HARM REDUCTION INTERNATIONAL

TOWARDS AN INCLUSIVE PANDEMIC TREATY:

INCORPORATING PEOPLE DEPRIVED OF LIBERTY IN PANDEMIC RESPONSE

03/23

HARM REDUCTION INTERNATIONAL

People deprived of liberty were - and continue to be - disproportionately impacted by COVID-19, due to structural problems as well as governments' inability to adequately prepare for, and respond to, a pandemic hitting places of detention. While to a degree necessary, some of the measures introduced to limit the spread of COVID-19 in prisons proved disproportionate and ineffective to protect the health and rights of people in detention. These developments highlighted how critical it is to specifically address places of detention in any pandemic prevention, preparedness, response, and recovery effort.

Nevertheless, the zero draft of the so-called 'Pandemic Treaty', currently negotiated at WHO, does not acknowledge people deprived of liberty as vulnerable subjects, nor places of detention as settings requiring specific attention.[1]

This briefing outlines key reasons for addressing the needs of people deprived of liberty in the Pandemic Treaty and provides recommendations for amendments in that sense.

[1] In December 2021, the World Health Assembly (WHO) established an intergovernmental negotiating body (INB) to draft and negotiate an international instrument to strengthen pandemic prevention, preparedness and response (PPPR), known as the 'Pandemic Treaty'. More information on this process can be found here: https://inb.who.int/.

Background: people deprived of liberty and the COVID-19 pandemic

Over 11.5 million people are incarcerated globally, with drug offences accounting for nearly 20% of the prison population.[2] Prison settings are high-risk environments for the transmission of diseases due to overcrowding, limited access to clean water and inadequate sanitary conditions, lack of healthcare and access to good-quality food, among others. Additionally, members of vulnerable and marginalised groups are overrepresented in prisons. 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, leading to a higher risk of becoming seriously ill if contracting a disease.[3]

Despite that, **measures to control the spread of COVID-19 in prison have largely overlooked the vulnerabilities of the prison population while restricting the enjoyment of the rights of people in detention** and worsening their living conditions and access to health.[4] Harm Reduction International (HRI)'s latest report found that people living in prisons were and continue to be deeply affected by both COVID-19 and disproportionate measures taken to control its spread. Indeed, rather than improving the health and safety of people in prison, in too many cases preventive measures have negatively impacted the already limited provision of health services in prisons (including harm reduction services), and have made people in detention more vulnerable to health and human rights harms. For example, lockdowns were reportedly implemented in prisons at the beginning of the COVID-19 pandemic in the majority of countries studied, with people confined to their cells for sometimes 23 or 24 hours a day, and regular activities - including work, school, leisure and physical activities - fully suspended in most prisons. In many countries, these lockdowns were indefinitely prolonged, regardless of their necessity. Suspension of visits was also reported in all countries, which prevented access to prisons not only to family and friends but also to service providers, including those implementing harm reduction and other health services. 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 essential health services.[5]

Additionally, redirection of resources and staff to support COVID-19-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, Indonesia, Kenya, Mauritius, Mexico and Nepal. The shortage of medical personnel in France, Indonesia, and Italy reportedly disrupted and/or limited the availability and accessibility of medical

[2] Penal Reform International (2023), Global Prison Trends 2022. DOI https://cdn.penalreform.org/wp-content/uploads/2022/05/GPT2022.pdf

[3] Dolan, K., Wirtz, A.L., Moazen, B., et al. (2016), "Global burden of HIV, viral hepatitis, and tuberculosis in prisoners and detainees", in The Lancet Series: *HIV and related infections in prisoners;* Penal Reform International (2007). Health in Prisons: realizing the right to health. Penal Reform Briefing No 2. DOI https://cdn.penalreform.org/ wpcontent/uploads/2013/06/rf-02-2007-health-in-prisons-en_01.pdf

[4] Prison Insider and Centre of Studies on Justice and Society PUC. "Managing Uncertainty in Prison: Diverse response to Covid-19 (2021) available at https://www.prison-insider.com/en/articles/managing-uncertainty-in-prison; Prison Insider, Amnesty International and Thailand Institute of Justice "Forgotten Behind Bars: Covid-19 and Prisons" doi https://www.amnesty.org/en/documents/pol40/3818/2021/en/; Penal Reform International (2021) "Global Prison Trend 2021" (2021). doi https://www.prison-insider.com/en/articles/les-tendances-mondiales-de-l-incarceration2021?referrer=%2Fen%2Farticles%3Fpage%3D1%26tag%255B0%255D%3Drapport; Amy Fetting and The Sentencing Project (2022) "Can Covid-19 Teach Us how to End Mass Incarceration? Doi https://repository.law.miami.edu/umlr/vol76/iss2/3/#.YhUuXjVLWSc.twitter; Prison Reform Trust (2020), "Beyond the Emergency of the Covid-19 Pandemic: Lessons for Defence Rights in Europe; Amnesty International (2022) "Forgotten Behind Bars" doi https://www.amnesty.org/en/documents/pol40/3818/2021/en/l

[5] HRI (2023) Prison after COVID-19: Beyond Emergency Measure. p. 18 DOI https://hri.global/publications/prison-after-cov…ergency-measures/

services in prisons. Benin, Kenya and Mauritius reported not only the shortage of essential medicines but also limited access to Personal Protective Equipment 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.[6]

Meanwhile, **decongestion measures undertaken during the pandemic** - critical to reduce overcrowding and thus limit the spread of infectious diseases - **have proven to be grossly insufficient**. Although UN experts recommended countries to release "those charged for minor and non-violent drug and other offences" in the context of COVID-19,[7] mapping in mid-2020 by HRI found that decongestion measures resulted in the release of only 5.8% of the global prison population, while most countries continued imprisoning individuals during the emergency, including for offences directly related to COVID-19. Individuals benefiting from decongestion measures were mostly those who had served a significant portion of their sentence, elderly prisoners, or prisoners with pre-existing health conditions such as HIV, tuberculosis, disabilities, and chronic or terminal illnesses. Type of offences was reported to be a significant and recurring criterion for exclusion from release, with over 25% of the countries studied explicitly excluding people detained for certain drug offences, regardless of whether they suffered from health conditions or belonged to a vulnerable group.[8]

Furthermore, **COVID-19 vaccination programs have too often disregarded the prison population and staff.** Research by HRI and Penal Reform International (PRI) published in December 2021 revealed a widespread lack of transparency and information regarding vaccination rates of people living in prison and prison staff globally,[9] which makes it difficult to monitor access to COVID-19 vaccination and constitutes, in itself, a violation of the right to health.[10]

Despite evidence of its effectiveness, and guidance from international authorities,[11] the inclusion of people detained and working in prison as an at-risk/priority group in national vaccination plans has been contentious, leading to piecemeal and often insufficient implementation. Countries adopted vastly different approaches to these populations: while some explicitly prioritised people in prison and/or prison staff, others included people in prison in their plans, but not as a priority group; another group followed the same categories for people in prison as those in the broader community, and a fourth group did not make any reference to prisons national vaccinations programmes. In addition, independent reports raised concerns about prioritisation and/or exclusion of people in prison from vaccination based on political motives in a number of countries. In some countries, a lack of targeted information campaigns translated into higher rates of vaccine hesitancy in prisons than in the general population.

---

[6] Ibid. p 19.
[7] OHCHR (16 April 2020), 'Statement by the UN expert on the right to health* on the protection of people who use drugs during the COVID-19 pandemic. Available at: https://www.ohchr.org/en/statements/2020/04/statement-un-expert-right-health-protection-people-who-use-drugs-during-covid-19?LangID=E&NewsID=25797
[8] HRI (2020) COVID-19, Prison and Drug Policy: Global Scan March - June 2020.
[9] While only Argentina, Canada, Chile, Colombia, Italy, and Thailand, publish official and updated statistics on people in detention or staff who have received at least one dose, fewer countries provide desegregated data in that regard. Some countries, such as Australia, acknowledge data is not systematically recorded. As of September 2021, information on vaccination plans was found in only 46 countries and for 47 countries was unclear whether vaccination of imprisoned population had started, whereas, in 78 countries, there was no information about the vaccination rate of prison staff. HRI research also highlights that information is particularly scant for African countries.
[10] OHCHR and WHO (2008), 'OHCHR Factsheet no. 31: The Rights to Health' (Geneva: United Nations), DOI https://www.ohchr.org/documents/publications/factsheet31.pdf.
[11] WHO Regional Office for Europe "Preparedness, prevention and control of COVID-19 in prisons and other places of detention" (2020), DOI https://www.euro.who.int/__data/assets/pdf_file/0003/442416/COVID-19-prisons-visitors-eng.pdf

The result was an uneven roll-out of vaccination campaigns in prisons worldwide, with only a handful of countries reporting satisfactory vaccination rates by the end of 2021.

With regards to how prisons have adapted during and after the most intense phase of the pandemic, HRI's latest report found that while most countries have lifted the majority of COVID-19 restrictions in the broader community, and appear to be following general guidance on preventing and managing the spread of the virus in closed settings, **prisons in some countries continue to implement incredibly restrictive measures years into the pandemic**, and in some cases still have highly restrictive measures in place as of March 2023. In many countries, lockdowns continued to be imposed in prisons long after they were lifted in the broader community. In the UK, for example, a survey of 1,400 people in detention found that half reported still being locked up for 23 hours a day as of February 2022, and most felt prison conditions had stayed the same or gotten worse since the pandemic.[12] According to a source, the "general consensus…was lockdown restrictions were not a historical aberration… but were about to become the new normal for those in prison". 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.

This raises questions as to the proportionality and necessity of these measures, as well as their exceptional or temporary nature; and heightens the concern that more restrictive measures introduced during the pandemic are becoming a "new normal" for those in prison. At the same time, while some important adaptations and minor reforms have been adopted to help protect the rights and health of people living in prisons during the pandemic, many settings missed an important opportunity for positive structural changes.

[12] User Voice and Queen's University Belfast (June 2022), Coping with COVID in Prison: The Impact of the Prisoner Lockdown, p. 177.

Recommendations

This brief overview of measures adopted to confront COVID-19 in places of detention, and their limitations, confirms the importance of specifically addressing these settings, and the people detained therein, in any PPPR effort; including in national plans.

The Pandemic Treaty is a unique opportunity to ensure domestic authorities comply with their obligations to protect the health and rights of people deprived of liberty ahead of and during the next pandemic, but it currently fails to do so. We thus urge Member States negotiating the Treaty to prioritise this population, including by proposing the following amendments to the text of the Zero Draft:[13]

a. **PP 8**. Recalling the International Health Regulations of the World Health Organization and the role of States Parties and other stakeholders in preventing, protecting against, controlling and providing a public health response to the international spread of disease in ways that are [**ADD** *compliant with the principles of necessity, proportionality and legality,*] commensurate with, and restricted to, public health risks, and which avoid unnecessary interference with international traffic and trade [**ADD** *and human rights*];

b. **Article 1(d):** "persons in vulnerable situations" includes indigenous peoples, persons belonging to national or ethnic, religious or linguistic minorities, refugees, migrants, asylum seekers, stateless persons, persons in humanitarian settings and fragile contexts, marginalized [**ADD** *and criminalized*] communities, older people, persons with disabilities, persons with health conditions, pregnant women, infants, children and adolescents, [**ADD** *people deprived of liberty*] and those living in fragile areas, such as Small Island Developing States;

c. **Article 4(12):** Non-discrimination and respect for diversity – All individuals should have fair, equitable and timely access to pandemic-related products, health services and support, without fear of discrimination or distinction based on race, religion, political belief, economic or social condition [**ADD** *or other status*];

d. **Article 4(13).** Rights of individuals and groups at higher risk and in vulnerable situations – Nationally determined and prioritized actions, including support, will take into account communities and persons in vulnerable situations, places and ecosystems. Indigenous peoples, [...] marginalized [**ADD** *and criminalized*] communities, older people, persons with disabilities, persons with health conditions, pregnant women, [**ADD** *people deprived of liberty,]* infants, children and adolescents, for example, are

[13] Some of these recommendations were formulated by members of the Civil Society Alliance for Human Rights in the Pandemic Treaty (CSA), and were first published in the briefing available here: https://bit.ly/ZeroDraftHumanRights (last accessed 07 March 2023).

disproportionately affected by pandemics, owing to social and economic inequities, as well as legal and regulatory barriers, that may prevent them from accessing health services;

e. **Article 14(2):** Towards this end, each Party shall:

(a) incorporate into its laws and policies human rights protections during [**ADD** *which should apply to situations in which states take action to prevent, prepare for or respond to public health emergencies, including by ensuring that limitations or derogations of human rights during public health emergencies must be: (i) provided for and carried out in accordance with the law; (ii) based on scientific evidence; (iii) directed toward the legitimate objective of protecting public health; (iv) strictly necessary in a democratic society; (v) the least intrusive and restrictive means available to protect public health; (vi) neither arbitrary nor discriminatory in application; (vii) of limited duration; and (viii) subject to review;*

[(b) ensure that all measures taken that limit or derogate human rights in the context of a public health emergency] including but not limited to, provision of health services and social protection programmes, are non-discriminatory and take into account [**ADD** *and prioritize*] the needs of people at high risk and persons in vulnerable situations;

[**ADD** *(c) ensuring that*] people living under any restrictions on the freedom of movement, such as quarantines and isolations **[ADD** *or in prisons or other detention settings*]:

(i) have sufficient access to **[ADD** *all necessary medication,*] health services **[ADD** *products, and technologies*];

[**ADD** *(d) Ensure that people retain, at all times, meaningful access to justice and effective remedies, including for alleged violations of rights perpetrated in the context of public health emergencies. Such remedies must include judicial remedies*];

f. **Article 15(c):** develop, as necessary, and implement global policies [**ADD** *with direct and meaningful participation of affected persons and community-led organizations*] that recognize the specific needs, and ensure the protection of, persons in vulnerable situations, indigenous peoples, [**ADD** *people deprived of liberty*] and those living in fragile environments or areas, such as Small Island Developing States, who face multiple threats simultaneously, by gathering and analysing data, including data disaggregated by gender [**ADD** *and other prohibited grounds of discrimination*], to show the impact of policies on different groups.