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Prisons and COVID-19:
Lessons from an ongoing crisis

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Introduction

The disruption caused by COVID-19 has exposed the health inequities faced by marginalised communities globally, particularly those deprived of their liberty in prison settings. As a result of the extreme risks posed by COVID-19 to these individuals, international organisations, civil society organisations (CSOs), and community advocates have called for urgent criminal justice system and prison reforms. Calls have been made to address chronic overcrowding in prisons, the suspension of arrests and incarceration of people for minor or non-violent offences, and the urgent roll-out of life-saving health and harm reduction measures for people who use drugs in custodial facilities and the community.[2] While it is the state's legal obligation to provide adequate care to people deprived of their liberty,[3] COVID-19 has shed light on how many states have reneged on this responsibility. As aptly expressed by a group of researchers, 'we cannot forget that prison health is public health by definition'.[2]

While many states heeded the call to release people in prison, few have taken substantial steps toward addressing the structural issues exposed by COVID-19 within their criminal justice systems. Meanwhile, others have not fulfilled their promises to carry out measures such as early release programmes to reduce overcrowding in prisons. While these issues received widespread attention during the early stages of the pandemic, 'many incarcerated individuals and CSOs working on protecting their rights, health and wellbeing have been left without support'.

The objective of this brief is to bring attention to the ongoing crisis posed by the COVID-19 pandemic in prison settings around the world, while prompting public authorities to provide adequate care for, and to reduce the numbers of, people in prison, with specific attention to those incarcerated for minor or non-violent drug offences. The research for this brief has been guided by examining the impact of the COVID-19 pandemic in three specific areas:

- Policies and procedures in place before a person is incarcerated, e.g. alternatives to incarceration and diversion programmes to prevent incarceration.
- Impact of the COVID-19 pandemic on prison conditions, including provision of harm reduction and treatment services.
- Post-release care and community integration programmes available to formerly incarcerated individuals, with a focus on people imprisoned for drug offences.

As such, the briefing paper seeks to shed light on the experiences of people involved with the criminal justice system *prior to*, *during* and *after* incarceration, with a focus on four case study countries: Colombia, Ireland, Indonesia and Kenya.

Key issues

- A number of countries that have made commitments to decongest prisons have explicitly excluded people detained for drug offences, including two of the case study countries in this brief (Colombia and Indonesia).
- Many countries that have implemented decongestion measures have simultaneously failed to prevent or reduce the continued and disproportionate arrest and imprisonment of people for minor drug offences, thus undermining attempts to reduce prison overcrowding.
- Due to overcrowding and the lack of adequate drug treatment and harm reduction services, hygiene products and sanitation measures, people in prison, particularly people who use drugs, are at much higher risk of contracting COVID-19 and suffering serious adverse health consequences from the virus than individuals in the general public.[5]
- There is already a lack of adequate drug dependence treatment and harm reduction measures inside prisons.[6] Where such services do exist, incarcerated people have experienced serious restrictions to accessing them during the COVID-19 pandemic
- Community integration programmes have failed to support people released from detention to return to their communities during the COVID-19 pandemic.

Methodology

This briefing paper is based on a review of the academic and grey literature, which guided the research project design. In addition, it is based on interviews with 11 key stakeholders from CSOs working with incarcerated individuals and people who use drugs in particular. The paper focuses on four case study countries, namely Colombia, Indonesia, Ireland (Republic of) and Kenya. The selection of case study countries was guided by an overview of the literature, with specific attention to the three specific areas mentioned previously, in addition to the capacity of local CSOs to participate in the research.

Within these case studies, a number of cross-cutting issues are raised in relation to the three specific areas covering before, during and after incarceration, while focusing on one over-arching thematic issue per country:

- **Colombia:** the consequences of COVID-19 and the state response to women in prison
- **Indonesia:** the consequences of poorly managed decongestion policies
- **Ireland:** the lack of access to health and social care for vulnerable and marginalised people in prison
- **Kenya:** using the COVID-19 pandemic as a policy window to implement urgent reform to ensure provision of drug dependence treatment

The impact of COVID-19 on people in prisons

By February 2021, at least 504,000 people in prison had contracted COVID-19 across 121 countries, with over 3,800 recorded deaths across 47 countries.[7] This is likely an underestimate due to gaps in data collection in custodial settings and since many countries do not have COVID-19 testing arrangements in place in prisons or do not make data publicly available.[8] These sombre statistics demonstrate how COVID-19 has exposed and exacerbated unacceptable conditions across prisons globally[9] and that prisons and other detention facilities are extreme-risk environments for the spread of COVID-19, particularly in overcrowded contexts and where hygiene and sanitation standards are lacking.[10]

The priority responses to COVID-19 that have been implemented in the community, such as social distancing measures and access to hygiene products, have been severely restricted or absent in many detention settings due to prison overcrowding, and a lack of resources.[11] As a result, the WHO has marked prison facilities as centres of extreme risk unless action is taken to combat the spread of COVID-19.[12]

One of the most significant challenges to preventing the spread of COVID-19 in penitentiary settings is the endemic overcrowding of prisons globally. Overcrowding not only renders it impossible to implement COVID-19 infection prevention protocols, but it also violates fundamental human rights such as the right to health.[13] Incarceration should thus be limited to a "measure of last resort", [14] not only during the pandemic but also in the post-COVID-19 context. Indeed, more systemic and structural criminal justice system change is required in the long run to address the vulnerabilities exposed and exacerbated by the pandemic.[15]

As a result of abysmal prison conditions, there have been widespread unrest and protests across prisons globally.[16] As such, several CSOs have called for urgent prison and criminal justice system reforms to contain the virus and protect the health and wellbeing of people deprived of their liberty.[17]

Similar calls have been made by a number of international agencies, such as the World Health Organization (WHO), the United Nations Office on Drugs and Crime (UNODC), the UN Office for the High Commissioner on Human Rights (OHCHR) among many others.[18] As has been noted by UNODC, addressing the particular COVID-19 transmission risks in prisons (e.g. due to overcrowding, lack of hygiene products and unacceptable sanitation procedures) is not only key to controlling the spread of the virus inside custodial settings, but also in the broader community.[19] As a result of the crisis posed by COVID-19 in prisons, several UN agencies released a joint statement in 2020[20]calling for action by governments to take all appropriate public health measures to reduce the spread of the virus, including by reducing prison overcrowding, e.g. through granting early releases to incarcerated persons. Importantly, appeals have been made for governments to comply with international standards for the treatment of prisoners, such as the United Nations Standard Minimum Rules for the Treatment of Prisoners (the "Nelson Mandela Rules")[21] and the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the "Bangkok Rules").[22]

The heightened risks of incarceration for people who use drugs

People who use drugs in prisons have unique needs and face specific risks as a result of COVID-19, due to underlying health issues, a lack of access to harm reduction and healthcare services, and stigma and discrimination, among others.[23] While the majority of prisons globally still do not provide adequate treatment and harm reduction measures for people who use drugs, many of the few custodial settings that

ordinarily provided such services have temporarily suspended them due to COVID-19.[24]

There is a wealth of evidence showing that people who use drugs are far more likely to experience incarceration during their lives, and that incarceration widens pre-existing health disparities.[25] Among others, it has been estimated that between 56 to 90% of people who inject drugs will be incarcerated at some stage of their lives.[26] Evidence also shows that people in prison are more likely to live with drug dependence, HIV, tuberculosis and hepatitis compared to the general population.[27] For example, a 2015 study of 759 people recently admitted into two New York State prisons found that 34% suffered from respiratory illnesses.[28] These individuals are at a heightened risk of experiencing extreme adverse health consequences as a result of contracting COVID-19. Importantly, a recent report found that the COVID-19 mortality rate in the United States was three times higher in correctional settings compared to the general population.[29]

Reducing the imprisonment of people for drug offences

Based on UNODC estimates on the global prison population in 2017, 4% (470,000 persons) of all individuals in prison (approximately 11,750,000) were incarcerated for drug possession for personal use as the principal offence.[30] Overall, those imprisoned for drug offences as the principal offence represented roughly 18.5% total prison population in 2017.[31] Moreover, a higher proportion of women are in prison for drug-related offences (35% of all women in prison) compared to men (19% of all men in prison).[32]

The incarceration of people for drug offences is a major contributing factor to prison overcrowding globally, without having the deterrent effect on levels of drug use that governments had hoped to achieve. As such, releasing these individuals from prison is not only one of the most effective ways of addressing overcrowding but also of significant importance in protecting their health and wellbeing. Importantly, the available evidence shows that decongestion is one of the most effective interventions to prevent the spread of COVID-19.[33]

A review conducted by Harm Reduction International (HRI) found that at least 109 countries adopted decongestion measures between March and June 2020.[34] It further found that roughly a quarter of those countries explicitly excluded people incarcerated for at least certain drug offences in those decongestion programmes. As a result of complicated decongestion measures that excluded broad groups of individuals, including those charged with drug and other non-violent offences, by 24 June 2020 COVID-19 related prison decongestion schemes had only reduced the global prison population by less than 6%.[35]

While some countries have released people imprisoned for drug offences, few have taken substantial steps to prevent their re-arrest by adequately revising their drug laws and policies. The revolving door between prison and the community is an issue that predates the COVID-19 pandemic. Among others, studies in the United States have shown that re-arrest rates of individuals released from prison range from 50-83% during 8- and 9-year follow-up periods.[36] People who use drugs are particularly vulnerable to being re-arrested and are often stuck in a vicious cycle in and out of the criminal justice system, as a criminal conviction significantly hampers access to education, employment and social welfare opportunities.[37] As such, while the release of people in prison for drug offences will be key to controlling the spread of COVID-19, deeper structural reform is necessary to prevent their re-arrest by shifting the focus of government responses to drugs away from law enforcement and incarceration in favour of supporting harm reduction, treatment and social support services.[38] This is of particular importance during the COVID-19 pandemic, as any such services have heavily contracted or been discontinued.

Returning to the community from prison during COVID-19

Planning for community re-entry should be a proactive process taking place as soon as an individual is incarcerated to assess their specific needs for re-entry, as stipulated in the Mandela rules 87, 90 and 107.[39] This requires careful coordination with social and health workers in addition to community-based organisations and CSOs, since the early stages of incarceration. During the pandemic, effective planning for community re-entry is even more critical since COVID-19 has fundamentally altered the communities to which those released from detention facilities are returning.[40]

Mental health conditions and chronic health issues affect those re-entering into the community at disproportionate rates compared to the general population.[41] Individuals released from penitentiary settings also face a plethora of other complex challenges, such as barriers caused by a criminal record towards employment in the formal economy and accessing housing, in addition to worsening food insecurity, discrimination, and stigma.[42] Among others, research has found that those re-entering the community during COVID-19 face twice the rate of food insecurity and ten times the rate of homelessness compared to the

general population.[43] These issues are compounded by their reduced access to social welfare due to the pandemic, such as food and housing support.

Moreover, research suggests that people who use drugs in the community are already exposed to higher and greater range of risks during COVID-19, including drug overdose due to the higher degree of social isolation, disrupted or unavailable harm reduction and treatment services, and economic distress caused by the pandemic.[44] People who use drugs are exposed to other exacerbated health risks since harm reduction interventions have stalled, treatment programmes have been reduced, social services have contracted and isolation has increased across many settings.[45] A study conducted in England[46] found that restrictions had reduced the number of NSP clients by 36%, visits by 36% and the number of distributed needles by 29% in a 4-week period ending 12 April 2020.[47] Maintaining and adapting access to harm reduction interventions such as Opioid Agonist Treatment (OAT) and NSPs, and labelling such interventions as essential or first-line services, is thus an urgent challenge for states globally.[48] This is particularly important considering the wealth of research showing the extreme risks faced by recently released people who use drugs with regard to drug overdoses due to extended periods of abstinence or consumption of less potent substances while in prison.[49] This should include take-home doses for clients undergoing OAT and relaxation of other onerous regulations surrounding harm reduction and drug treatment, such as the requirement of travelling to a clinic to access a daily dose of methadone or buprenorphine.[50] This should also include the distribution of naloxone kits for people being released from prison who may need it.

Considering the disruption caused by COVID-19 to countries globally, with a focus on their economic, health and social systems, it is imperative that individuals released from prison are provided with an adequate post-release care plan.[51] Fundamentally, it is the responsibility of the state to prepare prisoners for their return to the community, which requires a cooperative approach and shared responsibility between multiple agencies.[52] Several studies have outlined the importance of carefully designed community re-entry programmes following release from incarceration,[53]with examples of how such programmes can support public safety and community rebuilding by, for example, providing health insurance for recently released individuals, ensuring continuity of medical and social care through transition clinics and community-based focal points, providing stable housing and income support, among others.[54]

Case Study 1: Colombia

Disproportionate impacts of drug policy and incarceration on women

Colombia prisons fact box[55]	
Prison administration	Instituto Nacional Penitenciario y Carcelario (INPEC)
Prison population	97,303
Women in prison[56]	6,908 (7.1%)
Women incarcerated for drug offences	46%[57] (3,140 out of 7,427 women in prison in 2020)
Men incarcerated for drug offences	18% (approximately 18,322 out of 101,793 men in prison in 2020)[58]
Individuals detained pre-trial/ individuals detained on remand	23.6%
Overcrowding rate	20.7%[59]
Prison population rate (per 100,000 individuals)	193
COVID-19 cases in prison	17,757 (and 84 deaths)[60]
Decongestion measures	**Decree 546, temporary release under house arrest (to return to prison after 6 months)** 815 prisoners released, including 38 women (0.8% of prison population). Decree 546 contained an extensive list of exceptions and limitations – over 100 crimes were ineligible for temporary release, including theft and drug offences.
Did the decongestion measures include people incarcerated for drug offences?	No

The Colombian incarceration rate per 100,000 individuals increased rapidly after 2006, from 136 to 242 in 2012.[61] However, in recent years official figures claim a reduction in the incarceration rate, which is now recorded at 193 per 100,000. While the overall incarceration rate has officially reduced in recent years, the number of women in prison has more than doubled since the year 2000, when there were an estimated 3,141 women deprived of their liberty. Overall, the prison population grew by 305% between 1994 and 2014.[62]

By 2009, individuals incarcerated for drug offences made up 17% of Colombia's total prison population.[63] Between 2004-2009 the proportion of the prison population incarcerated for drug offences generally fluctuated between 16-19%.[64] Women suffer disproportionately from being incarcerated for drug offences, with 46% of all women in prison incarcerated for drug offences in 2020, compared to 18% of all men.[65] Overall, the incarceration of people for drug offences is fuelling the ongoing prison crisis in Colombia, characterised by overcrowding, lacking health and safety standards and a severe lack of resources.[66]

Health and safety have been major concerns in the Colombian prison system. Between 2013-2015 an estimated 1,255 incarcerated individuals died inside the country's prisons from various causes, including disease and violence.[67] COVID-19 has further exposed the inadequate health standards in Colombian prisons. According to Prison Insider and Justice Project Pakistan, who curate a live global map titled "COVID-19: Infected Prisoners and Deaths Across the World", at least 17,757 individuals incarcerated in Colombian prisons had contracted COVID-19 by early-February 2021, and at least 84 people in prison had died from the virus.[68] At the outset of the COVID-19 pandemic, several deadly riots occurred in Colombian prisons. In March 2020, a riot in Bogotá left 24 people dead and 76 injured, after protests against the abysmal sanitary conditions in prison.[69] A study conducted by international forensic experts and commissioned by Human Rights Watch pointed towards the intentional killing of many of those persons, with the report stating that "Most of the gunshot wounds described in the autopsy reports are consistent with having been produced with the objective of killing", and that "The autopsy reports do not record any signs of gunshot injuries carried out with the intention of solely injuring individuals instead of killing them".[70] This was confirmed in interviews with local CSOs working with people in prison in Colombia.

As with other countries, access to prisoners deteriorated quickly after the onset of the pandemic. Interviewed CSOs reported that prisons prohibited access to family members and external staff such as social workers and CSOs.[71] This also affected healthcare workers such as psychiatrists and gynaecologists, meaning that women in prison did not have access to medical treatment as they are entitled to under the Nelson Mandela and Bangkok Rules. For example, Rule 78 of the Nelson Mandela framework requires that "prison staff shall include a sufficient number of specialists such as psychiatrists, psychologists, social workers, teachers and trade instructors".[72] According to CSOs, the lack of access to medical professionals and the curb on family visits had a significant adverse impact on the mental health of women in prison in particular. In addition to suspending family visits, INPEC also suspended visits from lawyers and put in place "virtual audiences" instead. However, the lack of technical equipment in most prisons have rendered virtual audiences impractical, or simply impossible.[73]

The civil society commission on the unconstitutional state of affairs concerning the prison system in Colombia undertook a three-month research project studying the conditions of women's prisons in Bogotá.[74] The findings of this work paint a distressing picture. Prior to the pandemic, there were already significant issues regarding access to quality food and healthcare. When the pandemic began the conditions worsened greatly. Among others, women in prison were not provided with adequate personal hygiene packs as stipulated in prison regulations and had to use one packet of menstrual pads over the course of three months. While women had previously relied on receiving hygiene products during family visits, the prohibition on prison visits meant they went months without access to such products. Access to personal hygiene products is enshrined in the Bangkok Rules. Rule 5 (supplementing Rule 18 of the Nelson Mandela Rules) stipulates that "women prisoners shall have facilities and materials required to meet women's specific hygiene needs".[75] The actions of the Colombian prison authorities meant that women had "virtually no access to products for personal hygiene".[76]

To address overcrowding, the Colombian Ministry of Justice published Decree 546 in mid-April 2020, which sought to grant temporary release, under house arrest, to at-risk people in prison. While prison authorities estimated that this would potentially benefit 4,000 people in prison, only 815 had been released by late-November 2020.[77] The failures of Decree 546 in reducing prison overcrowding stemmed from its extensive list of exceptions and limitations, with over 100 crimes ineligible for temporary release. This included theft offences (representing 15% of the total prison population) and certain offences related to

drug trafficking, thus substantially limiting the number of individuals eligible for temporary release under house arrest. Furthermore, these temporary released individuals have to return to prison after 6 months, rendering Decree 546 ineffective in addressing the overcrowding issue in Colombian prisons and in preventing the transmission of COVID-19 in correctional settings.

The lack of appropriate post-release community reintegration programmes in Colombia has also had devastating consequences during COVID-19 for formerly incarcerated people, particularly women. CSOs reported that women often have nowhere to go upon release, as their families may have abandoned them or due to intense stigma in their community as a result of their criminal record. On top of this, their criminal record prevents them from securing employment across many sectors, leaving them forced to undertake informal labour in professions where they are at higher risk of contracting COVID-19, e.g. as cooks or cleaners.[78] Research has shown that the barriers to formal employment faced by recently released individuals, particularly drug offenders, can render them with no option but to engage in illicit activities to make ends meet, such as selling or trafficking drugs.[79]

Moreover, when managing to obtain informal employment, formerly incarcerated individuals are vulnerable for exploitation. In Colombia CSOs noted that employers often exploit the situation of formerly incarcerated women, paying them meagre wages and forcing them to work long hours under poor conditions. Their criminal record also prevents them from opening bank accounts, meaning their wages have to be paid in cash with no ability to store their savings securely in the formal banking system. These issues have been compounded by the pandemic, as the formal economy has heavily contracted and opportunities for employment are rare. Since no formal programmes have been established for reintegrating formerly incarcerated women back into society, they now face extreme obstacles in rebuilding their lives during the pandemic.

Case Study 2: Ireland

Severely restricted access to social and health care for people in prison

Ireland prisons fact box[80]	
Prison administration	Irish Prison Service
Prison population	3,729
Women in prison	149 (4% of total prison population)
Women incarcerated for drug offences	3% (27 out of 894 women incarcerated in 2019)[81]
Men incarcerated for drug offences	7.3% (458 out of 6,276 men incarcerated in 2019)[82]
Individuals detained pre-trial/ individuals detained on remand	17%
Overcrowding rate	N/A (85.2% of official capacity)
Prison population rate (per 100,000 individuals)	74
COVID-19 cases in prison	51 (26 prison transmissions, 25 community transmissions)[83]
Decongestion measures	**Temporary release (10% commitment, fulfilled by 10 April 2020)** Conditions for those temporarily released were eased, such as extending the period between sign-ins in order to reduce the footfall in and out of prisons. Moreover, probation supervision was mainly undertaken through telephone contact rather than requiring physical contact. Two-thirds of those released were serving sentence of less than 12 months or had less than 6 months left on their sentence.[84]
Did the decongestion measures include people incarcerated for drug offences?	Yes

According to data from the Irish Prison Service, the national prison administration, 3,729 people were incarcerated in Irish prisons by the beginning of February 2021.[85] Ireland is the only case study country in this brief that does not have formal prison overcrowding, as the occupancy level is at circa 85.2% of official capacity. However, as noted earlier in this brief, prisons' occupancy levels have not been determined with a pandemic in mind.[86] As such, even though prisons may not be formally overcrowded, they still may not be able to comply with COVID-19 social distancing protocols for example.

According to the Irish Prison Service, 51 people in prison contracted COVID-19 between March 2020 and 20 January 2021.[87] An estimated 26 of these cases were prison-based transmissions and 25 were community transmissions. While the Irish Prison Service was hailed for their success in preventing the spread of COVID-19 in custodial settings in the early stages of the pandemic, this came at a great cost in relation to the restrictions imposed on accessing prisons.[88] CSOs working with people in prison reported that the access to their clients has been heavily restricted and their clients' mental health and wellbeing has deteriorated due to prolonged isolation from their family members and social workers.[89] While a recent report found that many improvements have been made since,[90] interviews with CSOs highlighted the severe negative impacts of prolonged isolation on the health and wellbeing of people in prison.

Ensuring access to family members, legal assistance and social workers is enshrined in the Nelson Mandela Rules (e.g. rules 43, 61 and 88). Rule 58 states that "Prisoners shall be allowed, under necessary supervision, to communicate with their family and friends at regular intervals" by receiving visits and correspondence in writing and where available through telecommunication, electronic, digital and other means.[91] Moreover, the Council of Europe has developed guidance which calls for at least two hours of meaningful contact every day.[92] While Rule 43 of the Nelson Mandela Rules states that "the means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order",[93] the lack of access to family contact facing Irish prisoners has been prolonged and caused significant harm to their health and wellbeing. Also medical specialists, such as drug treatment counsellors, have struggled with gaining access to their clients, thereby disrupting treatment programmes.[94]

One of the CSOs working with people who use drugs in prison in Ireland is Fusion Community Prison Links, whose mission is to provide a link between community and prison-based services through the development of treatment and rehabilitation for people who use drugs. As explained by a social worker, during the first months of the pandemic they had no access to their clients. While this was deemed acceptable due to the state of emergency, 10 months from the onset of the pandemic the social workers were solely getting limited access to their clients in *some* prisons through video calls. By December 2020 there were still clients whom they had no contact with since March 2020, despite repeated efforts.[95]

The social workers explained that the video calls often automatically cut-out after 15 minutes, meaning they could be in the middle of their session with a client who they had not had any contact with for months only for it to be cut short due to the long waiting list of people wishing to make calls. Not only has the access to clients via video calls been inadequate, but written correspondence has also been heavily delayed. A social worker explained that she received a letter from a client with a record of mental health issues and associated self-harm. Three and a half weeks after it was sent, due to the prison censorship procedure that monitors the correspondence between those incarcerated and the outside world.[96] While the letter had been read by the prison administrators, nothing had been done to address the urgent situation once the letter was received by the social worker almost a month later.

As stated by a social worker, "Our only option is to raise this issue at whatever level we can, including parliament and the highest level … there should be a mechanism for this, all we are asking for are phone calls, that's all! In this time of the pandemic … we need to have access." Rule 88 of the Nelson Mandela Rules makes clear that "there should be in connection with every prison social workers charged with the duty of maintaining and improving all desirable relations of a prisoner with his or her family and with valuable social agencies. Steps should be taken to safeguard, to the maximum extent compatible with the law and the sentence, the rights relating to civil interests, social security rights and other social benefits of prisoners."[97] As such, it is important that Irish Prison Service prioritises the access of people in prison to community workers, their family members and specialised medical treatment for drug dependence and other challenges associated with drug use.

Case Study 3: Kenya

Using COVID-19 to implement urgent reforms to enable harm reduction services in prison

Kenya prisons fact box[98]	
Prison administration	Kenya Prisons Service
Prison population	42,596
Women in prison	2,854 (6.7% of total prison population in 2019)
Women incarcerated for drug offences	Unknown
Men incarcerated for drug offences	Unknown
Individuals detained pre-trial/ individuals detained on remand	44%
Overcrowding rate	90%
Prison population rate (per 100,000 individuals)	81
COVID-19 cases in prison	1,728[99]
Decongestion measures	**Approximately 12,000 individuals released from prison between March-August 2020** (this is based on research conducted by a group of Kenyan researchers, the exact figure remains unknown).[100] Individuals released from prison included those who benefitted from a review of their bail terms (as a result of COVID-19), those serving sentences shorter than 6 months and individuals whose sentences were coming to an end (i.e. a remaining prison time of 6 months or less).
Did the decongestion measures include people incarcerated for drug offences?	Yes

In Kenya, the national focal point for prisons is the Kenya Prisons Service. According to data from September 2020 there were 42,596 people in Kenyan prisons, with 44% being in pre-trial detention or held on remand.[101] Meanwhile, the occupancy level is recorded at over 90% above the official capacity.

Kenyan CSOs successfully used the pandemic to push through a number of urgent measures necessary to protect the health and wellbeing of people who use drugs, both inside and outside prisons. These efforts show that while the pandemic has had disastrous consequences for vulnerable and marginalised populations globally, positive change can be made by learning from the weaknesses COVID-19 has exposed in criminal justice systems and by addressing these through rapid and sustained interventions. Moreover, the work by Kenyan CSOs show how important community organisations have been in supporting states in dealing with the negative consequences of COVID-19.

As a result of the efforts by CSOs, government officials and international organisations, a Medication-Assisted-Therapy (MAT) clinic was opened in the Shimo La Tewa Prison in Mombasa within one month of the first confirmed COVID-19 case in Kenya. This is now one of the few prison clinics providing methadone to people in custodial settings across Africa (in addition to Mauritius and the Seychelles).[102] Key to these efforts was the work of the Muslim Education and Welfare Association (MEWA). The rapid implementation of the clinic was coordinated between public officials and community groups, facilitated by the trust that had been built between these actors over a number of years. Among others, MEWA's work with the Kenyan government, police and prison services and the sharing of knowledge related to their methadone clinic in Mombasa was crucial to this development.

MEWA highlighted to Kenyan authorities that when their methadone-enrolled clients were incarcerated, the continuity of their treatment was jeopardised. Previously, people in prison had to be escorted from prison to their methadone clinic, an expensive and tedious arrangement that had many shortcomings. People who use drugs would be escorted to the clinic by armed guards, a demeaning experience that exposed them to shame and stigma. By working with the prison services, the judicial system and the UNODC, MEWA was able to highlight the economic, safety and health benefits of setting up a clinic within the prison walls.

COVID-19 provided the policy window for this intervention to be pushed through, as authorities feared introducing the virus to the overcrowded Shimo La Tewa prison facility. CSOs quickly mobilised their members to support the operation of the prison clinic, with roughly 80% of the clinic's staff drawn from CSOs. As a result of the work of MEWA and their colleagues, they were able to decongest the already overburdened community methadone clinic in Mombasa and establish a functioning clinic inside Shimo La Tewa. While the clinic is yet to have its official opening ceremony, it is currently serving 214 clients with methadone (89 women and 125 men). The provision of healthcare for people in prison is a state responsibility that is deeply enshrined in the Nelson Mandela Rules. As noted in Rule 24, "prisoners should enjoy the same standards of health care that are available in the community, and should have access to necessary health-care services free of charge without discrimination on the grounds of their legal status".[103]

While the establishment of the clinic has been a great achievement, it is now reaching capacity and as such new clients cannot be enrolled in the methadone programme due to so-called "security issues".[104] Furthermore, the establishment of the Shimo La Tewa MAT clinic raises another important issue, namely the disparate coverage of treatment services inside prisons located in different regions – as the clinic is the only one of its kind available in the country. As such, MEWA and other CSOs are now working with authorities to secure support for implementing MAT clinics in other prisons across Kenya. Moreover, CSOs reported that the harm reduction and drug treatment services provided by CSOs and at Shimo La Tewa are yet to be sufficiently anchored in domestic legislation. As such, government policies need to change in order to sustain these recent positive developments and to prevent any future cutbacks. This will also aid CSOs in being able to hold government institutions accountable to ensure the sustained provision of these life-saving services.

The establishment of the Shimo La Tewa MAT clinic is far from the only positive influence Kenyan CSOs have had during the pandemic. MEWA also supplied prisons with raw materials and equipment to produce face masks in-house, as the government did not have the capacity or resources to provide face masks to people in prison. These efforts underscore the importance of state and civil society partnerships to tackle complex public and social health issues during the pandemic.

Case Study 4: Indonesia:

Severely restricted access to social and health care for people in prison

Indonesia prisons fact box[105]	
Prison administration	Directorate General of Corrections
Prison population	251,546
Women in prison	12,829 (5.1% of total prison population)
Women incarcerated for drug offences	53% (5,579 women were incarcerated for 'non-violent drug offences' in January 2019)[106]
Men incarcerated for drug offences	Unknown (overall, individuals incarcerated for drug offences make up approximately 52% of the total prison population and detainees)[107]
Individuals detained pre-trial/ individuals detained on remand	19.1%
Overcrowding rate	85.4%
Prison population rate (per 100,000 individuals)	92
COVID-19 cases in prison	611[108]
Decongestion measures	Approximately 40,388 (April-August 2020)[109]
Did the decongestion measures include people incarcerated for drug offences?	No

The national prison administration in Indonesia is the Directorate General of Corrections, which is responsible for 464 correctional facilities across the country. An estimated 251,546 individuals were incarcerated in Indonesian prisons by the end of January 2021, representing an overcrowding rate of approximately 85.4%.[110] Between April and August 2020, state authorities released an estimated 40,388 individuals from prison in response to COVID-19.[111] While this is a substantial number of released persons, several issues have been identified in the decongestion programme.

The CSO Lembaga Bantuan Hukum Masyarakat (LBHM) undertook a comprehensive study of the state's so-called "Assimilation Program", which involved the early release of people from prison, and how it has impacted upon people in prison and the public.[112] Their research found that the Assimilation Program excluded a large proportion of incarcerated individuals based on the offences that they had been convicted for. This included people detained for drug offences, who make up approximately 52% of the total number of people in prison and detention in the country.[113] This is due to drug offences falling under the classification of "extraordinary crimes", which are ineligible for early release or parole, as are offences such as corruption, money laundering and terrorism. Furthermore, while the Indonesian penal code distinguishes between different types of drug offences, several issues have been identified with the application of the law. Among others, civil society actors have reported that individuals caught using or possessing drugs are likely to be charged with supply offences, such as dealing drugs, which carries harsh sentences. As such, people who use drugs and low-level couriers are often sentenced for more serious drug offences and subsequently face long periods of incarceration, even the death penalty, while being ineligible for early release or parole.[114] As such, while the intentions of the government may have been to release people imprisoned for minor offences, the design and implementation of the Assimilation Program have contained a number of significant flaws which have prevented it from having a substantial positive impact – particularly for individuals incarcerated for drug offences and people who use drugs.

Indonesian CSOs working with people caught in the criminal justice system have also noted that arrests of people for minor drug offences, particularly people who use drugs, have remained high.[115] The lack of coordination between prison and law enforcement authorities has undermined the government's attempt at reducing prison overcrowding and led to further adverse consequences for marginalised and vulnerable, including those who use drugs. Similar issues have also been identified in many other countries, whereby decongestion programmes have not been followed by revised policies on arresting and detaining people for minor drug offences. In Indonesia, CSOs have noted that individuals arrested during COVID-19 now spend prolonged periods in police detention facilities, where conditions are even worse than in the general prison system.[116] Individuals can legally be held for a total of 60 days in police detention facilities, which have been reported to even more overcrowded than prisons, posing high risks for contracting COVID-19. Furthermore, CSOs have noted that detained persons are extremely vulnerable for extortion in police detention facilities. Among others, individuals in police detention may be forced to pay bribes in order to be released or for reduced charges. In relation to people charged with drug offences, they may feel forced to pay bribes in order to be released from police detention and placed in a mandatory drug rehabilitation programme instead, and/or in exchange for reduced charges (e.g. to change the charges from drug dealing to drug use or possession). As a result of COVID-19, CSOs reported that detained persons may be more inclined to pay such bribes, as they fear contracting COVID-19 in overcrowded police detention facilities.[117]

Moreover, the interviewed CSO representatives stated that there had been no special community re-entry programmes implemented for those released during the pandemic. While there are a number of general social support programmes in Indonesia that formerly incarcerated people can enrol in, they require beneficiaries to be in possession of ID cards – something which many vulnerable and marginalised individuals (such as homeless people who use drugs) often do not possess.

Conclusions and Recommendations

The disruption caused by COVID-19 has provided a 'once-in-a-century opportunity to reconsider the legal architecture of drug policy and policing' worldwide.[118] Furthermore, rather than returning to a 'broken and inequitable status quo', this is the time to envision and implement new drug policies to protect health and security globally.[119] While criminal justice systems have typically proven to be stubborn to reform, the pandemic has shown how positive developments can be achieved more swiftly when there is a will to do so. This includes the establishment of the methadone clinic in Mombasa's Shimo La Tewa prison for example. However, the shortcomings of many states in protecting the rights of vulnerable and marginalised individuals during the pandemic have by and large outweighed these positive developments. As such, urgent action is now needed.

The world's overcrowded and under-resourced prisons are simply not able to protect the health and rights of people deprived of liberty. This is especially true at times of COVID-19, but the issue of prison overcrowding pre-dated and will most likely outlive the global pandemic. Furthermore, prisons are not an appropriate or just environment to address the causes for people´s involvement in illegal drug activities. Therefore, the recommendations provided in this paper must be interpreted within a broader set of efforts to reduce prison populations worldwide.[120] As such, measures aimed at curbing the number of people in prison should be prioritised.

In line with the policy recommendations made by IDPC, Penal Reform International (PRI), Harm Reduction International (HRI), Reprieve and many others, this briefing paper calls for urgent reform in penitentiary and criminal justice systems globally to address the spread of COVID-19 in prisons, detention facilities and the broader community – and should be sustained and expanded in the long-term, beyond the COVID-19 pandemic. These measures should be taken with the utmost attention to protecting the health and wellbeing and basic human rights of marginalised and vulnerable people in prison. As such, this briefing paper makes policy recommendations in four different areas, namely at the structural level, prior to incarceration, during incarceration and after release.

Recommendation 1 - Structural-Level Reforms: Drug Laws and Prison Policies

- Decriminalise drug use and drug possession for personal use, as well as cultivation and other activities ancillary to the personal use of drugs. Decriminalised activities should be subject to no administrative penalty, including detention.
- Revise drug laws and policies to ensure that prisons are only used as a last resort. This includes reforming laws that mandate or prioritise pre-trial detention for drug offences, removing mandatory minimum prison sentences, establishing more proportionate penalties for illegal drug activities, and ensuring that people charged with drug offences are eligible for alternatives to incarceration.
- At-risk populations[121] should immediately be considered for release through the use of various measures such as early release, pardons or suspended sentences.
    - Pregnant women or women with children and people suffering from underlying health issues who may be particularly at risk of COVID-19 should be immediately released.
    - People incarcerated for minor or non-violent offences (including drug offences) should be immediately released.
    - Given that some jurisdictions impose disproportionately severe sentences for drug offences, including the death penalty, the assessment of whether a person should be eligible for release should not be determined by the crime for which the person is detained, or length or type of sentence, but by personal circumstances (such as pre-existing health conditions), prison conditions, and the ability of the system to effectively protect incarcerated people from COVID-19
    - States must provide effective consular assistance to nationals detained for drug offences overseas, which includes advocating for their release.
- Establish task forces and other forms of formal collaboration with CSOs to tackle the impacts of COVID-19 on vulnerable and marginalised groups within custodial settings.
- Collect and publish disaggregated data on the number, gender, and demographic characteristics of people involved in the criminal justice system, disaggregated by type of offence. Additional data on support services, including drug services, and alternatives to incarceration should be provided.

Recommendation 2 – Reduce the numbers of people entering prisons

- Ensure that pre-trial detention is an exception, and not the norm. Release people in pre-trial detention unless there is a legitimate and real public safety concern.
- Suspend or reduce arrests and admissions into prison and other detention facilities, in particular for minor offences, including those related to drug use, and where applicable those related to the cultivation, manufacturing, transportation and sale of drugs
    - Decisions around detention, whether pre-trial or as a sentence, should be made with due regard of COVID-19 risks, with detention as last resort
    - States should suspend or deprioritise policing practices that disproportionately target groups that are particularly at risk during COVID-19, such as people who are homeless and others who cannot socially distance or use drugs in private places/
- Implement comprehensive diversion programmes and meaningful alternatives to incarceration for people involved with the criminal justice system, including people charged with a drug offence.
- Improve access to quality legal representation in order to increase access to bail, as well as to the existing diversionary measures and alternatives to punishment and incarceration.

Recommendation 3 –Ensure adequate conditions in prison

- Ensure compliance with the international standards related to the treatment of people in prison, particularly the Nelson Mandela Rules and the Bangkok Rules. During the COVID-19 pandemic, special attention needs to be paid to the following areas:
    - Ensuring meaningful human contact every day.
    - Ensuring meaningful contact with family, partners, and support networks.
    - Ensuring access to healthcare workers, social workers, legal advice, and other forms of psychosocial support, including for sexual and reproductive health.
- Institute adequate COVID-19 prevention measures in prisons, following insofar as possible the WHO guidelines on social distancing and hygiene and sanitation standards to reduce the spread of COVID-19 in prisons[122]
    - Provide prisons with the appropriate testing capacity to prevent the transmission of COVID19 within custodial settings.
    - Prioritise people deprived of liberty and other people working in custodial settings in COVID-19 vaccine roll outs, as well as in the provision of Personal Protective Equipment (PPE).
- Ensure that people who remain in prison during the pandemic have access to essential and strictly voluntary and evidence-informed, rights-based, and gender-sensitive drug services including drug dependence treatment, harm reduction and additional support services.

Recommendation 4 – Ensure positive community re-integration and care upon release

- Put in place a post-release continuum of care to ensure the safety and security of individuals released from incarceration, with specific attention to the risks and vulnerabilities faced by those released during COVID-19
    - For example, address the vulnerabilities faced by individuals recently released from prison to ensure that they can comply with any curfew rules and other restrictions to movement and travel
- Ensure that harm reduction and drug treatment services are accessible and provided free-of-cost in the community, especially overdose prevention measures
    - Such services should be tailored with COVID-19 in mind, for example by providing people who use drugs and who are enrolled in OAT programmes with take-home doses to reduce their need to travel to and from health clinics.
- Establish public support mechanisms for people released from prison, from housing to psychosocial support, with particular attention to the vulnerabilities they are likely to experience during the COVID-19 pandemic
- Repeal laws and policies that ban people convicted of drug offences, and people who use drugs, from accessing housing, employment, education, banking, driving and welfare benefits.

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About this Briefing Paper

Drawing on four case studies, this briefing paper provides a snapshot of the lessons than can be learnt from the impact of the COVID19 pandemic on the world's overcrowded prison systems. While at the outset of the pandemic some states announced prison decongestion measures to prevent the spread of the virus in detention centres, these releases where deeply flawed, and limited. Instead, countries opted for cutting off people deprived of liberty from the community writ large, thus seriously limiting access to basic services, and meaningful human contact.

About IDPC

The International Drug Policy Consortium is a global network of non-government organisations that specialise in issues related to illegal drug production and use. The Consortium aims to promote objective and open debate on the effectiveness, direction and content of drug policies at national and international level and supports evidence-based policies that are effective in reducing drug-related harm. It produces briefing papers, disseminates the reports of its member organisations, and offers expert advice to policy makers and officials around the world.

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