Why people living and working in detention facilities should be included in national COVID-19 vaccination plans

ADVOCACY BRIEF

World Health Organization
REGIONAL OFFICE FOR Europe

Key messages

The evidence shows that the risk of transmission of SARS-CoV-2 is much higher in prisons and other closed settings and that people living in such settings have proportionately a higher burden of comorbidities compared to the outside community, thereby increasing their chances of suffering severe outcomes. Therefore:

1. People living in prison should be included in national COVID-19 vaccination plans on the basis of their increased vulnerability, the principle of equivalence, and the duty of governments to protect those deprived of their liberty, leaving no one behind.

2. People living in prison should have a guaranteed right to be informed about how to protect themselves from COVID-19 by immunization and other public health measures.

3. If facility-wide vaccination (everyone included) is not possible, vulnerable groups in detention settings should be prioritized.

Prison health-care staff in direct contact with COVID-19 cases are as likely to become infected as their health-care colleagues in the community; indeed, given that limited resources in prison may hinder quick identification of asymptomatic individuals and adoption of preventive measures, health-care staff in detention settings may even be at higher risk. The mobility of prison staff between prisons and surrounding communities, coupled with the constant flow of people in prison between pretrial and detention centres and between prison facilities, increases the risk of SARS-CoV-2 entering prisons and spreading from there to the outside community. As such:

4. The prison workforce (health-care workers and prison staff) should be prioritized for vaccination as health and care workers and as personnel at higher risk.

Key questions answered by this brief

- What are the reasons for including prison populations in national vaccination plans against COVID-19?
- What are the principles at stake if prisons are excluded from the health response?

Methodology

This information product was developed through a rapid literature review (including scientific studies and media reports), followed by input from our external stakeholders and partners – the United Nations Office on Drugs and Crime (UNODC) and Penal Reform International (PRI). Identification of good practice examples was achieved by a call issued by the WHO Health in Prisons Programme to European Member States to share their national plans, with special reference to the inclusion of prisons. UNODC and PRI ensured that the coverage extended beyond Europe and the outreach was global. This call took the form of written contributions and participation in special events. The conformity of the information given here with WHO policy has been ensured by expert review from relevant WHO divisions.

Introduction

The recent approvals of COVID-19 vaccines around the world have been accompanied by much discussion of the optimal approaches to vaccine rollout. It is encouraging to see that vulnerable and at-risk groups have increasingly been included in national deployment and vaccination plans, but more needs to be done. While prioritizing certain groups, such as older people, is generally uncontroversial, there has been less agreement about the inclusion of others, such as people living and working in detention facilities. Despite ample evidence that prison populations have experienced COVID-19 outbreaks and that they are particularly vulnerable to SARS-CoV-2, a consequence of both congregate living conditions and poor underlying health conditions, offering vaccination to such people has been inconsistently applied and even contentious, as evidenced by the different approaches to vaccine allocation taken by different countries. The series of considerations outlined in the following brief are intended to inform the global community of the importance of including detention facilities in their vaccination plans and to support them in implementing their current COVID-19 vaccine allocation efforts.

Background

There are many reasons why people deprived of their liberty experience a situation of increased vulnerability to infectious diseases such as COVID-19. Conditions that are often overcrowded, unhygienic and poorly ventilated, frequent movement of people within and between detention facilities, and situations of stress paired with sometimes suboptimal nutritional status are responsible for amplifying the occurrence and transmission of infectious diseases.[1] In addition, the underlying health problems of the imprisoned population, combined with health services that are generally inferior to those in the outside community, increase the risk of serious illness or death.

The limited resources available for the prison population, including access to testing and personal protective equipment (PPE), present an additional challenge. For these reasons, updating prevention measures, including the vaccination status of the prison population, is a key public health measure, especially as many detainees have little or no regular contact with health care prior to incarceration.[2] Implementing schemes for vaccine-preventable diseases should therefore be recommended and has proven to be beneficial in terms of cost.[3]

The most recent data (March 2021), gathered from 122 countries, indicate that there are currently well over half a million cases of COVID-19 among people in prison.[4] Among people living in prison in the USA, the COVID-19 case rate in June 2020 was 5.5 times higher than that in the general population, while the death rate was three times higher.[5] Indeed, 90 of the 100 largest cluster outbreaks in the USA occurred in detention facilities.[6] Awareness of the risks and of the need for constantly updated data has led to cumulative COVID-19 cases and deaths (and rates) in US detention facilities being made publicly available.[7]

For all these reasons, severe response measures have had to be introduced in prisons and other closed settings worldwide in order to prevent the virus from entering these vulnerable communities.[8] WHO's timely development of recommendations on pandemic management in detention facilities contributed to effective country responses during the first wave of the pandemic. The severity of the second wave, which hit various countries harder and, in some cases, led to infection rates in detention settings that were higher than in the outside community, warranted a revision of the recommendations and a call for stricter measures. In the United Kingdom, as early as September 2020, the infection rate in detention facilities was already twice as high as that reported in the general population. Such alarmingly unbalanced situations are currently being observed (as of March 2021) in Lithuania and Slovenia.

The end of 2020 brought hope to many with regulatory approval (emergency use listing) of vaccines against COVID-19. It is anticipated that there will be 2 billion doses available by the end of 2021 – though this should be seen in the context of a world population (according to World Bank estimates) of over 7.7 billion people. The number of people incarcerated globally at any given time is growing, currently standing at more than 11 million. Taking into account the total number of people moving through detention settings (inflow and outflow), this number exceeds 30 million per year.[9] Despite the devastating impact the pandemic has on people in detention facilities on any given day, there is a risk that this population will be excluded from current national vaccination plans as other populations are prioritized or issues linked to the vaccine and logistics supply chain occur.

People in detention facilities should be included in national COVID-19 vaccination plans across the world. Failing to do so is likely to undermine efforts to ensure equitable access to all population groups in a country and thereby to control the disease. Previous historical outbreaks of infectious diseases dating back to 1918 have shown that failing to act early in confined settings produces catastrophic effects.[10] Additional risk is likely as shown by frequent outbreaks of other infectious diseases in detention facilities.[11] High rates of reoffending and short cycles of liberty and incarceration also contribute to the difficulty in containing the infection within prison walls.[9] Moreover, staff in detention facilities move in and out on a daily basis, and many health-care professionals and other personnel who provide support care programmes (such as civil society and religious representatives) do not work exclusively in a single facility. Procuring reliable supplies of PPE has proven to be as much of a challenge in clinical and social settings as it is outside the health system.[12]

The WHO SAGE (Strategic Advisory Group of Experts on Immunization) values framework has been developed to offer guidance on the allocation of COVID-19 vaccines between countries and on the prioritization of groups for vaccination within countries while supply is limited.[13] Even though the general principles are established, their interpretation and adaptation to local context may be less straightforward. Specifically, in relation to prisons and other detention settings, unique challenges such as limited integration of health records may hamper identification of eligible populations and result in key groups being omitted from the vaccine allocation process. The following brief provides evidence-based considerations and principles to support the inclusion of people living and working in detention facilities in national COVID-19 vaccination plans, in line with the principles outlined in the WHO SAGE framework.

Considerations for inclusion of people living and working in detention facilities in national COVID-19 vaccination plans

Recognizing that settings will differ from place to place, countries may adapt regional and global recommendations on prioritized population groups depending on vaccine availability, local disease epidemiology, and size and proportion of each priority group.[14]

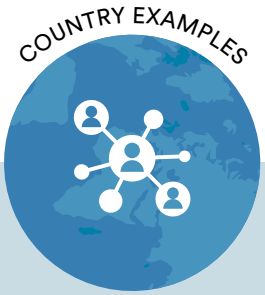
1) Include prison populations as communities that are unable to take appropriate public health measures to prevent infection (including physical distancing and hygiene)

Studies of previous infectious disease outbreak management have shown particular challenges for detention facilities in adhering to physical distancing and other public health measures commonly implemented during pandemics such as isolation and quarantine.[15]

Limited access to water and shortage of handwashing facilities in many detention settings globally are also key issues.[16] Unpublished information collected by the Vance Center for International Justice and PRI focusing on females in detention facilities suggests that prison authorities in Malawi and Colombia failed to provide potable water, hand sanitizers or soap, face masks, gloves or disinfectant.[17] Lack of information on steps needed to prevent spread of the virus and limited opportunity to wash hands regularly due to interrupted water supply were highlighted. There are also examples, in Sierra Leone, where civil society organizations had to donate protective materials, water tanks and handwashing stations.

The limited testing capacity in prisons compared to the outside community increases the risk as asymptomatic individuals may spread the infection. Recent data indicate that, over a one-week period, only 23 individuals out of 71 097 living in Polish prisons were tested (0.03%); in the Republic of Moldova, over the same period, only one test was carried out in a population of 6449 (0.02%).[18]

Analysis of COVID-19 risk factors in detention settings pointed to dormitory housing as the highest risk factor for acquiring SARS-CoV-2 infection.[19] In the course of the COVID-19 pandemic, many detention facilities across Europe have resorted to noncustodial measures of incarceration to reduce overcrowding and hence the risk of transmission. Of 43 European prison administrations, 27 reported that their prison populations decreased in spring 2020.[20] Globally, by June 2020 decongestion measures had been adopted by 109 countries.[21] These measures, coupled with other factors including decreased activity of criminal justice systems, have led to a decrease in occupancy during the pandemic. However, concerns have already been expressed about further overcrowding once emergency measures are lifted.[22]



Spain
Inclusion of people in prison in stage 2 of the country's vaccination plan was justified on the grounds of prisons being closed institutions and hence the increased risk of in-prison transmission and amplification.

South Africa and **Morocco**
In South Africa, arguments in favour of prioritizing people in prison were strongly based on the inability to physically distance, considering the severe overcrowding in the country's prisons.

However, perhaps given the limited amount of vaccines available in African countries, South Africa was the first African country taking this approach. More recently, Morocco also launched a vaccination campaign for people in prisons.

2) Include older people living in prison

In most countries, the recommendation to target the elderly, with the oldest being the highest priority for vaccination followed by younger ages in an age-banded approach, has been followed. However, specific age cut-offs and age bands are decided by Member States according to their circumstances. For the prison population it has been shown that the cut-off for the elderly band should be lowered to 50 years because of the poor health status of people in detention and the ageing effect of prison itself.[23,24]

Advanced age has been shown to be a significant risk factor for developing more severe outcomes. In the European Union and the United Kingdom, COVID-19 deaths in people aged 80 years and over accounted for two thirds of all deaths, with the proportion rising to 95% when those aged 60 years and over are considered.[25] The same data showed that the likelihood of being admitted to hospital as a result of COVID-19 was four times higher in people aged over 80 years compared to people in their 50s, with a 7.4 times higher chance of death. In a study of COVID-19 patients aged 60 years and over in Spain, 81.9% of patients had at least one comorbidity.[26] It has been estimated that 5% of the prison population in the WHO European Region are aged 55 years and over.[27] Among people in detention facilities, it has been shown that each additional decade of life is associated with a threefold increase in the risk of death.[19]

In Europe COVID-19 deaths in people aged 80 years and over account for two thirds of all deaths.

In Ireland, where around 14% of the prison population are aged over 50 years, 46% of COVID-19 cases recorded in February 2021 were among this age group.[28] The global prison population, which is becoming both larger and older, is also more likely to experience noncommunicable diseases (NCDs).[29] A study of the prevalence of NCDs among people over 50 years of age in detention facilities revealed a high NCD burden, including 8% cancer, 14% diabetes, 38% cardiovascular disease (CVD) and 39% hypertension.[30] All of these conditions are known to be strong risk factors for COVID-19 (see the next point below). In the United Kingdom, the COVID-19 infection rate in people aged 60 or over living in detention facilities was 15.5 per 1000 – twice as high as that in the general population.[6]

Considering the ageing effect of incarceration, national vaccination plans should be adapted to take account of the specific conditions that apply to detention settings, otherwise most “true elders” will be missed.

United Kingdom
People in the priority age cohorts living in prison began to be vaccinated as of January 2021.

Russian Federation
There is a coordinated nationwide vaccination rollout in prisons using the same criteria as in the general population. By 18 February 2021, more than 2000 elderly people living in prison had been vaccinated.

3) Include people in prison with underlying health conditions

Evidence has consistently shown a strong link between the presence of certain underlying conditions and more severe outcomes of COVID-19. In one study, about half (51.7%) of diagnosed COVID-19 cases had a pre-existing comorbidity, while the great majority of those who died (83.2%) had such a condition.[31] Several NCDs, such as diabetes, hypertension and other CVDs, have been identified as major risk factors for COVID-19.[32]

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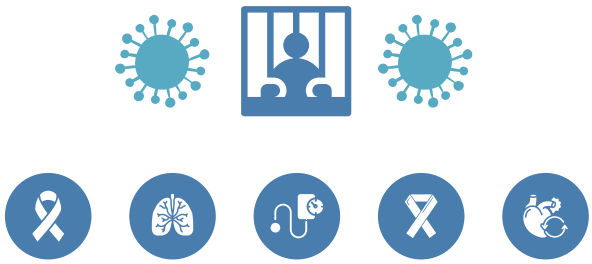

The prison population experiences a higher burden of many NCDs. The risk of hospitalization and death as a result of CVDs is higher in prisons than in the general population.[33] The leading causes of death in prisons in England and Wales have been reported to be diseases of the circulatory system (including coronary artery disease and strokes: 43% of all deaths) followed by neoplasms (cancers: 32%).[34] Another study found that, in the USA, people in prison are 1.5 times more likely to report high blood pressure, diabetes or asthma than the general population, while 40% of those in detention reported a current chronic condition.[35] Emerging evidence suggests that people with tuberculosis (TB) – which has been found to be up to 64 times more common in prison than in the general population – may have worse COVID-19 outcomes.[36,37] The spread of COVID-19 among people living with HIV and viral hepatitis is also an issue of global concern. Women are at greater risk than men of entering prison with HIV, hepatitis B and/or hepatitis C and frequently have complex health conditions, so it is paramount that consideration is given to including female detainees in COVID-19 vaccination plans.[38]

Portugal

People in prison meeting the criteria for high-risk groups in the general population covered in the first vaccination stage (people of 50 years or over with underlying conditions including congestive heart failure, coronary disease, chronic obstructive pulmonary disease, and renal insufficiency) were included in stage 3 of the vaccination plan. Eligible people in prison have been identified by the clinical services of each prison unit and communicated centrally.

4) Include prison staff and health-care staff as essential health and care workers

In many countries health-care workers have been included as a priority group for vaccination because of the high risk of infection they face as a result of direct exposure to COVID-19 patients while delivering an essential societal service. A study conducted in the USA and the United Kingdom found that the likelihood of testing positive for COVID-19 among health workers was three times higher than in the general population.[39] Another systematic review study reported a 51.7% COVID-19 infection rate among health-care workers, with 15.1% hospitalized and 1.5% dying.[40] The risk was shown to be further increased by factors such as workplace setting, with the highest risk reported among health-care workers in inpatient settings and closed living facilities. Moreover, detention facilities in several countries still face issues of limited supply of PPE,[5] even for health-care workers, thereby further increasing their already greater baseline risk. In some countries, such as Pakistan, securing enough PPE was only achieved by relying on charities.[41] Thus, failing to protect prison and health-care staff by vaccination will also place those in detention at increased risk of exposure to SARS-CoV-2 from external sources.

Outbreaks of COVID-19 infections among staff and people in detention facilities have been seen in most countries of the WHO European Region, including Azerbaijan, Belgium, Czechia, Finland, France, Germany, Greece, Ireland, Israel, Italy, Latvia, Lithuania, Malta, Poland, the Republic of Moldova, Romania, Slovakia, Spain, Turkey and the United Kingdom (England and Northern Ireland only). In Poland, by February 2021 there had been 4207 COVID-19 cases identified among prison staff, representing 85% of all cases in this setting.[28] In South Africa, 5000 infections had been recorded among prison staff by December 2020, representing 62% of all COVID-19 cases identified in detention facilities.[42]

Studies found that in the USA and the United Kingdom the likelihood of testing positive for COVID-19 among health workers was three times higher than in the general population.

COVID-19 outbreaks in detention facilities

SOUTH AFRICA:
Up to December 2020, prison staff accounted for 62% of all COVID-19 cases identified in detention settings.

POLAND:
Up to February 2021, prison staff accounted for 85% of all cases identified in detention settings.

Israel and **Lithuania** included all prison staff in their vaccination campaigns.

Ireland and the **Republic of Moldova** included prison health staff in the second phase of their vaccination strategies.

5) Include prisons because of the risk of transmission into the community

Each year, more than 30 million people go in and out of prisons globally, without counting staff and other personnel who move in and out of detention settings on a daily basis. Contrary to popular belief, most prison stays are relatively short – usually a matter of months rather than years.[43] Prisons can never be completely isolated from surrounding communities, so failing to protect those in prison increases the risk of infectious diseases spreading into the community. Visitors to prisons may also become carriers into their own communities, especially when not equipped with PPE. Previous studies have shown that, on average, the proportion of TB cases in the general population attributable to exposure in prisons was 8.5% in high-income countries and 6.3% in low- and middle-income countries.[44] Despite the challenges associated with the public perception of vaccinating people in prison, action must be taken to demonstrate how failing to protect people living and working in prison will ultimately affect surrounding communities. It is therefore crucial to consider detention facilities as spaces where prisoners can access health care with vaccination coverage, thus having a direct impact not only on the prison population itself but also on the community.[45]

6) Include prisons on grounds of social vulnerability

Limited access to health care among socially vulnerable groups, including difficulties in accessing vaccines for vaccine-preventable diseases, is a persistent challenge that has been exacerbated by the COVID-19 pandemic.[46,47] Public health and policy experts have stressed the importance of including or even prioritizing vulnerable groups, such as people living in prison, during COVID-19 vaccination campaigns.[48] People in prison often come from marginalized groups of society with a higher burden of poverty and discrimination and with limited prior access to health care, and this results in increased risk from COVID-19.[49] Some groups, including women, non-nationals, and indigenous and rural populations, seem especially vulnerable to inequalities in care provision and face particular discrimination in access to health care and social stigma.[50] Studies have shown that immunization of the prison population for common infectious diseases is generally inadequate at a global level and was so during previous pandemics.[51] During the swine flu (H1N1) pandemic of 2009, despite sufficient vaccine availability, many prisons and jails in the USA were not included in allocation plans.[52]