries surveyed. This was reportedly possible largely because of structural conditions and occupancy rates, which made it easier to implement physical distancing measures and less severe lockdowns.[103] For example, in some prisons instead of full facility lockdowns, special measures were taken from the outset to prevent contact between wings. This allowed for continued freedom of movement, social contact and work within individual wings. Where work opportunities were suspended, people in detention continued to receive compensation.[104] In juvenile detention centres, outdoor activities continued to be

permitted if social distancing rules were respected and family visits could take place if quarantine measures were adhered to.[105] In some prisons in the country, the goal was to maintain peoples' daily routine and to avoid unrest. In others, where stricter lockdowns were implemented, the goal was to ensure the highest possible security against the pandemic.[106] In these institutions, potential unrest was avoided through the implementation of a comprehensive communication strategy and the expansion of communication channels, including video telephony and extended telephone calls.[107] In Champ-Dollon Prison specifically, informal seminars were held on each prison floor to communicate risk to people living and working in the prison. During these seminars, people living in prisons were encouraged to ask questions and share how they felt about the measures implemented during the pandemic.[108]

In Canada, the pandemic response has evolved in some institutions, with key developments in federal prisons including population management strategies based on the cohort model similar to that adopted in Switzerland that allows groups on the same range of living units to attend work, school, programmes or recreation time together.[109] It is hoped that this alongside other measures such as enhanced video visitation capacities, rapid tests, and vaccine rollouts, will help to limit as much as possible resorting to indiscriminate measures like general lockdowns and other harmful practices such as isolation and solitary confinement.[110] It is worth noting that the Office of the Correctional Investigator also implemented a virtual visit model from January 2021, which ensures, as much as possible, secure means to conduct confidential interviews with people in prison through visual electronic platforms.[111]

In other countries, health and harm reduction services were either introduced or modified during the pandemic to safeguard the health of people who use drugs in prison. In Kenya, for example, the first prison-based medication-assisted-therapy (MAT) clinic was opened in the Shimo La Tewa Prison in Mombasa within one month of the first confirmed case of COVID-19 in the country.[112] This intervention was able to be pushed through because of a policy opportunity created by the pandemic, where prison authorities feared allowing individuals to leave for treatment would introduce the virus to the overcrowded prison facility.[113] As of 2021, the clinic was providing methadone to 214 clients.[114]

In Scotland, where approximately 25% of people in prisons receive a daily dose of OAT (methadone), a decision was taken early on in the pandemic to switch to the use of depot buprenorphine (Buvidal) for all people currently on methadone in prison serving sentences of six months or longer.[115] Available as 7-day or 28-day injection, depot buprenorphine helps to ensure continuity of OAT while COVID-19 restrictions are in place and minimises contact with healthcare staff. Ministers and the Scottish Government agreed emergency funding of up to £1.9 million to cover the cost of transferring methadone administration to Buvidal in prisons for an initial four-month period (May-August 2020), and the Scottish government reports a step-by-step approach was put in place to ensure a careful transition for those who required it.[116] It must be noted that the exclusion of people serving shorter sentences or not currently on OAT but who might now wish to be in Scotland appears arbitrary and could therefore amount to a violation of their human rights.

In France, prison authorities reportedly made sure that continuity of essential medical care was maintained for people with chronic conditions. For example, patients receiving OAT did not have to consult a physician to renew their prescribed doses once the pandemic hit.[117] Instead, nurses delivered doses directly to patients in their cells, a change made to avoid unnecessary movement of individuals and to eliminate avoidable personal contact.[118] Nevertheless, one important lesson from the pandemic response in prisons in France has reportedly been "the need for closer and institutionalised cooperation between drug services, other health services and prison administrations".[119] This was said to be critical, particularly as many NGOs discontinued the provision of their voluntary health and social services during lockdown.[120] Prison authorities also made use of article 29 of the Penitentiary Law, which states that "prisoners must be consulted by the prison administration on the activities proposed to them." Spaces were set up for people in detention to discuss the measures adopted to deal with the crisis, supposedly a first step towards the creation of spaces for dialogue and consultation with people in detention and an important step in fulfilling their right to participation.[121]

Some of the countries surveyed also adopted telemedicine services - the delivery of medical care and information through communications technology - at some point during the pandemic, including but probably not limited to Canada, France, Italy, Moldova, Nepal, and the UK. It is not clear, however, if the use of telemedicine in prisons in these countries will continue into the future or if it is just a temporary measure. The use and benefits of telemedicine in prisons have been widely endorsed and recognised,[122] and if employed on a permanent basis, could serve as a tool to minimise the constraints imposed by restrictive measures, maintain health care service continuity, and improve the equivalence of care for people in prisons.

5.

ANALYSIS

5. ANALYSIS

Limiting certain rights in times of an emergency may be legitimate and reasonable, and is explicitly provided for in both the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights.[123] Any measures taken, however, must be strictly required and comply with specific criteria. In the context of COVID-19, the Committee on Economic, Social and Cultural Right has confirmed that measures limiting economic, social and cultural rights must be necessary to combat the public health crisis, and be reasonable and proportionate.[124] They must also not be abused and should be lifted as soon as they are no longer necessary for protecting public health.[125] Similarly, measures limiting civil and political rights must be temporary, necessary, proportionate, non-discriminatory, legally authorised, subject to review and the least-restrictive alternative.[126] In the case of prisons specifically, States also have a responsibility to take steps to ensure that any restrictions are minimised,[127] and reflect the principle of "do no harm".[128]

While some of the COVID-19 prevention and control measures reviewed in this report may have been justifiable and proportionate for a time, the longer they remained in place – and particularly when they remained in place long after they were lifted in the broader community – the more this became questionable. This is particularly true for some of the more extreme measures adopted, such as extended and frequent lockdowns, preventive quarantine, and limitation of visits. These measures have caused and continue to cause an extraordinary level of direct and indirect harm, including on the mental health of people in detention and by limiting the availability and accessibility of essential health and harm reduction services. In many prison systems, the application of preventive quarantine was not grounded in law and/or was implemented in a blanket fashion, i.e. applied to all new arrivals or transfers rather than being based on an individual assessment of risk of infection.[129] This is contrary to World Health Organization recommendations, which state that medical isolation for COVID-19 should be limited to people in detention who are infected or suspected of being infected.[130]

The fact that some of these measures are still in place in some prisons, such as preventive quarantine and limitations on visits, suggests that they have become normalised and routine practice, as opposed to temporary in nature. As access to, and coverage of, rapid COVID-19 tests and vaccines expanded in prison settings - alongside the mainstreaming of handwashing and physical distancing - the use of these types of highly restrictive measures became even more egregious and disproportionate. As less restrictive means of controlling COVID-19 became more available, they should have completely replaced the more restrictive ones. This was, however, not often the case in the countries surveyed. For these reasons, the use of lockdowns, preventive quarantine and visit limitations to prevent and control the spread of COVID-19 in prisons in many of the countries surveyed likely failed – at least at a certain point – to meet the necessity and proportionality test to justify their use. They appear to have been, and/or continue to be, arbitrary, excessive, and abusive, giving rise to concerns that they could in some cases amount to a violation of human rights, including the right to health and the prohibition of torture and ill-treatment.

On top of having their rights disproportionately limited, people deprived of their liberty in the countries surveyed

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also appear to have experienced a violation of some of their *absolute* rights. While some rights can be restricted, other human rights are absolute and can therefore never be limited, even during exceptional circumstances and emergencies. In the context of this report, these rights include: the right to access to health facilities, goods and services *on a non-discriminatory basis* (the principle of equivalence); the right to essential medicines; and the prohibition of torture and ill-treatment. In addition, and as confirmed by the Human Rights Committee, States "cannot derogate from their duty to treat all persons, including persons deprived of their liberty, with humanity and respect for their human dignity, and they must pay special attention to the adequacy of health conditions and health services in places of incarceration, as well as to the rights of individuals in situations of confinement".[131]

Some of the measures adopted to prevent and control COVID-19 reviewed in this report likely had the effect, either directly or indirectly, of violating these absolute rights. The impact of extended lockdowns, preventive quarantines and restrictions on visits, for example, obstructed access to essential medicines, as well as essential health facilities, goods and services on a non-discriminatory basis, for people in detention in many of the countries surveyed, effects which are still being felt today in some countries. In most, if not all, of the countries surveyed, these measures continued long after those in the broader community were lifted, and even after testing and vaccines were rolled out in prison settings. This is a direct contravention of the principle of equivalence, which provides that people in detention should be afforded provision of, or access to, appropriate services or treatment which are at least consistent in range and quality with that available outside of prisons.

Furthermore, the use of strict lockdowns and preventive quarantine in many countries had the effect of subjecting people in prisons to prolonged and indefinite isolation regimes, some of which mimicked conditions of solitary confinement. The Nelson Mandela Rules define solitary confinement as "the confinement of prisoners for 22 hours or more a day without meaningful human contact."[132] This measure must only be used in exceptional cases as a last resort, for as short a time as possible, and it must be subject to independent review and pursuant to the authorisation by a competent authority.[133] As interpreted by Amnesty International, "[i]solation or quarantine measures should only be imposed if no alternative protective measure can be taken by authorities to prevent or respond to the spread of infection in prisons."[134] The Nelson Mandela Rules further state that prolonged solitary confinement, or isolation beyond 15 days, is considered a form of torture and is prohibited at all times.[135] It appears some of the lockdown and preventive quarantine measures taken in prisons to prevent the spread of COVID-19 in the countries surveyed were arbitrary and excessive, and effectively constituted solitary confinement, or prolonged solitary confinement in some cases. The damaging effects of these measures on the mental, physical and social health of people in detention have been widely documented and internationally recognised, and could amount to a breach of the prohibition of torture and other, cruel, inhuman or degrading treatment of punishment. As affirmed by the CPT, protective measures must never result in inhuman and degrading treatment of persons deprived of their liberty.[136] The UN Working Group on Arbitrary Detention has also emphasised "that the prohibition of arbitrary detention of liberty is absolute and universal. Arbitrary detention can never be justified, whether it for any reason related to national emergency, maintaining public security or health."[137]

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This research has also further revealed just how fragile and vulnerable to interruptions essential health and harm reduction services in prison settings are, in part due to the fact that they are often provided by external service providers. This demonstrates the urgent need for States to consider prison health as a public health issue and take full responsibility for guaranteeing equal access to quality health and harm reduction services for people in detention. While innovative measures such as the establishment of the first MAT clinic in the Shimo La Tewa Prison in Mombasa are commendable and essential, these must be anchored in domestic law and enjoy full government support – financial, political and other – to ensure their sustainability.

Unfortunately, this research further reveals that the adoption of innovative measures and reforms such as these to help protect the health and rights of people deprived of their liberty in this and future health emergencies were the exception and not the rule. More research is needed on whether prisons are now better placed to face future health emergencies without disproportionately limiting the rights of people deprived of their liberty, even if this is likely to expose limited progress. For many prisons systems it appears to be back to "business as usual", with conditions in some countries' prisons identified as having worsened since the pandemic.[138] Sadly, this suggests that an opportunity for crucial structural change in prisons has largely been missed.

What is manifestly clear however, is that the severe measures imposed in prisons in the fifteen countries surveyed were often disproportionate and have had the impact of making people deprived of their liberty more vulnerable to health and human rights harms and abuses. Additionally, some restrictive measures such as preventive quarantine and imitations on visits, appear to be becoming routine and normalised as a form of COVID-19 risk management. At this point, it seems undeniable that lives could have been protected by other, less restrictive means.

6.

CONCLUSIONS

6. CONCLUSIONS

Preventing and controlling the spread of COVID-19 in prisons globally has been an enormous challenge. The extreme measures and restrictions implemented to achieve these aims were certainly well-intentioned in the urgency of the moment, and may even have succeeded in containing the spread of COVID-19 and reducing related sickness and death in some isolated cases – but at what costs? People deprived of their liberty are not only more vulnerable to the risks of COVID-19, but also to human rights violations. This is the justification for the heightened duty of care they are owed on the part of States. While inadequately protecting them from the risks of COVID-19 would amount to a human rights violation, so too does the unreasonable or disproportionate restriction of their rights under the pretext of protecting their health. As asserted by the Committee on Economic, Social and Cultural Rights, if the measures adopted by States to prevent the spread of COVID-19 are not taken within a human rights framework, a clear risk exists that they might violate human rights and increase the suffering of the most marginalised groups.[139] It is a delicate balance to strike, and one which this report demonstrates was not achieved in the fifteen countries surveyed.

The prevention and control measures reviewed in this report have had reverberating effects on the provision of essential health care in prisons, with direct implications for State compliance with international human rights standards and norms. While COVID-19 represents an extraordinary challenge for governments and prison authorities the world over, they had and continue to have an obligation to apply a human rights framework and prioritise more effective and less restrictive approaches to manage the crisis and minimise the negative impacts on the health and human rights of people in detention.

As the world marks three years since the pandemic began, we are at yet another critical juncture where the opportunity for reflection and change are still possible. Governments and prison authorities must reflect closely on the failings and lessons learned, and ultimately on how the rights, health and wellbeing of people deprived of their liberty could have been, and can be, better protected going forward. Initiatives to set standards and policies for pandemic prevention, preparedness and response at the international level must pay specific attention to the particular needs of people deprived of their liberty, learning from the successes and failures of the COVID-19 response. Authorities are urged to meaningfully include people in detention in these processes to ensure that their unique experiences and needs are adequately considered. Similarly, more qualitative research on the experiences of people in detention is required to encourage and support honest and high-level conversations around reflection and change.

Considering the deplorable state of prison health and conditions before COVID-19, a return to pre-pandemic prison conditions cannot be an option. Decriminalisation of drug use and possession, as well as large-scale decarceration would have the effect of radically reducing the global prison population. As now widely recognised, these measures should have been among the less restrictive means adopted – in a sustainable way – to protect people in detention from the risks of COVID-19 and human rights abuses, and must be the ultimate goal moving forward. At the same time, urgent action must be taken to harness, and anchor in domestic legislation, those positive adaptations and reforms that did take place during the crisis, to ensure their sustainability and improve conditions for those who will remain in prisons during the current pandemic and beyond.

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