



Preparedness, prevention and control of COVID-19 in prisons and other places of detention

> Interim guidance 8 February 2021



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Interim guidance 8 February 2021 This document is an update of the guidance first published on 15 March 2020. It presents 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.

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ABBREVIATIONS

ARDS	acute respiratory distress syndrome
COVID-19	coronavirus disease 2019
СТ	community transmission
ECDC	European Centre for Disease Prevention and Control
HCID	high-consequence infectious disease
IPC	infection prevention and control
NAAT	nucleic acid amplification test
nCoV	novel coronavirus
PHE	Public Health England
PPE	personal protective equipment
RDT	rapid diagnostic test
RT-PCR	reverse transcription polymerase chain reaction
SARI	severe acute respiratory infection
SARS	severe acute respiratory syndrome
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2
UNODC	United Nations Office on Drugs and Crime

GLOSSARY

Cohorting Placement of suspected or confirmed COVID-19 cases in the same cell and separated from others. This strategy is used when single cells are not available, or the occupancy rate is anticipated to be at 100% or more. In such situations, suspected, probable or confirmed COVID-19 patients should be grouped together (cohorted) – suspected with suspected, probable with probable, etc. – in adequately ventilated areas with beds placed at least 1 metre apart (1).

Medical isolation Separation of suspected or confirmed COVID-19 cases in a single room (1). Individuals in medical isolation are believed to be infected – i.e. have signs and symptoms suggestive of COVID-19 and/or have tested positive for SARS-CoV-2. In WHO technical guidance, the term "isolation" is used for such separation; however, in the prison context, it is necessary to distinguish medical isolation, in this sense, from isolation of individuals as an application of security rules or punishment.

Quarantine Restriction of activities and/or separation from others who are not ill in such a manner as to prevent possible spread of infection or contamination (2). In the context of the current COVID-19 pandemic, WHO recommends that all contacts of confirmed or probable COVID-19 cases be quarantined in a designated facility or in their cell for 14 days from their last exposure (3).

Refined allocation procedures Separate placement of people in prison at highest risk of complications or poor outcomes. This procedure may be used when implementing quarantine of contacts, if necessary, depending on available space and those eligible for quarantine.

PREPAREDNESS, PREVENTION AND CONTROL OF COVID-19 IN PRISONS AND OTHER PLACES OF DETENTION







1. INTRODUCTION

People deprived of their liberty, such as people in prisons and other places of detention,¹ are likely to be more vulnerable to coronavirus disease (COVID-19) than the general population because of the confined conditions in which they live together for prolonged periods of time. Moreover, experience shows that prisons, jails and similar settings where people are gathered in proximity may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons. The response to COVID-19 in prisons and other places of detention is particularly challenging, requiring a whole-of-government and whole-of-society approach, for the following reasons (*4*, *5*):

- 1. Widespread transmission of an infectious pathogen affecting the community at large poses a threat of introduction of the infectious agent into prisons and other places of detention; the risk of rapidly increasing transmission of the disease within prisons or other places of detention is likely to have an amplifying effect on the epidemic, swiftly multiplying the number of people affected.
- 2. Efforts to control COVID-19 in the community are likely to fail if strong infection prevention and control (IPC) measures, adequate testing, treatment and care are not carried out in prisons and other places of detention.
- 3. Regardless of the ministry responsible for the provision of health care in prisons and other places of detention, coordination and collaboration between health and justice sectors are paramount to protect the health of people in prisons and other places of detention and the wider community.
- 4. People in prisons and other places of detention are already deprived of their liberty and may react differently to further restrictive measures imposed upon them.
- 5. Critical measures for COVID-19 prevention and control may be more difficult to implement in lowcapacity settings. While poorly implemented measures can increase the risks of COVID-19 transmission, inadequately adapted interventions can have adverse impacts on overall public health as well as a range of other far-reaching consequences (6).

¹ Places of detention, as defined for the purposes of these guidelines, comprise large, institutional, residential establishments, including prisons (public and privately managed), justice-related detention settings, immigration detention centres, and the children and young people's detention estate.

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- The current version of this guidance updates the recommendations included in the version published on 15 March 2020. The main differences and additions compared to the previous version include the following:
 - update of signs and symptoms of COVID-19
 - revision of case definitions
 - update of transmission scenarios
 - guidance on use of masks in prisons and other places of detention
 - updated information on vaccine availability and recommendations for access
 - addition of a section focusing on the sustainability of services to people in prison
 - additional detail on the main indicators to report for surveillance purposes
 - testing strategy for prisons and other detention settings
 - update on guidance for quarantine, medical isolation and modified strategies for the prison context, including refined allocation procedures and cohorting
 - additional recommendations, specifically in light of emerging outbreaks in prisons, on preventive measures for individuals entering prison (people newly admitted to prison or transferred).

2. RATIONALE

In addition to differences in demographic characteristics, people deprived of their liberty typically have a greater underlying burden of disease and worse health conditions than the general population. They frequently face greater exposure to risks such as smoking, poor hygiene and weak immune defence due to stress, poor nutrition, or prevalence of coexisting diseases, such as bloodborne viruses, tuberculosis and drug use disorders.

The COVID-19 outbreak, which was first detected in Wuhan, China, in December 2019, has been evolving rapidly. On 30 January 2020, the WHO Director-General declared that the current outbreak constituted a public health emergency of international concern (PHEIC), and on 11 March 2020 the COVID-19 outbreak was declared a pandemic (*7, 8*).

Prisons and places of detention are enclosed environments where people (including staff) live in close proximity. In these circumstances, prevention of introduction of the virus into prisons and other places of detention is an essential element in avoiding or minimizing the occurrence of infection and of serious outbreaks in these settings and beyond.

Depending on the transmission pattern of COVID-19 in a specific country/territory/area (no cases, sporadic cases, clusters of cases and community transmission), the risk of introducing COVID-19 into prisons and other places of detention may vary. In all countries, the fundamental approach to be followed is prevention of introduction of the infectious agent into prisons or other places of detention, limiting the spread within the prison, and reducing the possibility of spread from the prison to the outside community. This will be more challenging in countries or areas with more intense transmission.

Every country has a responsibility to increase its level of preparedness, alert and response to identify, manage and care for new cases of COVID-19. Countries should prepare to respond to different public health scenarios, recognizing that there is no one-size-fits-all approach to managing cases and outbreaks of COVID-19. Four transmission scenarios that could be experienced by countries at subnational level have been defined for COVID-19 (Table 1) (9). The community transmission (CT) scenario is the most intense and has itself now been divided into four levels, from low incidence (CT1) to very high incidence (CT4). Consequently, there are now seven categories, each with its own aim and strategic actions for each priority area of work. Each country should assess its transmission scenarios at subnational level, and full details about the recommended measures for each scenario should be consulted (10).

Table 1. Definition of COVID-19 transmission scenarios

Transmission scenario	Definition
No (active) cases	No new cases detected for at least 28 days (twice the maximum incubation period), in the presence of a robust surveillance system. This implies a near- zero risk of infection for the general population.
Imported/sporadic cases	Cases detected in the past 14 days are all imported, sporadic (e.g. laboratory-acquired or zoonotic) or are all linked to imported/sporadic cases, and there are no clear signals of further locally acquired transmission. This implies minimal risk of infection for the general population.
Clusters of cases	Cases detected in the past 14 days are predominantly limited to well- defined clusters that are not directly linked to imported cases, but which are all linked by time, geographic location and common exposures. It is assumed that there are a number of unidentified cases in the area. This implies a low risk of infection to others in the wider community if exposure to these clusters is avoided.
Community transmission – level 1 (CT1)	Low incidence of locally acquired, widely dispersed cases detected in the past 14 days, with many of the cases not linked to specific clusters; transmission may be focused in certain population subgroups. Low risk of infection for the general population.
Community transmission – level 2 (CT2)	Moderate incidence of locally acquired, widely dispersed cases detected in the past 14 days; transmission less focused in certain population subgroups. Moderate risk of infection for the general population.
Community transmission – level 3 (CT3)	High incidence of locally acquired, widely dispersed cases in the past 14 days; transmission widespread and not focused in population subgroups. High risk of infection for the general population.
Community transmission – level 4 (CT4)	Very high incidence of locally acquired, widely dispersed cases in the past 14 days. Very high risk of infection for the general population.

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3. PLANNING PRINCIPLES AND HUMAN RIGHTS CONSIDERATIONS

Contingency planning is essential in ensuring an adequate health response and maintaining secure, safe and humane detention settings. Generally, plans are available for local, short-lived emergency and resilience actions. However, the evolving nature of infectious outbreaks of epidemic or pandemic proportions, locally, nationally and globally, go beyond such plans, having a potential impact on security, the wider judicial system and, in extreme cases, civil order. In addition, business continuity plans should be in place for ensuring the security and safety functions inherently associated with prisons and other places of detention.

It is of paramount importance to work in partnership across public health agencies, health-care services and places of detention, bringing together community services and prison/detention services.

The human rights framework provides guiding principles in determining the response to the outbreak of COVID-19. The rights of all affected people must be upheld, and all public health measures must be carried



out without discrimination of any kind. People in prisons and other places of detention are not only likely to be more vulnerable to infection with COVID-19, they are also especially vulnerable to human rights violations. For this reason, WHO reiterates important principles that must be respected in the response to COVID-19 in prisons and other places of detention, which are firmly grounded in human rights law as well as the international standards and norms in crime prevention and criminal justice (*11*):

- The provision of health care for people in prisons and other places of detention is a state responsibility.
- People in prisons and other places of detention should enjoy the same standards of health care that are available in the outside community, without discrimination on the grounds of their legal status.
- People in prisons and other places of detention should be supported to have the same access to safe water, sanitation and hygiene, and IPC measures that are available to the general population (12).
- New detentions of migrants, for reasons associated with migration or health, should be stopped, and conditions in places of immigration detention should be improved while alternatives are being scaled up and implemented.
- Special consideration should be given to children in institutions as they become more vulnerable to lockdowns and closure of social services and may face arbitrary arrest and detention, where they are also vulnerable to sexual violence (6).
- Prisons and other detention authorities need to ensure that the human rights of those in their custody are respected, that people are not cut off from the outside world, and most importantly that they have access to information and adequate provision of health care (13).
- Availability of sufficient quantities of safe water and handwashing supplies should be ensured throughout the outbreak response; approaches adopted to meet this requirement may include mobilization of available and external resources and partners (8).
- Addressing overcrowding in detention settings is a basic measure to decrease the risk of transmission (14). Enhanced consideration should be given to using non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial, sentencing and post-sentencing stages. Priority should be given to non-custodial measures for alleged offenders and people in prison with low-risk profiles and caring responsibilities, with preference given to pregnant women and women with dependent children.
- Similarly, refined allocation procedures should be considered that would allow people in prison at highest risk of complications or poor outcome to be placed separately from others in the most effective and least disruptive manner possible and that would permit limited single accommodation to remain available to the most vulnerable.
- The psychological and behavioural reactions of people in prison or those detained in other settings are likely to differ from those of people who observe physical distancing in the community; consideration should therefore be given to the increased need for emotional and psychological support, for transparent awareness-raising and information-sharing on the disease, and for assurances that continued contact with family and relatives will be upheld.
- Adequate measures should be in place to ensure a gender-responsive approach in addressing the COVID-19 emergency in prisons and places of detention – specifically, the need for additional psychological and behavioural support and sustainability of services targeted at women and children (12).
- Adequate measures should be in place to prevent stigmatization or marginalization of individuals or groups suspected or confirmed to have transmissible diseases.

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- Any decision to place people in prisons and other places of detention in conditions of medical isolation should always be based on medical grounds as a result of a clinical decision and subject to authorization by law or by the regulation of the competent administrative authority.
- The potential for "coercive isolation" on the pretext of public health is a particular risk (6).
- People subjected to medical isolation for reasons of public health protection, in the context of prisons and other places of detention, should be informed of the reason for being placed in medical isolation and given the option of having a third party notified.
- Adequate measures should be in place to protect persons in medical isolation from any form of ill treatment and to facilitate human contact as appropriate and possible in the given circumstances (for instance, by audiovisual means of communication and, whenever possible, by exploiting digital technologies).
- The COVID-19 pandemic must not be used as a justification for undermining adherence to all fundamental safeguards incorporated in the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) including, but not limited to, the requirement that restrictions must never amount to torture or other cruel, inhuman or degrading treatment or punishment; the prohibition of prolonged solitary confinement (i.e. in excess of 15 consecutive days); the requirement that clinical decisions may only be taken by health-care professionals and must not be ignored or overruled by non-medical prison staff; and that while the means of family contact may be restricted in exceptional circumstances for a limited time period, it must never be prohibited altogether (*15*).
- The COVID-19 pandemic must not be used as a justification for objecting to external inspection of prisons and other places of detention by independent international or national bodies whose mandate is to prevent torture and other cruel, inhuman or degrading treatment or punishment; such bodies include national preventive mechanisms under the Optional Protocol to the Convention against Torture (*16*), the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (*17*), and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (*18*).
- Even in the circumstances of the COVID-19 pandemic, bodies of inspection in the above sense should have access to all people deprived of their liberty in prisons and other places of detention, including to persons in medical isolation, in accordance with the provisions of the respective body's mandate. All monitoring bodies should, however, observe the "do no harm" principle when dealing with persons in places of detention (19).



4. SCOPE AND OBJECTIVES

4.1 Scope

This document is based on the international standards and norms in crime prevention and criminal justice related to prison management and non-custodial measures as well as international guidance on prison health, including the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) (15), the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) (20), the Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) (21), the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules) (22), and *Health in prisons: a WHO guide to the essentials in prison health* (2007) (23). The document aims to assist countries in developing specific plans and/or consolidating further action for prisons and other places of detention in response to the COVID-19 pandemic, with consideration of preparedness plans, prevention and control strategies, and contingency plans to interface with the wider health and emergency planning system.

4.2 Objectives

- 1. To guide design and implementation of adequate preparedness plans for prisons and other detention settings to deal with the COVID-19 pandemic situation in such a way as to:
 - → protect the health and well-being of people detained in prisons and other closed settings, those who work there (custodial, health-care and other staff), and people who visit prisons and other places of detention (legal visitors, family and friends of people in prison, etc.);
 - \rightarrow support the continued safe operation of prisons and other detention settings;
 - → reduce the risk of outbreaks which could place a considerable demand on health-care services in prisons and in the community;
 - → reduce the risk of COVID-19 introduction and spread within prisons and other places of detention and from such settings into the community;
 - → ensure the needs of prisons and other detention settings are included in national and local health and emergency planning.
- 2. To present effective preventive and response mechanisms for:
 - \rightarrow preventing the introduction of COVID-19 into prisons and other places of detention;
 - \rightarrow preventing the transmission of COVID-19 in prisons and other places of detention;
 - \rightarrow preventing the spread of COVID-19 from prisons and other closed settings to the community.

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- 3. To outline an appropriate approach to dovetailing the prison health system and the national and local health and emergency planning system for:
 - → IPC measures, including physical distancing, hand hygiene stations, cleaning and disinfection of the environment, and adequate ventilation;
 - → disease surveillance, including contact tracing;
 - → identification of suspected cases and laboratory confirmation testing;
 - → dedicated enhanced surveillance for some high-risk groups residing in closed settings to ensure prompt detention of cases and clusters (this includes active case finding through daily screening for signs and symptoms of COVID-19, including daily temperature monitoring and daily zero-reporting for all high-risk groups under surveillance);
 - → medical isolation and treatment of individuals with COVID-19 and referral for those requiring specialized or intensive care;
 - → management of wider system impacts (including impact of other measures on workforce, e.g. need for home isolation, etc.).

5. TARGET AUDIENCE

This guidance is intended to assist health-care and custodial staff working in prisons and other places of detention to coordinate public health action in such settings; it provides information on:

- SARS-CoV-2, the virus responsible for COVID-19;
- how to help prevent spread of COVID-19 (24);
- what to do if a person in prison or other place of detention or a staff member with suspected or confirmed COVID-19 infection is identified;
- what advice to give to people in prisons or other places of detention and their family members, or to staff members.

The information given here will also be useful for prison authorities, public health authorities and policymakers, prison governors and managers, health-care professionals working in prison settings, detention centre employees, people in detention, and the social contacts of people in detention.



6. GENERAL APPROACH

Preventing COVID-19 from being introduced and spreading within prisons and other places of detention and passing from such settings into the community is pivotal to avoiding COVID-19 outbreaks and thus protecting the health and well-being not only of all those who live and work in them and those who visit them, but also of people in the community outside. Establishing such control is dependent on the coordinated efforts of health-care and custodial staff, working with local and national public health agencies and with justice and interior ministries and their local counterparts, in applying the general approach summarized below.

- 1. Actions need to be taken to enable and support coordinated, collaborative efforts across organizations to achieve IPC, following national guidance. Such actions should be commensurate with the level of emergency at the time to avoid panic and to ensure implementation of the most appropriate response at the appropriate time.
- 2. Joint planning
 - → Custodial/detention staff should work together with health-care teams in prisons and other places of detention, following existing national protocols and country arrangements, to enable identification of suspected cases among employees and their subsequent management in accordance with national guidelines.
 - → Custodial/detention staff should work together with health-care teams in prisons and other places of detention to enable identification of suspected cases among people living in prison, their subsequent medical isolation in single accommodation and a subsequent clinical assessment.
- 3. Screening and surveillance as part of risk assessment and risk management
 - → The identification of risk factors that could increase the risk of introduction of the virus into the facility is part of the risk management strategy and includes evaluation of ventilation, spacing, availability of hand hygiene stations, and organization of interactions and activities, including for people in prison, staff and visitors.

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- → As part of the overall risk assessment, specific recommendations for health screening, implementation of quarantine and medical isolation need to be clearly conveyed.
- → Hand hygiene stations and masks should be available at points of entry to prisons and space of at least 1 metre between all individuals should be maintained during the screening process.²
- → Early identification, medical isolation and care of COVID-19 cases are essential. Persons who should be checked include new entrants, transfers and returnees from hospital, regardless of their legal status (whether they are detainees, visitors or prison staff).
- → Screening at point of entry should include assessment of symptoms of COVID-19 and checking for prior COVID-19 diagnosis with maintenance of symptoms (26). An algorithm for rapid implementation of source control measures should be in place in the event that a staff member, visitor or detainee is identified as symptomatic.
- \rightarrow Information should be collected on any symptoms compatible with COVID-19 (27).
- → A dedicated area should be identified for immediate medical isolation of any person who presents with a fever or symptoms during the screening process until appropriate transport or care can be arranged with local health authorities.
- → Individuals with symptoms suggestive of COVID-19 should be adequately managed they should be medically isolated until further evaluation and testing are possible, and visitors and staff should be denied access; a communication process with local public health authorities should be put in place.
- → Staff working with patients suspected of having COVID-19 must have access to the required personal protective equipment (PPE).
- → Prison staff (prison officers and health-care providers) with signs and symptoms of COVID-19 should not come to work and should be tested and treated according to national protocols. Only those who have tested negative or who have recovered can return to work/come into the detention facility, according to the criteria for release from isolation (28). Whenever testing is not available, the criteria for discharging people from isolation without retesting may be applied.
- → Policies for sick leave should be in place and communicated to staff so that they can notify occupational health services if they develop any symptoms suggestive of COVID-19 or have been identified as a contact of someone with COVID-19.
- → Advice to visitors should be provided well in advance of their visiting prisons/other detention facilities so that those who must travel are not disadvantaged. Visitors presenting symptoms suggestive of COVID-19 should be excluded from visiting. Any visitor must observe physical distancing, perform hand hygiene, follow respiratory etiquette and wear a non-medical mask. Those who have been in close contact with known COVID-19 cases in the past 14 days should be in quarantine and not visit the facility.
- → In areas with community transmission, people at higher risk of complications or poor outcomes (such as older individuals and those with underlying health conditions) should be given the opportunity for separation ³ and IPC to prevent exposure to the wider prison population (14).
- → Identification of individuals falling in the category of those considered medically vulnerable should be made by medical risk assessment at prison entry and updated, if needed, according to periodic medical assessments during the prison stay.

² A minimum space of 1 metre is recommended by WHO (updated 4 June 2020). Whenever possible, a 2-metre distance is advised (14), particularly for those at higher baseline risk of infection (25).

³ Protective isolation, also known as shielding or cocooning, falls into the scope of public health strategies through which selected individuals considered to be at higher risk of severe disease are separated from the remaining people in prison, including staff, to minimize their interactions. The groups more commonly identified include people aged over 70 and those with underlying health conditions (cardiovascular disease, chronic respiratory disease, diabetes, hypertension, chronic kidney disease, immune compromised status, including cancer, and obesity).

- → A detailed daily registry of all people moving in and out of the prison/other detention facility should be maintained.
- → Health-care teams, using recommended PPE including eye protection (face shield or goggles), gloves, medical mask and gown, should ensure that appropriate biological samples are taken in a timely manner and in compliance with clinical and information governance procedures, on advice from their public health agency, from any suspected cases and sent for analysis to laboratory facilities as per local protocols. Enough PPE supplies should be maintained and kept secure to ensure their availability under the indicated circumstances.



- → Prison/detention management should consider implementing measures to limit the mobility of people within the prison/detention system and/or to limit access of non-essential staff and visitors to prisons and other places of detention, depending on the level of risk in the specific country/area. These measures are particularly appropriate during the community transmission scenario (14). Decisions to limit or restrict visits should consider the impact on the mental well-being of people in prison and the increased levels of anxiety that separation from children and the outside world may cause. The psychological impact of these measures should be mitigated as much as possible, and basic emotional and practical support for affected people in prison should be available (29).
- → Prison/detention management should increase the level of information on COVID-19 proactively shared with people in detention. Restrictions, including a limitation of visitors, need to be carefully explained in advance and alternative measures to provide contact with family/friends, such as remote means of communication, should be introduced.
- 4. Referral system and clinical management
 - → In the context of the COVID-19 pandemic, contact tracing should begin immediately after a suspected case has been identified in a prison without waiting for laboratory confirmation, to avoid any delays in reducing transmission through public health action.
 - → In parallel, the containment strategy should include prompt testing of all suspected cases. Testing capacity may be extremely weak, if not absent, in detention facilities. Suspected cases who cannot be tested should be considered as probable cases and their contacts traced accordingly (6). For contacts who do not develop symptoms, quarantine of 14 days' duration is advised.
 - → All suspected cases should be medically isolated immediately, managed on site or in a medical facility, and discharged when tested negative or following recovery, according to WHO criteria for release from isolation (28) and as per national protocols (see section 13). According to current evidence, laboratory testing is not required for leaving quarantine after 14 days.
 - → Confirmed and suspected cases should be medically isolated in single-cell accommodation. Whenever medical isolation in single-cell accommodation is not feasible in the local context, it is advised that alternative accommodation for high-risk people in prison be established (6). Such a strategy (known as cohorting) involves placing these individuals in separate structures according to shared characteristics: suspected cases grouped with suspected cases, and confirmed cases grouped with confirmed cases. This approach should also take into account the level of severity. Even using this strategy, a minimum distance of at least 1 metre must be maintained.
 - \rightarrow All contacts of suspected cases should be quarantined for 14 days from the last time they were

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exposed to a COVID-19 patient (3). Contact tracing may be stopped once results of suspected cases are negative. For contacts of cases, WHO recommends that such persons be interviewed to collect information on clinical history and possible contacts that occurred from 48 hours before symptom onset until they were isolated. Contacts of cases should also be provided with information about IPC measures and symptom monitoring.

- → Communication should be immediately established with local public health authorities in relation to contacts who may need follow-up in the community.
- → Prison authorities should be informed and made aware of the hospitals to which they can transfer those requiring admission (respiratory support and/or intensive/semi-intensive care units). Appropriate actions need to be taken for any confirmed cases, including transfer to facilities for adequate medical isolation and treatment, as required; appropriate escorts should be used and advice on safe transfers followed. However, consideration should be given to protocols that can manage the patient on site with clear criteria for transfer to hospital, as unnecessary transport creates risk for both transport staff and the receiving hospital.
- \rightarrow A process to ensure access to laboratory testing for COVID-19 detection should be in place.
- 5. IPC measures
 - Environmental and engineering controls intended to reduce the spread of pathogens and contamination of surfaces and inanimate objects should be in place; these should include:
 - → provision of adequate space of at least 1 metre between people (detainees and staff where possible and also among staff in their workspaces);⁴
 - \rightarrow well-ventilated environments; and
 - → routine cleaning and disinfection of the environment (with frequency in accordance with the potential exposure to the virus from all touched surfaces, and according to WHO guidance) (30). High-touch surfaces should be identified for priority disinfection. These include door and window handles, kitchen and food preparation areas, counter tops, bathroom surfaces, toilets and taps, gymnasiums and workout equipment, touchscreen personal devices, personal computer keyboards, and work surfaces. The disinfectant and its concentration should be carefully selected to avoid damaging surfaces and to avoid or minimize toxic effects.
 - Administrative controls and policies for the prevention and control of transmission of COVID-19 within prisons and other places of detention include, but may not be limited to:
 - → developing and implementing IPC policies and procedures, including early recognition of detainees and staff with suspected COVID-19, hand hygiene, respiratory etiquette, physical distancing, use of masks (according to national or local guidance) (31), environmental cleaning and disinfection, and PPE use;
 - \rightarrow provision of training to staff on IPC measures as outlined above;
 - \rightarrow education and communication of IPC measures as outlined above;
 - \rightarrow establishing sustainable IPC activities, including preventing overcrowding;
 - \rightarrow providing dedicated waiting areas for symptomatic patients;
 - → planning for isolation and care of COVID-19 patients (this may involve, for instance, repurposing of other prison areas);

⁴ A minimum space of 1 metre is recommended by WHO (updated 4 June 2020). Whenever possible, a 2-metre distance is advised (14), particularly for those at higher baseline risk of infection (25).

- \rightarrow ensuring adequate supplies of PPE; and
- → ensuring adherence to IPC policies and procedures by all people.⁵
- Consideration should be given to measures such as distributing food in rooms/cells instead of a common canteen, staggered mealtimes to ensure physical distance is maintained between people in prison, and splitting out-of-cell time, which could be divided by wing/unit to avoid concentration of detainees/staff in open spaces. With these caveats, access of people in prison to the open air should be maintained and not fall below a minimum of one hour per day.
- Prison/detention management and health-care staff should work alongside local public health agencies to implement the IPC recommendations described in this document; at all times, they must balance public health risk against any operational pressures on prisons and other places of detention and the wider secure and detained estate.

7. COVID-19 VIRUS: PATHOGEN CHARACTERISTICS, SIGNS AND SYMPTOMS, TRANSMISSION

The most common symptoms of COVID-19 known to date are fever, tiredness and dry cough. Other symptoms that may affect some patients include aches and pains (e.g. myalgia), headache, coryza, sore throat, dyspnoea, diarrhoea, nausea or vomiting, and loss or change of taste or smell (*32, 33*).

Current evidence suggests that SARS-CoV-2 is predominantly spread from person to person, primarily by droplet spread (*34*). The virus may also survive on surfaces for varying periods of time depending on a number of factors, but under most circumstances the amount of infectious virus on any contaminated surface is likely to have decreased significantly within 48 hours. For information on cleaning and disinfection of environmental surfaces, see Annex 1; further details are available on the WHO website (*35, 36*).

Infection with SARS-CoV-2 primarily causes respiratory illness, ranging from mild disease (around 80% of cases) to severe disease and death (about 6% requiring specialist medical care, including mechanical ventilation). Some people infected with the virus never develop symptoms. Older people and those with underlying medical problems, such as cardiovascular disease, chronic respiratory disease, diabetes, hypertension, chronic kidney disease, immunocompromised status including cancer, and obesity, are more likely to develop serious illness.

Most estimates of the incubation period of COVID-19 range from 1 to 14 days, with a median of 5–6 days (*37*). This means that if a person remains well 14 days after exposure (i.e. contact with an infected person), they may not have been infected. Evidence suggests that SARS-CoV-2 RNA can be detected in people 1–3 days before onset of symptoms, with the highest viral loads, as measured by RT-PCR, observed around the day of symptom onset, followed by a gradual decline over time. These estimates may be updated as more data become available. For more detailed information, refer to the WHO situation reports on the pandemic, available on the WHO website (*38*).

⁵ For specific recommendations for health-care workers, including managing COVID-19 cases, see sections 13 and 14.



8. PREPAREDNESS, CONTINGENCY PLANNING AND LEVEL OF RISK

To manage a COVID-19 outbreak, there need to be effective planning and robust collaborative arrangements between the sectors (health and justice or interior, as applicable) that have responsibility for the health and well-being of people in prisons and other places of detention. Such collaboration will be critical in ensuring a sustainable health-care delivery system within prisons and places of detention.

Important steps in setting up such collaborative planning include the following:

- Appropriate contingency plans (39), including checklists (40), are needed to help prison and detention systems to self-assess and improve their preparedness for responding to infectious diseases.
- A checklist issued by WHO to evaluate preparedness, prevention and control of COVID-19 in prisons and other places of detention may be used as a self-assessment tool, allowing for subsequent sharing of

data (41, 42). Close collaboration/direct links with local and national public health authorities and other relevant agencies (e.g. local crisis units, civil protection) should be established; regular contact should be maintained throughout the planning period to share information, risk assessments and plans.

- A comprehensive risk assessment should be undertaken at the beginning of the planning phase and reviewed regularly; it should have input from (or be led by) the public health authority and include an up-to-date evaluation of the epidemiological situation. It is crucial to identify the different levels of risk and what impact they may have on the prison system and other places of detention (e.g. local circulation, including in the area where the prison institution is located; circulation within the prison system).
- Action plans in each country/custodial institution should be developed to mitigate all risks identified in the assessment. Some actions will be the responsibility of the national public health authority to deliver; some will be the responsibility of the local health service provider; and prisons and other places of detention will be responsible for others. Each action plan should specify who is responsible for delivering a particular action, the timescale for delivery, and how and by whom delivery will be ensured. Action plans should include (*43*):
 - \rightarrow integration with national emergency planning and response plans for infectious diseases;
 - → command and control arrangements to facilitate rapid communication of information and efficient situation analyses and decision-making;
 - → disease surveillance and detection (e.g. will there be an initial syndromic surveillance (screening for symptoms) for all on entry (staff/visitors)? Is testing available to all people newly arrived in prison?);
 - → dedicated enhanced surveillance for some high-risk groups residing or working in closed settings to ensure that cases and clusters are detected more promptly than through primary care or hospitalbased surveillance (in closed settings, such surveillance includes use of active case finding through daily screening for signs and symptoms of COVID-19, including daily temperature monitoring and daily zero-reporting for all individuals in high-risk groups under surveillance) (27);
 - → case management (e.g. how will suspected COVID-19 cases in prison be treated? Is there an appropriate place for rapid health assessment and medical isolation? Can units be created to house suspected cases? Is there a mechanism for safely transporting ill travellers to designated hospitals, including identification of adequate ambulance services? What response will be available in a health-care emergency involving people in prisons?);
 - → staffing contingency planning with a special focus on (a) staff availability and business continuity, including local minimum service (e.g. essential medications, diabetic checks, wound dressings, etc.); and (b) health-care needs and provision discuss the possibility/feasibility of providing care within prison versus the need to transfer patients to community health-care services for specialized/intensive care, as well as the expected impact on custodial staff contingency planning.

An essential element to be carefully considered in any preparedness plan for respiratory infectious diseases such as COVID-19 is availability and supply of essential supplies, including PPE and products for hand hygiene and environmental sanitation and disinfection. It is therefore recommended that prison governors, in collaboration with health-care professionals in prisons and other places of detention, assess the need for PPE and other essential supplies in order to ensure continuity of provision and immediate availability. It should be noted that, in order to avoid inappropriate use and misuse of PPE (*44*), staff and people in prison should be adequately trained (see section 9). The proportion of the population in detention that meets the criteria for influenza vaccination may be used as a basic proxy measure of the potential demand on

health-care services in the case of a COVID-19 outbreak in detention settings. The WHO COVID-19 Essential Supplies Forecasting Tool (ESFT) has been designed to help governments, partners and other stakeholders to estimate potential requirements for essential supplies to respond to the current pandemic of COVID-19 and is publicly available (45).

Given the possibility that some common disinfectants, such as those containing alcohol, may be misused, soap and water, together with personal towels, should be considered as a first option for hand hygiene. These should be supplied in rooms/cells night and day. In the case of environmental disinfection, however, it is necessary to ensure that products are kept locked up when not being used by service providers.

9. TRAINING AND EDUCATION

Training of staff is a key element of any preparedness plan for prisons and other places of detention. Training activities should be appropriately planned and targeted towards custodial and health-care staff operating in prison settings. Such activities should, at a minimum, cover the following areas:

- basic disease knowledge, including pathogen, transmission route, signs and clinical disease progression
- hand hygiene practice and respiratory etiquette
- appropriate use of, and requirements for, PPE
- environmental prevention measures, including cleaning and disinfection.

In response to the COVID-19 pandemic, WHO has developed several resources that may be useful in prisons and other places of detention, including:

- Online training courses on IPC and clinical management of COVID-19 available, free of charge, from Open WHO, WHO's web-based knowledge platform. These basic courses give a general introduction to COVID-19 and emerging respiratory viruses (46).
- A risk communication package for health-care facilities provides health-care workers and health-care facility management with the information, procedures and tools required to work safely and effectively. The package contains a series of simplified messages and reminders based on WHO's more in-depth technical guidance on IPC in health-care facilities in the context of COVID-19 and can be adapted to local context (47).
- A range of technical guidance covering many topics, including case management, operational support and logistics advice on use of masks (48).

Finally, before embarking on any initiative, it is absolutely essential to engage the prison population in widespread information and awareness-raising activities, so that people in prison/detention and visitors are informed in advance and understand the procedures to be adopted and why they are necessary. It is especially important that any potential restrictive measures are explained, and their temporary nature emphasized.

Because of stigma or fear, some health-care workers responding to COVID-19 in places of detention may experience avoidance by their family or community. This can make an already challenging situation far more difficult. Health-care personnel should be advised to stay connected with loved ones and have access to mental health and psychosocial support.

10. RISK COMMUNICATION

In an event such as the COVID-19 pandemic, it is crucial that there is good coordination between the teams at national and subnational levels involved in risk communication. Close contacts must be established to ensure rapid clearance of timely and transparent communication messaging and materials in such crisis situations.

Key messages for people in prisons and other places of detention, custodial staff, health-care providers and visitors must be coordinated and consistent. WHO has produced a fact sheet addressed to people in prison and another addressed to visitors (49, 50). To overcome language barriers, translation or visual materials may been needed. Information resources for custodial and health-care staff, visitors, vendors and detained persons, such as short information sheets, flyers, posters, internal videos and any other means of communication, should be developed and placed in prison common areas and in areas designated for legal visits and family visits.

Consideration should be given to how messages about risk can be delivered quickly; this should include:

- (1) an overall assessment of the local risk (community risk and risk within the prison);
- (2) advice on preventive measures, especially hand hygiene practices, respiratory etiquette and physical distancing (and use of PPE when control measures cannot be achieved);
- (3) information on use of masks as part of a comprehensive package to limit the spread of certain respiratory viral diseases, including COVID-19 (see section 12.2);
- (4) advice on measures to adopt if symptoms develop;
- (5) information about disease signs and symptoms, including warning signs of severe disease that require immediate medical attention;
- (6) advice on self-monitoring for symptoms and signs, including temperature checking;
- (7) advice on access to local health care if necessary, including how to do so without creating a risk to health-care workers.

An assessment of any language or communication issues should be made and access to a language interpretation/translation service must be provided.

PREPAREDNESS, PREVENTION AND CONTROL OF COVID-19 IN PRISONS AND OTHER PLACES OF DETENTION



11. IMPORTANT DEFINITIONS: SUSPECTED CASE, PROBABLE CASE, CONFIRMED CASE, CONTACT, CASE REPORTING

The WHO case definitions given below are based on information available as of 16 December 2020 and are being revised as new information accumulates (*26*). Countries may need to adapt these case definitions depending on their own epidemiological situation. WHO guidance for global surveillance of COVID-19 disease should be consulted for updated definitions.

11.1 Definition of a suspected case

A suspected case is:

(A) A person who meets the clinical AND epidemiological criteria.

Clinical criteria

- (1) Acute onset of fever AND cough; OR
- (2) Acute onset of ANY THREE OR MORE of the following signs or symptoms: fever, cough, general weakness/fatigue, headache, myalgia, sore throat, coryza, dyspnoea, anorexia/nausea/vomiting, diarrhoea, altered mental status.

AND

Epidemiological criteria

- (1) Residing or working in an area with high risk of transmission of the virus: for example, closed residential settings and humanitarian settings, such as camp and camp-like settings for displaced persons, anytime within the 14 days prior to symptom onset; OR
- (2) Residing in or travelling to an area with CT2 anytime within the 14 days prior to symptom onset; OR
- (3) Working in a health setting, including within health facilities and within households, anytime within the 14 days prior to symptom onset.

- (B) A patient with severe acute respiratory illness (SARI): acute respiratory infection with history of fever or measured fever \geq 38 °C; cough; onset within the last 10 days; requires hospitalization.
- (C) An asymptomatic person not meeting epidemiological criteria with a positive SARS-CoV-2 Antigen-RDT.⁶

11.2 Definition of a probable case

- (A) A patient who meets the clinical criteria above AND is a contact of a probable or confirmed case, or linked to a COVID-19 cluster.
- (B) A suspected case with chest imaging showing findings suggestive of COVID-19. Typical chest imaging findings include the following (*51*):
 - chest radiography: hazy opacities, often rounded in morphology, with peripheral and lower lung distribution
 - chest CT (computed tomography): multiple bilateral ground-glass opacities, often rounded in morphology, with peripheral and lower lung distribution
 - lung ultrasound: thickened pleural lines, B-lines (multifocal, discrete or confluent), consolidative patterns with or without air bronchograms.
- (C) A person with recent onset of anosmia (loss of smell) or ageusia (loss of taste) in the absence of any other identified cause.
- (D) Death, not otherwise explained, in an adult with respiratory distress preceding death AND who was a contact of a probable or confirmed case or linked to a COVID-19 cluster.

11.3 Definition of a confirmed case

- (A) A person with a positive NAAT.
- (B) A person with a positive SARS-CoV-2 Antigen-RDT AND meeting either the probable case definition or suspected criteria (A) OR (B).
- (C) An asymptomatic person with a positive SARS-CoV-2 Antigen-RDT who is a contact of a probable or confirmed case.

11.4 Definition of contacts

A contact is a person who has experienced ANY ONE of the following exposures during the two days before and the 14 days after the onset of symptoms of a probable or confirmed case:

- (1) face-to-face contact with a probable or confirmed case within 1 metre and for at least 15 minutes
- (2) direct physical contact with a probable or confirmed case
- (3) direct care for a patient with probable or confirmed COVID-19 without using recommended PPE
- (4) other situations as indicated by local risk assessments.

More information on contact ascertainment is available in WHO's Contact tracing in the context of COVID-19 (52).

Note: for confirmed asymptomatic cases, the period of contact is measured as the two days before, and the 14 days after, the date on which the sample that led to confirmation was taken.

⁶ Note that a nucleic acid amplification test (NAAT) is required for confirmation.

Contacts in detention settings are defined as:

- those living in the same cell as a COVID-19 case (53)
- those within 1 metre of a COVID-19 case for more than 15 minutes, e.g. in canteen, gym or detention transfer vehicle
- those having direct physical contact with a COVID-19 case (e.g. shaking hands)
- those having unprotected direct contact with infectious secretions of a COVID-19 case (e.g. being coughed on)
- those providing direct care for a COVID-19 case or collecting and handling specimens from a COVID-19 case, without recommended or appropriate PPE.

As part of a comprehensive strategy, case identification, medical isolation, testing and care, and contact tracing and quarantine are critical activities to reduce transmission and control the epidemic (52).

For contact tracing to be effective, detention settings must have adequate capacity to test suspected cases in a timely manner. If this is not possible, contact tracing strategies may instead focus on specific high-risk individuals.

Contact tracing requires individuals to agree to daily monitoring, to be willing to report signs or symptoms of COVID-19 promptly, and to be prepared to go into quarantine for at least 14 days or into medical isolation if they become symptomatic.

Engagement with the prison community and their leaders should help to identify potential challenges for contact tracing, including language and literacy barriers. It is also critical – particularly in detention settings – that contact tracing and associated steps, such as quarantine of contacts and medical isolation of cases, are not used punitively or associated with security measures.

11.4.1 Identification of contacts

To identify contacts, a detailed case investigation and interview with the COVID-19 patient or their caregiver are needed. Interviewing the coordinator/administrator of the facility may provide additional information. The list of people living in prison, working staff and visitors, and their location and movements, are also useful sources of information to identify contacts within a given timeframe.

11.4.2 Informing contacts

Each contact should first be contacted to determine whether they meet the contact definition and thus require monitoring. In the event that they are confirmed as contacts, they should be given information about contact tracing and its rationale, and information on quarantining.

11.4.3 Managing and monitoring contacts (3)

- All contacts should be quarantined and provided with information about IPC measures and symptom monitoring.
- When quarantine is necessary, authorities should ensure that adequate food, water, protection, hygiene and communication provisions can be made for the quarantine period.
- Facilities used to quarantine people should have sufficient ventilation and fresh and clean outdoor air to control contaminants and odours.
- Contacts should be monitored for potential signs and symptoms for 14 days from the last unprotected contact exposure (i.e. one without use of recommended PPE or with a possible breach of PPE use).
- Monitoring should be carried out by prison health-care or custodial staff with daily visits to see if symptoms have developed (this is important as people in prison may have a disincentive to self-report and admit to developing symptoms as they could be put in medical isolation).
- If a contact develops symptoms, the individual should be placed in medical isolation and follow the established referral pathway for testing and treatment.
- Any newly identified probable or confirmed cases should have their own contacts identified and monitored.
- The monitoring phase ends 14 days after the contact last came into contact with a COVID-19 patient, or if the contact develops COVID-19.
- In the event that contacts are in close proximity to each other, such as being in the same cell, and one of them becomes a COVID-19 case, the follow-up period is reset to 14 days after the last exposure to the new case.

Contact tracing should begin immediately after a suspected case has been identified in a prison or detention facility, without waiting for a laboratory result, in order to avoid delays in implementing health measures when necessary. This should be conducted by prison health-care or custodial staff under the supervision of the national or local health authority and according to national preparedness plans. Every effort should be made to minimize exposure of the suspected case to other people and the environment and to quarantine contacts

(separate them from others) as soon as possible (54). Contacts outside the prison (visitors, etc.) should be provided with information about IPC measures and followed up by health authorities.

Any person living in prison or staff who have had contact with a known case of COVID-19 should be placed in quarantine, in single accommodation, for 14 days from the last possible day of contact. If it is not possible to house the detainee separately, then other people with similar risk factors and exposures may be housed together while they undergo quarantine (see section 6). The individual should wear a medical mask while being transferred to a separate room. During quarantine, the person should be under medical observation as described above.

11.5 Case reporting

COVID-19 is a high-consequence infectious disease (HCID) with outbreak potential in prisons and other detention settings; all cases in such settings should therefore be notified straightaway to responsible public health authorities, who will then report to national and international authorities. Cases should remain traceable as cases identified in detention settings. If the national system does not allow such information to be preserved, countries are encouraged to report – either in an aggregated manner to public health authorities using local agreed protocols or directly to WHO – a minimum dataset that allows for close surveillance of COVID-19 in detention settings.

The following information, disaggregated by sex and age group where possible, is considered part of this dataset:

- (A) Total number of people in prison
- (B) Number of people in prison and staff tested for COVID-19
- (C) Number of suspected and probable COVID-19 cases among people in prison
- (D) Number of **confirmed** COVID-19 cases among people in prison and among staff members
- (E) Number of people in prison hospitalized for COVID-19
- (F) Number of COVID-19-related deaths among people in prison (55)
- (G) Number of people vaccinated against COVID-19 (disaggregated also by health-care professionals, prison staff and people in prison, if possible).

11.6 Managing outbreaks in prison

Whenever it is determined that there is a suspected case of COVID-19, the local prison outbreak management plan should be activated. During outbreaks in the prison, all staff (including guards) should be provided with medical masks.

Before an outbreak in prison is declared over, the ECDC advises that two clear COVID-19 incubation periods (28 days), starting from identification of the last case among people in prison or staff, should be considered. This decision should be made by an outbreak management team including prison, health-care and public health staff (14).

11.7 Testing strategy

WHO's most recent recommendation advises that suspected and probable cases should be investigated for the presence of SARS-CoV-2 using available laboratory tests (56). The decision to test should be based on both clinical and epidemiological factors. While recommended response activities are largely the same for probable and confirmed cases, testing of probable cases, where resources allow, is still useful since it can exclude patients as cases and reduce the burden required to isolate and contact-trace those patients.

Prison outbreaks are most likely to occur as a result of introduction of the virus from external sources, especially if there is widespread community transmission. Testing should therefore be considered primarily for people coming into prison (new arrivals, transfers from other institutions, or those moving on or off the premises), as an extra measure, in addition to quarantining, before they are allowed to join the general prison population.

Depending on the intensity of transmission in a specific location, the number of cases and laboratory capacity, a subset of suspected or probable cases can be prioritized for testing, as indicated by WHO's recommendations for prioritizing testing in settings where testing capacity cannot meet demand (57). These recommendations focus on early identification and protection of vulnerable people and health-care workers and identify three main groups:

- (1) people at risk of developing severe disease and vulnerable populations, who will require hospitalization and advanced care for COVID-19;
- (2) health workers (including emergency services and non-clinical staff) regardless of being contacts of a confirmed case (to protect health workers and reduce the risk of nosocomial transmission); and
- (3) the first symptomatic individuals in prisons, so that outbreaks can be identified quickly and containment measures taken promptly (all other individuals with symptoms related to the closed settings may be considered probable cases and isolated without additional testing if testing capacity is limited).

Where resources are not scarce and there is no need to prioritize testing, a "whole-prison" testing approach may be useful after identification of the first case, to be adopted in conjunction with other mitigation strategies (including case finding, contact tracing and other preventive measures) and according to national or regional recommendations (14, 58, 59). The rationale for this approach is based on the higher probability of within-prison transmission, which may be aggravated by the difficulty in maintaining physical distance. This facility-wide testing approach has been advocated for long-term care facilities, which share characteristics of congregate living and having service providers moving in and out on a daily basis (60).

Laboratory testing for SARS-CoV-2 in suspected cases should be conducted using diagnostic NAATs, such as RT-PCR, as per the WHO laboratory COVID-19 testing guidance (*61*). Note that the use of direct detection of SARS-CoV-2 viral proteins in nasal swabs and other respiratory secretions using lateral flow immunoassays giving results in less than 30 minutes (commonly known as rapid diagnostic tests, or RDTs) may only be considered if they meet minimum performance requirements (e.g. \geq 80% sensitivity and \geq 97% specificity compared to a NAAT reference assay) and exceptions are observed (e.g. do not use in individuals without symptoms unless the person is a contact of a confirmed case) as detailed in WHO guidance (*62*).

²⁴ **12. PREVENTION MEASURES**

All staff and people in prisons and other places of detention should have comprehensive awareness of COVID-19 prevention strategies, including adherence to hand hygiene measures, respiratory etiquette (covering coughs and sneezes), physical distancing (maintaining a distance of at least 1 metre from others), being alert to signs and symptoms of COVID-19, staying away from ill people, and (in the case of staff) staying home when ill. Staff should also comply with any screening measures put in place by local authorities. In alignment with local health authorities, a workplace protocol should be developed to determine how to manage any personnel who meet the definition of a suspected or confirmed COVID-19 case or their contacts.

There are currently vaccines available to prevent COVID-19. WHO defends the position that everyone, everywhere who could benefit from safe and effective COVID-19 vaccines should have access as quickly as possible, starting with those at highest risk of serious disease or death. Two key documents have been released to help guide the allocation and prioritization of populations to receive COVID-19 vaccines: (a) *WHO SAGE values framework for the allocation and prioritization of COVID-19 vaccination*, which offers high-level guidance globally on the values and ethical considerations regarding allocation of COVID-19 vaccines between countries, and offers guidance nationally on the prioritization of groups for vaccination within countries while supply is limited (63); and (b) *Roadmap for prioritizing population groups for vaccines against COVID-19*, which recommends public health strategies and target priority groups for different levels of vaccine availability and epidemiological settings (64).

In prisons, the principle of equivalence must be followed. This is based on the Mandela Rules (65), where it is clear that, for the principle of non-discrimination to be put into practice, prison administrations should take account of the individual needs of people in prison, in particular the most vulnerable. Measures to protect and promote the rights of people in prison with special needs are required and should not be regarded as discriminatory (Rule 2). Furthermore, the provision of health care for prisoners is a state responsibility; prisoners should therefore enjoy the same standards of health care that are available in the community and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status (Rule 24). This implies that the same principles highlighted in the *Roadmap for prioritizing population groups for vaccines against COVID-19* should be equally applied in detention settings (64). The target priority groups include health-care professionals, non-health-care staff providing services that carry significant risk of infection, older adults, and people at high risk of death because of underlying conditions such as heart disease and diabetes.

12.1 Personal protection measures

It is recommended that the following general precautions for infectious respiratory diseases are taken to help prevent people (staff, visitors, vendors, detainees, etc. in prisons) from catching and spreading COVID-19:

- hands should be washed often with soap and water and dried with single-use towels (see section 13.1);
- physical distancing of at least 1 metre should be observed;
- a disposable tissue should be used to cover mouth and nose when coughing or sneezing, then thrown in a bin with a lid; when a tissue is not available, cough or sneeze into a bent elbow; always perform hand hygiene after coughing or sneezing;
- touching of eyes, nose or mouth should be avoided if hands are not clean.

If possible, wall-mounted liquid soap dispensers, paper towels and foot-operated pedal bins should be made available and accessible in key areas such as toilets, showers, gyms, canteens and other high-traffic communal areas to facilitate regular hand hygiene. Security staff should assess whether such fixtures pose a security and safety risk to people in prisons and places of detention prior to their installation.

12.2 Use of masks

WHO recommends the use of masks as part of a comprehensive package of IPC measures to limit the spread of SARS-CoV-2 (*31*). WHO has developed technical guidance on the use of masks in the context of COVID-19. This guidance includes scientific evidence relevant to the use of masks for reducing the spread of SARS-CoV-2 and is applicable to health facilities in areas with community, cluster and sporadic transmission, and to the public in areas with community and cluster transmission. The guidance contains alternatives to non-medical masks for the public and indicates mask use during vigorous-intensity physical activity.

The same general principles recommended for the public are considered suitable for use in prisons and other places of detention. For health-care workers in prisons, the same principles as those applied to health facilities in the community should be followed. It is very important to train people in prison as soon as possible to understand general hygiene and ways of transmission and to make it clear that, if masks are to be used, this measure must be combined with physical distancing, hand hygiene and other IPC measures to prevent human-to-human transmission of COVID-19.

26 Masks can be used either for protection of healthy persons or to prevent onward transmission (source control). Anyone who is suspected or confirmed to have COVID-19 or is awaiting laboratory test results should wear a medical mask in the presence of others. This recommendation applies to people in prison and to prison staff. Given that it may not be possible to respect physical distancing in prison settings, use of medical masks, as described in WHO and other technical guidance, by **health-care workers** when providing care to suspected or confirmed COVID-19 cases is recommended for all scenarios (*14, 66*).

When scenarios of no cases or sporadic cases exist in the surrounding community, continuous use of a medical mask is recommended for **prison staff** when making contact with detainees at distances of less than 1 metre, during security and health checks, and during transfer of COVID-19 cases to other prisons or hospitals. During periods of widespread community transmission, in view of the importance of asymptomatic and presymptomatic transmission of COVID-19, all prison staff should continuously wear a medical mask during their routine activities.

In areas of known or suspected community or cluster transmission of COVID-19, WHO advises that:

- (a) all **people in prison** should wear a non-medical mask both indoors and outdoors where physical distancing of at least 1 metre cannot be maintained;
- (b) if indoors, unless ventilation has been assessed to be adequate,⁷ people in prison should wear a nonmedical mask, regardless of whether physical distancing of at least 1 metre can be maintained;
- (c) people with higher risk of severe complications from COVID-19 (older individuals and those with underlying conditions such as cardiovascular disease, diabetes mellitus, chronic lung disease, cancer, cerebrovascular disease or immunosuppression) should wear medical masks when physical distancing of at least 1 metre cannot be maintained (14).

Visitors to prison are advised to wear non-medical masks, in addition to observing other preventive measures, where physical distancing of at least 1 metre is not possible or when no physical barriers are in place, in areas of known or suspected community or cluster transmission of COVID-19, and according to WHO guidance on use of masks or national/local requirements for mask use (*31*). Anyone with signs and symptoms compatible with COVID-19 should be prevented from visiting prison.

For any type of mask, appropriate use, storage and cleaning, or disposal, are essential to ensure that it is as effective as possible and to avoid any increased risk of transmission (44, 67). For detailed advice on use of various kinds of PPE in prison settings, according to the epidemiological COVID-19 situation, consulting Table 1 (page 6) of the ECDC guidance is recommended (14); see also section 13.1.

Given scarce resources, many prisons may opt to use home-made masks, except for cases where use of medical masks is recommended. Detailed recommendations on manufacturing non-medical (fabric) masks are available through WHO technical guidance (44).

⁷ A recommended ventilation rate of 10 litres per second per person should be met (except in health-care facilities that have specific requirements). For further details, see: Mask use in the context of COVID-19. Interim guidance. 1 December 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/item/advice-on-the-use-of-masks-in-the-community-during-home-care-and-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak).
12.2.1 Management of masks

WHO provides the following guidance on the correct use of masks:

- Perform hand hygiene before putting on the mask.
- Inspect the mask for tears or holes, and do not use a damaged mask.
- Place the mask carefully, ensuring it covers the mouth and nose, adjust to the nose bridge, and tie it securely to minimize any gaps between the face and the mask. If using ear loops, ensure these do not cross over as this widens the gap between the face and the mask.
- Avoid touching the mask while wearing it. If the mask is accidently touched, perform hand hygiene.
- Remove the mask using the appropriate technique untie it from behind, avoiding touching the front of the mask.
- Replace the mask as soon as it becomes damp with a new clean, dry mask.
- Either discard the mask or place it in a clean plastic resealable bag where it is kept until it can be washed and cleaned. Do not store the mask around the arm or wrist or pull it down to rest around the chin or neck.
- Perform hand hygiene immediately after discarding a mask.
- Do not reuse single-use mask.
- Discard single-use masks after each use and properly dispose of them immediately upon removal.
- Do not remove the mask to speak.
- Do not share your mask with others.
- Wash fabric masks in soap or detergent and preferably hot water (at least 60 °C/140 °F) at least once a day. If it is not possible to wash masks in hot water, then wash them in soap/detergent and room-temperature water, followed by boiling for 1 minute.

12.3 Environmental measures

Environmental cleaning and disinfection procedures must be followed consistently and correctly. Cleaning with water and household detergents and with disinfectant products that are safe for use in prison settings should be used for general precautionary cleaning.

Cleaning personnel should be made aware of the facts of COVID-19 infection to ensure that they clean environmental surfaces regularly and thoroughly. They should be protected from COVID-19 infection and wear disposable gloves when cleaning or handling surfaces, clothing or linen soiled with body fluids, and should perform hand hygiene before and after removing gloves.

Premises and areas that may have been contaminated should be cleaned and disinfected before they are reused, with regular household detergent followed by disinfectant. Hypochlorite-based solutions of 0.1% (100 ppm) are an option. For surfaces that do not tolerate bleach, 70% ethanol can be used. If bleach or ethanol cannot be used in prison for security reasons, a disinfectant able to inactivate enveloped viruses may be used. Prison authorities should follow national guidance for use of disinfectants.

Manufacturer's instructions should be followed for safe preparation and handling of disinfectants, including use of appropriate PPE to avoid chemical exposure. Janitorial and housekeeping personnel should first clean

surfaces with a mix of soap and water, or a detergent, then apply the disinfectant for the required contact time, as per the manufacturer's recommendations, and finally rinse off with clean water.

Clothes, bedclothes, towels, etc. can be cleaned using regular laundry soap and water or machine-washed at 60–90 °C with common laundry detergent. All health-care waste produced during the care of COVID-19 patients should be collected safely in designated containers and bags, treated, and then safely disposed of or treated, or both, preferably on site.

Full information on water, sanitation, hygiene and waste management is available on the WHO website (36). For further guidance on environmental cleaning following a suspected case of COVID-19 in a place of detention, see Annex 1. Additional guidance on environmental cleaning is also available from the ECDC (68).

12.4 Physical distancing measures

The difficulty in applying physical distancing measures in a detention setting will vary according to the local context, the prison environment, the occupancy level and the staff available. In most cases, it will require modifications of the space distribution and in the routines and processes in place. Some possible strategies to enable people in prison to keep a distance of **at least** 1 metre from each other include using floor markings in communal spaces, including canteens and exercise areas; creating subgroups of people who have different meal and exercise times; and making spaces available in which people can separate voluntarily.

In prisons where such measures are particularly challenging, use of a firebreak approach may be considered. This strategy consists of creating subgroups of people in prison and of staff who are restricted from encountering each other. These subgroups are formed for all activities that encourage contact, including use of areas for hygiene, for exercise, for meals and for praying or culture.

During prison transfers or during health-care provision, arrangements should be made to allow the necessary physical distancing to be maintained, by adjusting schedules and/or by increasing the frequency of transfers to allow for a smaller number of people in each transfer. When maintaining the necessary distance is impossible, more stringent application of all other preventive measures is needed to minimize the transmission risk.

12.5 Consideration of access restriction and movement limitation

An assessment of each case and setting should be undertaken by prison staff in conjunction with the local public health agency. Advice on the management of staff or people in prison or places of detention will be based on this assessment.

A temporary suspension of on-site prison visits will need to be carefully considered in line with local risk assessments and in collaboration with public health colleagues and should include measures to mitigate the negative impact such a measure is likely to have on the prison population.

Such restrictions may apply to external health-care providers, in which case they may have a disproportionate impact on people living with pre-existing conditions and in need of sustained provision of care and those considered medically more vulnerable, including children living with a parent in prison.

Separation from family may also affect the psychological and mental well-being of people in prison, particularly women separated from their children, and should be considered.

Measures to restrict movement of people in and out of the detention setting, including restricting transfers within the prison/detention system and limiting access to non-essential staff and visitors, need to be considered carefully in line with appropriate risk assessments, as such restrictions will have a wider impact on the functioning of the detention system. Measures that may be considered include, as appropriate, restriction of family visits, reducing visitor numbers and/or duration and frequency of visits, and introduction of video conferencing for family members and representatives of the judicial system, such as legal advisers. Especially in situations where prison control measures differ from community control measures, given the high-risk nature of detention settings, reinforcement of support for mental health and well-being is recommended.

In particular:

- screening may be considered on entry with a self-reporting questionnaire to exclude those with symptoms;
- visitors who feel unwell should stay at home and not visit the establishment;
- visitors are recommended to wear non-medical masks when accessing the prison, in addition to adopting the appropriate respiratory etiquette and hand hygiene, alongside physical distancing;
- staff must stay at home and seek medical attention should they develop any signs and symptoms.

A workplace protocol for how to manage such situations, including a suspected or confirmed COVID-19 case or their contacts, should be in place.

12.5.1 Consideration of special precautions to prevent introduction of virus in community transmission scenarios

Prison outbreaks are most likely to occur as a result of introduction of the virus from external sources, especially if there is widespread community transmission. It is therefore advised that a 14-day period of quarantine is used for all people coming into prison (new arrivals and transfers from other institutions) before they are allowed to join the general prison population (*59*). The same quarantining principles that are used for case contacts should be followed.

12.6 Staff returning to work following travel to affected areas or with a history of potential exposure

Custodial/detention staff working in places of detention should consult occupational health services in their respective organization if they have travelled or live in a high-risk community/area where COVID-19 is spreading. They should adopt the recommended public health measures according to the transmission scenario (*9*); they should also keep up to date on the latest information on the COVID-19 pandemic, available on the WHO website and through the national and local public health authority, to familiarize themselves with any possible restrictions/quarantine periods in place.

Prisons should review their continuity and contingency plans and update them to ensure that they can perform critical functions with reduced numbers of personnel, in a manner that does not have a negative impact on the security of the prison.

³⁰ 12.7 What to do if a member of staff becomes unwell and believes they have been exposed to COVID-19

If a member of prison staff becomes unwell at work, they should be provided with a medical mask, perform hand hygiene, and be removed to a designated well-ventilated room that has been identified for staff who become symptomatic or unwell. The room should be equipped with a hand hygiene station, PPE and any other necessary medical equipment and have access to a bathroom. The unwell staff member should wear a medical mask, perform frequent hand hygiene and maintain a distance of at least 1 metre from others. They should also be advised to cover their mouth and nose with a disposable tissue when coughing or sneezing, put the tissue in a bag and throw it in a bin, and then perform hand hygiene. If they do not have any tissues available, they should cough and sneeze into their bent elbow.

Prison health-care professionals (or the individual who is unwell) should call health services or emergency services (if they are seriously ill or their life is at risk) and explain their current clinical symptoms and their epidemiological and travel history (if applicable). If the person affected is not able for any reason to call a doctor themselves, then another staff member should call on their behalf. Any staff (medical or other) involved in caring for the unwell person should wear PPE (medical mask, eye protection, gown and gloves). They should be trained in procedures for safely putting on and removing PPE and performing hand hygiene.

Laboratory testing for COVID-19 should be made available promptly for staff under such conditions. If testing is not available, the individual should be restricted from working for 10 days after symptom onset, plus at least three additional days without symptoms (including without fever and without respiratory symptoms). Prison staff should be allowed to self-quarantine at home for 14 days after the last exposure to a COVID-19 case, without fear of financial or job loss.

Once the unwell person has been transported to an appropriate facility for further assessment, the room and bathroom must be cleaned and disinfected.



13. ASSESSING SUSPECTED CASES OF COVID-19 IN PEOPLE IN PRISON/DETENTION

Case identification should be performed in accordance with available national/supranational guidance for primary care and community settings. Suspected cases among people in prison may be identified by notifications received from custodial/detention staff, other detainees, self-referral, and screening at reception, or by other means; for case definitions, see section 11. If it is determined that there is a suspected case of COVID-19, the local prison outbreak management plan should be activated. The suspected case should immediately be instructed to wear a medical mask and follow respiratory etiquette and hand hygiene practices. IPC measures, such as medical isolation, should be applied.

Medical staff should evaluate individuals with COVID-19-compatible symptoms in a designated medical area to determine whether they should be tested or further medical action taken. In this regard, it is recommended that, within each prison and other place of detention, according to the indications of health-care staff on duty and relevant national/international guidelines, a space is identified where suspected cases or confirmed cases not requiring hospitalization can be placed in medical isolation (*66*).

In the event that there are insufficient or inadequate facilities to isolate suspected cases, pragmatic solutions should be sought. These may include cohorting – medical isolation of people in prison in groups sharing the same characteristics of exposure (see section 14.2).

There are two sets of criteria for discharging patients from isolation (i.e. discontinuing transmission-based precautions) without requiring retesting:

- for symptomatic patients 10 days after symptom onset, plus at least three additional days without symptoms (including without fever and without respiratory symptoms)
- for asymptomatic cases 10 days after positive test for SARS-CoV-2.

13.1 Advice on use of PPE and other standard precautions for health-care staff and custodial staff with patient-facing roles

Health-care professionals in prisons and other detention settings are most likely to work directly with patients with a possible diagnosis of COVID-19, but custodial staff and transport services may also be engaged, especially at initial presentation. This means that all staff (custodial and health-care workers) should be educated about standard precautions, basic IPC measures and how to deal with a person suspected of having COVID-19 as safely as possible to prevent the infection from spreading.

Standard precautions are intended to reduce the risk of transmission of bloodborne and other pathogens from both recognized and unrecognized sources. Such precautions include wearing PPE according to risk assessment and ensuring safe waste management, proper linens, environmental cleaning, and sterilization of patient-care equipment.

13.1.1 PPE for health-care and custodial staff

It is recommended that health-care staff dealing directly with a suspected or confirmed COVID-19 case use, as a minimum, the level of PPE detailed in this section. Other custodial staff may also be involved in activities

- that involve close contact with a suspected or confirmed case of COVID-19, including interviewing people at a distance of less than 1 metre, or arrest and restraint. In such circumstances, the level of recommended PPE is the same and includes:
 - hand hygiene supplies
 - eye protection (e.g. goggles or face shield)
 - medical mask
 - disposable gown (or apron)
 - disposable gloves.

During periods of widespread community transmission, in view of the importance of asymptomatic and presymptomatic transmission of COVID-19, all health-care workers and staff in prisons should continuously wear a medical mask during their routine activities and not merely when dealing with suspected or confirmed cases.

In addition to PPE, health-care staff should have at their disposal general-purpose detergent and disinfectant solutions that have been approved for use by the prison authorities. They should also have available biohazard waste bags, appropriate sharps containers, and approved detergent and disinfection solutions for use on environmental surfaces as well as approved disinfectants for noncritical medical equipment.

Health-care staff should use respirators only for aerosol-generating procedures; for further details on use of respirators, see section 14 below and WHO guidance on PPE use (44).

In the event that there are any shortages of PPE, the protection of health-care workers is paramount, and they and others caring for COVID-19 patients must be prioritized for use of PPE, including medical masks, respirators, gloves, gowns and eye protection. Strategies to optimize PPE availability should be adopted if necessary (44).

For all staff, PPE must be changed after each interaction with a suspected or confirmed case.

The minimum level of PPE for cleaning staff is detailed in Annex 1.

To mount an optimal response to the COVID-19 pandemic, IPC standards must be in place to provide minimum protection to people in prison, health workers, prison officers and visitors. Use of PPE is part of IPC, and rational and correct use of PPE reduces exposure to pathogens. The effectiveness of PPE strongly depends on:

- (1) staff training on putting on and removing PPE
- (2) prompt access to sufficient supplies
- (3) appropriate hand hygiene
- (4) health worker compliance
- (5) regular monitoring and feedback by IPC personnel.

PPE should be removed in an order that minimizes the potential for cross-contamination. Before leaving the room where the patient is held, gloves, gown/apron, eye protection and mask should be removed (in that

order, where worn) and disposed of as clinical waste. After leaving the area, the face mask can be removed and disposed of as clinical waste in a suitable receptacle. The correct procedure for removing PPE is:

- (1) remove gloves and dispose of as clinical waste
- (2) remove apron first (if used) and gown by folding in on itself and place in clinical waste bin
- (3) perform hand hygiene, by handwashing
- (4) remove goggles/face shield only by the headband or sides and dispose of as clinical waste; if reusable, clean and disinfect after use
- (5) remove medical mask from behind and dispose of as clinical waste
- (6) perform hand hygiene, by handwashing.

All used PPE must be disposed of as clinical waste. For further information on safe application and disposal of PPE, refer to WHO guidance (including illustrations) on putting on and taking off PPE (66, 69, 70).

13.1.2 Hand hygiene

Scrupulous hand hygiene is essential to reduce cross-contamination. It should be noted that the recommendations for people in prison encourage use of water and soap, given the potential for misuse of alcohol-based products. However, for custodial and health-care staff the following principles should be applied:

- hand hygiene involves cleaning hands either with an alcohol-based hand rub or with soap and water;
- alcohol-based hand rubs are preferred if hands are not visibly soiled;
- if an alcohol-based hand rub is used, it should be between 60-80% alcohol;
- always wash hands with soap and water when they are visibly soiled.

All staff should apply the "My five moments for hand hygiene" approach to cleaning their hands:

- (1) before touching a patient
- (2) before any clean or aseptic procedure is performed
- (3) after exposure to body fluid
- (4) after touching a patient
- (5) after touching a patient's surroundings.

More information on how to wash hands properly is available on the WHO website (71), together with fact sheets intended for people in prison and visitors providing recommendations on preventing COVID-19 in prisons (49, 50).

13.2 Advice for policing, border force and immigration enforcement activities

For police, border force and immigration enforcement officers, there may be situations where an individual who needs to be arrested or is in custody is identified as potentially at risk of COVID-19 (72). If assistance is needed for an individual who is symptomatic and identified as a possible COVID-19 case, the person should, wherever possible, be placed in a location away from others. If there is no physically separate room, people who are not involved in providing assistance should be asked to stay away from the individual. If barriers

³⁴ or screens are available, they may also be used. Appropriate IPC measures should be implemented. In activities that involve close contact with a symptomatic person who is suspected of having COVID-19 (such as interviewing at a distance of less than 1 metre, or arrest and restraint), staff should wear the same PPE as indicated in section 13.1.

14. CASE MANAGEMENT

Case management should be performed in accordance with available national/supranational guidance for primary care and community settings.

14.1 Clinical management of severe acute respiratory infection (SARI) when COVID-19 is suspected

WHO has issued guidance intended for clinicians involved in the clinical management and care of adult, pregnant and paediatric patients with or at risk of SARI when infection with SARS-CoV-2 is suspected (73). It is not meant to replace clinical judgement or specialist consultation but rather to strengthen clinical management of these patients and to provide up-to-date guidance. Best practices for IPC, triage and optimized supportive care are included.

14.2 Additional precautions

If more suspected cases are detected and if individual spaces are not available, patients suspected of being infected with COVID-19 should be grouped together (cohorting) *(66)*. However, all patients' beds should be placed at least 1 metre apart regardless of whether they are suspected of COVID-19 infection. Cohorting can also apply to groups of single-cell accommodation to create a unit. Creating units according to medical isolation status (e.g. new receptions, vulnerable patients) in separate areas of the prison can be a practical approach to ensuring staff work with designated groups of people in prison, further enhancing infection control.

A team of health-care workers and custodial/detention staff should be designated to care exclusively for suspected or confirmed cases to reduce the risk of transmission.





14.3 How to undertake environmental cleaning following a suspected case in a prison or other place of detention

Once a suspected case of COVID-19 has been transferred out of the prison or other place of detention to a hospital facility, the room where the patient was placed and the room where the patient was residing should not be used until appropriately cleaned and disinfected; the doors should remain shut (or a sign should be placed to indicate that the rooms need to be cleaned and disinfected) with windows open, until the rooms have been cleaned with detergent and disinfectant that is approved for use in the prison setting. Detailed information on cleaning and disinfection is provided on the WHO website (74) and in Annex 1.

Medical devices and equipment that are reusable should be cleaned and decontaminated according to standard precautions and policies in place. Soiled linen should be placed in clearly labelled, leakproof bags or containers; machine-washing with warm water at 60–90 °C and laundry detergent is recommended (*36*). Medical waste should be managed in accordance with the medical waste policy at the facility. Once the cleaning process has been completed, the room can be put back in use immediately. For further information, consult *COVID-19 technical specifications for personal protective equipment and related IPC supplies (75)*.

14.4 Discharge of people from prisons and other places of detention

If a person who has served their sentence is an active COVID-19 case at the time of their release, or is the contact of a COVID-19 case and still within their 14-day medical isolation or quarantine period, the prison health authorities should ensure that the person discharged has a place to go, that the local authority is notified that the person has been discharged, and thus that follow-up is transferred from the prison authorities to the local authorities. If a discharged individual is transferred to a hospital or other medical facility after their prison term is over, but they are still under quarantine/medical care for their COVID-19 infection, the receiving facility should be notified of the person's COVID-19 status (confirmed or suspected) so that it is ready to provide proper medical isolation.

15. MAINTAINING THE DELIVERY OF ESSENTIAL (NON-COVID-19) SERVICES DURING THE PANDEMIC

The risk of severe disease outcomes from COVID-19 is higher in older individuals and in those with at least one underlying chronic condition. For this reason, greater emphasis should be given to investing in sustaining services to prevent and manage these underlying conditions. It is possible to apply innovative service delivery platforms, including the use of telemedicine, digital technologies, telephone triage and video consultations, in prisons and other places of detention, where they may be used to minimize the constraints imposed by mobility restriction measures.

WHO has published operational guidance on maintaining essential services across the entire health system during the COVID-19 pandemic (*76*). Under normal circumstances, prison health care should offer preventive, promotive, curative, rehabilitative and palliative health services. Some of these may be postponed during the pandemic, but others are essential for managing both infectious and noncommunicable diseases. As an example, continuous treatment of patients with diabetes, hypertension or heart disease prevents disease

36 complications that, if not followed up, may require hospitalization or result in death. Therefore, provision of medications and supplies for the ongoing management of chronic diseases, including mental health conditions, is among the key essential services that should be sustained. Care of pregnant women also implies sustaining prenatal care visits in prisons hosting females.

Essential preventive health services, including routine immunizations, must also be sustained, and in the prison context this is particularly important for those vaccines (such as hepatitis B) that are recommended to be routinely offered following admission. WHO recommends that for all transmission scenarios, surveillance of vaccine-preventable diseases should be maintained and reinforced; to this end, development or review of strategies for delivering immunization services is recommended (9).

Provision of mental health care and psychological support is a crucial service in prisons under normal circumstances, given the high prevalence of mental health and substance use disorders. Demand for such services is likely to increase following the pandemic and the restrictive measures that have been imposed.

Dental care services are one of the priority areas that should be sustained in prisons and other places of detention. The Centers for Disease Control and Prevention has issued guidance for dental care according to the level of transmission of COVID-19 experienced in the community; it advises that dental care should be provided to individuals without suspected or confirmed infection following strict recommendations to protect patients and staff from COVID-19 spread (77). The ECDC guidance applicable to primary care in general also provides useful recommendations on procedures to reduce the risk of transmission of COVID-19 when providing dental care (78).

Conversely, it is advised that non-essential services and group activities, including rehabilitation activities, be offered using an online format whenever possible. The precise selection of essential services must be guided by the prison system context and the local burden of disease. Some of these services may benefit from the creation of new models of delivery, including electronic prescribing (eventually allowing for extended duration of prescriptions in well-managed patients) and web-based consultations (*79*).



16. INFORMATION RESOURCES

WHO general guidance on COVID-19

COVID-19 information portal: https://www.who.int/emergencies/diseases/novel-coronavirus-2019

Daily situation updates on the COVID-19 outbreak https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports

WHO specific guidance on COVID-19

Antigen-detection in the diagnosis of SARS-CoV-2 infection using rapid immunoassays. Interim guidance, 11 September 2020 https://www.who.int/publications/i/item/antigen-detection-in-the-diagnosis-of-sars-cov-2infection-using-rapid-immunoassays

Case definitions of COVID-19 and definition of symptoms. 16 December 2020 https://www.who.int/publications/i/item/WHO-2019-nCoV-Surveillance_Case_Definition-2020.1

Cleaning and disinfection of environmental surfaces in the context of COVID-19. Interim guidance, 15 May 2020 https://apps.who.int/iris/bitstream/handle/10665/332096/WHO-2019-nCoV-Disinfection-2020.1-eng.pdf

Considerations for implementing and adjusting public health and social measures in the context of COVID-19. Interim guidance, 4 November 2020

https://www.who.int/publications/i/item/considerations-in-adjusting-public-health-and-social-measures-in-the-context-of-covid-19-interim-guidance

Contact tracing in the context of COVID-19. Interim guidance, 1 February 2021 https://www.who.int/publications/i/item/contact-tracing-in-the-context-of-covid-19

COVID-19 technical specifications for personal protective equipment and related IPC supplies. 7 August 2020 https://www.who.int/medical_devices/priority/Technical_Specs_PPE_Covid19_final_V6.docx

Criteria for releasing COVID-19 patients from isolation. 17 June 2020

https://www.who.int/publications/i/item/criteria-for-releasing-covid-19-patients-from-isolation

Critical preparedness, readiness and response actions for COVID-19. Interim guidance, 4 November 2020 https://www.who.int/publications/i/item/critical-preparedness-readiness-and-response-actions-for-covid-19

Diagnostic testing for SARS-CoV-2. Interim guidance, 11 September 2020 https://www.who.int/publications/i/item/diagnostic-testing-for-sars-cov-2

Infection prevention and control during health care when coronavirus disease (COVID-19) is suspected or confirmed. Interim guidance, 29 June 2020

https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-2020.4

Laboratory testing strategy recommendations for COVID-19. Interim guidance, 21 March 2020 https://apps.who.int/iris/bitstream/handle/10665/331509/WHO-COVID-19-lab_testing-2020.1-eng.pdf

Mask use in the context of COVID-19. Interim guidance, 1 December 2020 https://www.who.int/publications/i/item/advice-on-the-use-of-masks-in-the-community-during-home-careand-in-healthcare-settings-in-the-context-of-the-novel-coronavirus-(2019-ncov)-outbreak

Public health surveillance for COVID-19. Interim guidance, 16 December 2020 https://www.who.int/publications/i/item/who-2019-nCoV-surveillanceguidance-2020.8 38

Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages. Interim guidance, 6 April 2020

https://apps.who.int/iris/bitstream/handle/10665/331695/WHO-2019-nCov-IPC_PPE_use-2020.3-eng.pdf

Water, sanitation, hygiene, and waste management for the COVID-19 virus. Interim guidance, 29 July 2020 https://www.who.int/publications/i/item/WHO-2019-nCoV-IPC-WASH-2020.4

Human rights and COVID-19

United Nations (2020). COVID-19 and human rights: we are all in this together https://www.un.org/sites/un2.un.org/files/un_policy_brief_on_human_rights_and_covid_23_april_2020.pdf

United Nations Human Rights Office of the High Commissioner (2020). COVID-19 guidance – human rights at the heart of response https://www.ohchr.org/Documents/Events/COVID-19_Guidance.pdf

United Nations Human Rights Office of the High Commissioner (2020). Information note: COVID-19, prison overcrowding, and serving sentences for serious human rights violations https://www.ohchr.org/EN/Issues/TruthJusticeReparation/Pages/infonotecovid.aspx

UNODC, WHO, UNAIDS and OHCHR joint statement on COVID-19 in prisons and other closed settings. 13 May 2020 https://www.who.int/news-room/detail/13-05-2020-unodc-who-unaids-and-ohchr-joint-statement-on-covid-19-in-prisons-and-other-closed-settings

Inter-Agency Standing Committee (2020). IASC interim guidance on COVID-19: focus on persons deprived of their liberty (developed by OHCHR and WHO)

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Refugees and migrants

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ANNEX 1 ENVIRONMENTAL CLEANING FOLLOWING A SUSPECTED CASE OF COVID-19 IN A PLACE OF DETENTION

Infection prevention and control (IPC) measures are essential to reduce the risk of transmission of infection in prisons and other places of detention. Environmental cleaning of health-care rooms or cells where a suspected case has been managed is an essential intervention to control infection as well as to allow facilities to be put back into use quickly. Once a possible case has been transferred from the prison or detention setting, the room where the patient was placed should not be used; the room door should remain shut until the room has been properly aired and cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back into use immediately.

Training

Training for cleaning staff should be based on the policies and standard operating procedures of the healthcare facility and national guidelines. It should be structured, targeted and delivered in an appropriate manner, and should be mandatory during staff induction to a new workplace. The training programme should include instructions on risk assessment and ensure that competence is clearly demonstrated in safe disinfectant preparation, mechanical cleaning and equipment use, standard precautions and transmission-based precautions.¹

Preparation

The responsible person undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

- perform hand hygiene and wear personal protective equipment (PPE) following the correct procedure;
- collect all cleaning equipment and clinical waste bags before entering the room;
- dispose of any cloths and mop heads as single-use items.

Personal protection measures

It is recommended that the following general precautions for infectious respiratory diseases are taken to help prevent cleaning staff from catching and spreading COVID-19:

- Hands should be washed often with soap and water and dried with single-use towels; alcohol hand sanitizer containing between 60–80% alcohol is also an option if available; detailed recommendations on hand hygiene practices are available in section 13.1.2 of the guidance.
- Physical distancing of at least 1 metre should be observed.
- Use of medical masks by cleaning staff is recommended.²

¹ Cleaning and disinfection of environmental surfaces in the context of COVID-19. 16 May 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications/i/ item/cleaning-and-disinfection-of-environmental-surfaces-inthe-context-of-covid-19).

² Rational use of personal protective equipment for coronavirus disease (COVID-19) and considerations during severe shortages. Interim guidance. 6 April 2020. Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331695/WHO-2019-nCov-IPC_PPE_use-2020.3-eng.pdf).

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- A disposable tissue should be used to cover mouth and nose when coughing or sneezing, then thrown in a bin with a lid; when a tissue is not available, cough or sneeze into a bent elbow; always perform hand hygiene after coughing or sneezing.
- Touching of eyes, nose or mouth should be avoided if hands are not clean.

It is advised that the minimum level of PPE that cleaning staff should wear is:

- face mask
- gown
- heavy-duty gloves
- eye protection (if risk of splash from organic material or chemicals is anticipated)
- closed work shoes.

Ventilation

Mechanical ventilation

Operate the heating, ventilation and air conditioning (HVAC) system with maximum outside air flow for two hours at normal speed before the room is occupied and for two hours at low speed after it is occupied;³ or achieve three air changes of outside air in the space.⁴

Natural ventilation

Open the windows of the cell/room to allow proper ventilation before and after it has been occupied with a suspected COVID-19 case. In such circumstances, windows should be opened for about 15 minutes when entering the room.³

On entering the room

- keep the door closed with windows open to improve airflow and ventilation while using detergent and disinfection products
- bag all items that have been used for the care of the patient as clinical waste for example, contents of the waste bin and any consumables that cannot be cleaned with detergent and disinfectant
- remove any fabric curtains or screens or bed linen and bag as infectious linen
- close any sharps containers, wiping the surfaces with either a combined detergent/disinfectant solution with a virucidal label claim, or a neutral-purpose detergent followed by disinfection with a virucidal product that has been approved for use in the facility.

³ How to operate HVAC and other building service systems to prevent the spread of the coronavirus (SARS-CoV-2) disease (COVID-19) in workplaces. 3 August 2020. Brussels: REHVA (Federation of European Heating, Ventilation and Air Conditioning Associations); 2020 (https://www.rehva.eu/fileadmin/user_upload/REHVA_COVID-19_guidance_document_ V3_03082020.pdf).

⁴ ASHRAE technical resources: commercial buildings (HVAC systems). Peachtree Corners (GA): American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE); 2020 (https://www.ashrae.org/technical-resources/commercial).

Cleaning process

Use disposable cloths/paper roll/disposable mop heads to clean and disinfect all hard surfaces/floor/chairs/ door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the two options below:

- either use a combined detergent/disinfectant solution with a virucidal label claim
- or use a neutral-purpose detergent, followed by a virucidal disinfectant approved by the prison authority.

Follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants. Any cloths and mop heads used must be disposed of as single-use items.

Cleaning and disinfection of reusable equipment

- clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers and glucometers, that are in the room prior to their removal
- clean all reusable equipment systematically from the top or furthest away point.

Carpeted flooring and soft furnishings

If carpeted floors/items cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use, following or combined with detergent cleaning.

On leaving the room

- discard detergent/disinfectant solutions safely at disposal point
- all waste from suspected contaminated areas should be removed from the room and discarded as medical waste as per the facility guideline for medical waste
- clean, dry and store reusable parts of cleaning equipment, such as mop handles
- remove and discard PPE as medical waste
- perform hand hygiene.

Cleaning of communal areas

Communal areas should be cleaned with detergent and disinfectant (as above) as soon as practicably possible, unless there has been a blood/body fluid spill, which should be dealt with immediately. Once cleaning and disinfection have been completed, the area can be put back into use.

Decontamination of vehicles following a transfer of a possible case

Any vehicle used to transport a possible case should be cleaned and disinfected (using the methods outlined above for environmental cleaning following a possible case) as soon as possible before it is brought back into service.

The WHO Regional Office for Europe

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