World Health Organization

REGIONAL OFFICE FOR Europe

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

Interim guidance

15 March 2020

1. INTRODUZIONE

Le persone private della loro libertà, come chi si trova nelle carceri e in altri luoghi di detenzione, sono probabilmente più vulnerabili all'epidemia di coronavirus (COVID-19) rispetto alla popolazione generale a causa dello spazio ristretto in cui vivono insieme, per un periodo di tempo prolungato.

L'esperienza mostra che prigioni, carceri e ambienti simili in cui le persone sono radunate nelle immediate vicinanze possono fungere da fonte di infezione, amplificazione e diffusione di malattie infettive all'interno e all'esterno delle carceri. La salute delle carceri è pertanto ampiamente da considerarsi un tema di salute pubblica. La risposta al COVID-19 nelle carceri e in altri luoghi di detenzione richiede un approccio di governo e di società civile per i seguenti motivi:

1. la diffusione di un patogeno infettivo che colpisce la comunità in generale rappresenta una minaccia di introduzione dell'agente infettivo nelle carceri e in altri luoghi di detenzione; il rischio di aumentare rapidamente la trasmissione della malattia all'interno di carceri o altri luoghi di detenzione potrebbe avere un effetto amplificante sull'epidemia, moltiplicando rapidamente il numero di persone colpite.

2. È probabile che gli sforzi per controllare COVID-19 nella comunità falliscano se non vengono condotte misure efficaci di prevenzione e controllo delle infezioni (IPC), test, cure e cure adeguate nelle carceri e in altri luoghi di detenzione.

3. In molti paesi, la responsabilità dell'assistenza sanitaria nelle carceri e in altri luoghi di detenzione spetta al ministero della Giustizia / Affari interni. Anche se questa responsabilità è detenuta dal Ministero della Sanità, il coordinamento e la collaborazione tra i settori della salute e della giustizia sono sufficienti per proteggere la salute delle persone nelle carceri e in altri luoghi di detenzione e della comunità in generale.

4. Le persone nelle carceri e in altri luoghi di detenzione sono già private della libertà e possono reagire in modo diverso alle ulteriori misure restrittive imposte loro.

2. RAZIONALE

Le persone private della libertà, come le persone in prigione, sono probabilmente più vulnerabili a varie malattie e condizioni. Il fatto stesso di essere privati della libertà implica, generalmente, che le persone nelle carceri e in altri luoghi di detenzione vivano in stretta vicinanza l'una con l'altra, il che potrebbe comportare un aumento del rischio di trasmissione da persona a persona e di goccioline di agenti patogeni come COVID-19.

Oltre alle caratteristiche demografiche, le persone nelle carceri hanno in genere un maggiore carico di malattie e condizioni di salute peggiori rispetto alla popolazione generale e spesso affrontano una maggiore esposizione a rischi come fumo, scarsa igiene e debole difesa immunitaria a causa di stress, cattiva alimentazione, o prevalenza di malattie coesistenti, come virus trasmessi dal sangue, tubercolosi e disturbi da uso di sostanze stupefacenti.

L'epidemia COVID-19, che è stata rilevata per la prima volta a Wuhan, in Cina, nel dicembre 2019, si è evoluta rapidamente. Il 30 gennaio 2020, il direttore generale dell'OMS ha dichiarato che l'attuale epidemia costituiva un'emergenza di sanità pubblica di rilevanza internazionale e il 12 marzo 2020 l'epidemia COVID-19 è stata dichiarata una pandemia. In tali circostanze, la prevenzione dell'importazione del virus nelle carceri e altri luoghi di detenzione sono un elemento essenziale per evitare o ridurre al minimo l'insorgenza dell'infezione e di gravi epidemie in questi contesti e oltre.

A seconda dell'andamento dell'epidemia nei diversi Paesi, il rischio di introdurre COVID-19 nelle carceri e in altri luoghi di detenzione può variare.

Nelle aree senza circolazione locale di virus, il rischio può essere associato al personale carcerario o alle persone appena ammesse che hanno recentemente soggiornato in paesi o aree colpiti o che sono state in contatto con persone di ritorno da paesi o aree colpiti.

Poiché diversi paesi in Europa stanno vivendo una diffusa trasmissione comunitaria, il rischio di trasmissione è aumentato notevolmente.

In tutti i Paesi, l'approccio fondamentale da seguire è la prevenzione dell'introduzione dell'agente infettivo nelle carceri o in altri luoghi di detenzione, limitando la diffusione all'interno della prigione e riducendo la possibilità di diffusione dalla prigione alla comunità esterna. Ciò sarà più impegnativo nei Paesi con una trasmissione più intensa.

Le carceri e altri luoghi di detenzione sono ambienti chiusi in cui le persone (incluso il personale) vivono molto vicine tra loro. Ogni paese ha la responsabilità di aumentare il proprio livello di preparazione, allerta e risposta per identificare, gestire e curare nuovi casi di COVID-19. I paesi dovrebbero prepararsi a rispondere a diversi scenari di sanità pubblica, riconoscendo che non esiste un approccio unico per la gestione di casi e focolai di COVID-19. Quattro scenari di trasmissione che potrebbero essere sperimentati dai paesi a livello subnazionale sono stati definiti per COVID-19, e pertanto i paesi dovrebbero adattare e adattare il loro approccio al contesto locale.

3. PRINCIPI DI PIANIFICAZIONE E CONSIDERAZIONI SUI DIRITTI UMANI

La pianificazione delle emergenze è essenziale per garantire un'adeguata risposta alla salute e mantenere impostazioni di detenzione sicure, protette e umane. In generale, sono disponibili piani per azioni di emergenza e di resilienza locali di breve durata. Tuttavia, la natura in evoluzione di focolai infettivi di proporzioni epidemiche o pandemiche, a livello locale, nazionale e globale, va oltre tali piani, con un potenziale impatto sulla sicurezza, sul sistema giudiziario più ampio e, in casi estremi, sull'ordine civile.

Inoltre, dovrebbero essere predisposti piani di continuità operativa per garantire la sicurezza e le funzioni di sicurezza intrinsecamente associate alle carceri e ad altri luoghi di detenzione.

È di fondamentale importanza lavorare in partenariato tra agenzie di sanità pubblica, servizi sanitari e luoghi di detenzione, riunendo servizi di comunità e servizi di detenzione / detenzione.

Il quadro dei diritti umani fornisce principi guida nel determinare la risposta allo scoppio di COVID-19. I diritti di tutte le persone interessate devono essere rispettati e tutte le misure di sanità pubblica devono essere attuate senza discriminazioni di alcun tipo. L**e persone nelle carceri e in altri luoghi di detenzione non sono probabilmente più vulnerabili alle infezioni da COVID-19, ma sono anche particolarmente vulnerabili alle violazioni dei diritti umani.** Per questo motivo, l'OMS ribadisce importanti principi che devono essere rispettati nella risposta a COVID-19 nelle carceri e in altri luoghi di detenzione, che sono saldamente fondati nella legge sui diritti umani, nonché gli standard e le norme internazionali in materia di prevenzione della criminalità e giustizia penale

La prestazione di assistenza sanitaria per le persone nelle carceri e in altri luoghi di detenzione è una responsabilità dello Stato.

• Le persone nelle carceri e in altri luoghi di detenzione dovrebbero godere degli stessi standard di assistenza sanitaria disponibili nella comunità esterna, senza discriminazioni sulla base del loro status legale.
• Dovrebbero essere messe in atto misure adeguate per garantire un approccio sensibile al genere nell'affrontare l'emergenza COVID-19 nelle carceri e in altri luoghi di detenzione.

• Le carceri e le altre autorità di detenzione devono garantire il rispetto dei diritti umani delle persone in custodia, che le persone non siano escluse dal mondo esterno e, soprattutto, che abbiano accesso alle informazioni e adeguate prestazioni sanitarie.

È necessario prestare maggiore attenzione al ricorso a misure non detentive in tutte le fasi dell'amministrazione della giustizia penale, comprese le fasi pre-processuali, processuali e penali nonché post-condanna. La priorità dovrebbe essere data alle misure non detentive per presunti colpevoli e detenuti

con profili a basso rischio e responsabilità di cura, con preferenza per le donne in gravidanza e le donne con figli a carico.
• Allo stesso modo, dovrebbero essere prese in considerazione procedure di assegnazione perfezionate che consentano di separare i detenuti a rischio più elevato dagli altri nel modo più efficace e meno disgregativo possibile e che consentirebbero a alloggi singoli limitati di rimanere disponibili per i più vulnerabili.
• Al momento dell'ammissione nelle carceri e in altri luoghi di detenzione, tutti gli individui devono essere sottoposti a screening per la febbre e i sintomi delle basse vie respiratorie; particolare attenzione dovrebbe essere prestata alle persone con malattie contagiose. Se hanno sintomi compatibili con COVID-19, o se hanno una precedente diagnosi di COVID-19 e sono ancora sintomatici, dovrebbero essere messi in isolamento medico fino a quando non ci saranno ulteriori valutazioni e test medici.

Le reazioni psicologiche e comportamentali dei prigionieri o di detenuti in altri contesti sono probabilmente diverse da quelle delle persone che osservano il distanziamento fisico nella comunità; si dovrebbe pertanto prendere in considerazione la crescente necessità di sostegno emotivo e psicologico, di una sensibilizzazione trasparente e di una condivisione delle informazioni sulla malattia e di garantire che i contatti continuativi con la famiglia e i parenti siano mantenuti.
• Dovrebbero essere messe in atto misure adeguate per prevenire la stigmatizzazione o l'emarginazione di individui o gruppi considerati potenziali portatori di virus.
• Qualsiasi decisione di collocare persone nelle carceri e in altri luoghi di detenzione in condizioni di isolamento medico dovrebbe sempre basarsi sulle necessità mediche a seguito di una decisione clinica e soggetta all'autorizzazione della legge o del regolamento dell'autorità amministrativa competente.
• Le persone sottoposte a isolamento per motivi di protezione della salute pubblica, nel contesto di carceri e altri luoghi di detenzione, dovrebbero essere informate del motivo per cui sono state messe in isolamento e avere la possibilità di comunicare la notifica a terzi.
• Dovrebbero essere messe in atto misure adeguate per proteggere le persone in isolamento da qualsiasi forma di maltrattamento e per facilitare il contatto umano come appropriato e possibile nelle circostanze date (ad esempio mediante mezzi di comunicazione audiovisivi).
• L'epidemia COVID-19 non deve essere utilizzata come giustificazione per minare l'adesione a tutte le garanzie fondamentali incorporate nelle Regole minime standard delle Nazioni Unite per il trattamento dei prigionieri (le Regole di Nelson Mandela) incluso, ma non limitato a questo, il requisito che le restrizioni non debbano mai equivalere a tortura o altre pene o trattamenti crudeli, disumani o degradanti; il divieto di isolamento prolungato (vale a dire oltre 15 giorni consecutivi); il requisito secondo cui le decisioni cliniche possono essere prese solo da operatori sanitari e non devono essere ignorate o disattese dal personale carcerario non medico; e che mentre i mezzi di contatto familiare possono essere limitati, in circostanze eccezionali ,per un periodo di tempo limitato, non devono mai essere del tutto vietati
•L'epidemia COVID-19 non deve essere utilizzata come giustificazione per opporsi all'ispezione esterna delle carceri e di altri luoghi di detenzione da parte di organismi nazionali o internazionali indipendenti il cui mandato è di prevenire la tortura e altre pene o trattamenti crudeli, disumani o degradanti; tali organismi comprendono meccanismi nazionali di prevenzione ai sensi del Protocollo opzionale alla Convenzione contro la tortura, il Sottocomitato per la prevenzione della tortura e altre pene o trattamenti crudeli, disumani o degradanti, e il Comitato europeo per la prevenzione della tortura e trattamenti disumani o degradanti o Punizione.
• Anche nelle circostanze dell'epidemia di COVID-19, i corpi di ispezione dovrebbero avere accesso a tutte le persone private della libertà nelle carceri e in altri luoghi di detenzione, comprese le persone in isolamento, in conformità con disposizioni del mandato del rispettivo organo.

4. FINALITA' E OBIETTIVI

4.1 Ambito di applicazione

Il presente documento si basa sugli standard e le norme internazionali in materia di prevenzione della criminalità e giustizia penale relative alla gestione delle carceri e alle misure non detentive, nonché di orientamento internazionale sulla salute delle carceri, comprese le norme minime standard delle Nazioni Unite per il trattamento dei detenuti (il Nelson Mandela Rules), regole delle Nazioni Unite per il trattamento delle donne detenute e misure non detentive per le donne detenute (le regole di Bangkok), norme minime standard per l'amministrazione della giustizia minorile (le regole di Pechino), Stati Uniti Norme minime

standard delle Nazioni per le misure non detentive (le regole di Tokyo), e la guida dell'OMS su prigioni e salute (2014) .
Il documento mira ad assistere i paesi nello sviluppo di piani specifici e / o nel consolidamento di ulteriori azioni per le carceri e altri luoghi di detenzione in risposta allo scoppio internazionale COVID-19, con considerazione dei piani di preparazione, strategie di prevenzione e controllo e piani di emergenza e interfaccia con il più ampio sistema di pianificazione sanitaria e di emergenza.

4.2 obiettivi
Obiettivo 1.
Guidare la progettazione e l'implementazione di adeguati piani di preparazione per le carceri e altre strutture di detenzione per far fronte alla situazione dell'epidemia di COVID-19 in modo tale da:
→ proteggere la salute e il benessere delle persone detenute nelle carceri e altri ambienti chiusi, e di coloro che vi lavorano (custodia, assistenza sanitaria e altro personale) e persone che visitano carceri e altri luoghi di detenzione (visitatori legali, familiari e amici di prigionieri, ecc.);
→ sostenere il funzionamento sicuro e continuo delle carceri e di altre strutture di detenzione;
→ ridurre il rischio di epidemie che potrebbero comportare una forte domanda di servizi sanitari nelle carceri e nella comunità;
→ ridurre la probabilità che COVID-19 si diffonda nelle carceri e in altri luoghi di detenzione e da tali contesti nella comunità;
→ garantire che le esigenze delle carceri e delle altre strutture di detenzione siano prese in considerazione nella pianificazione sanitaria e di emergenza nazionale e locale

Obiettivo 2.
Presentare meccanismi efficaci di prevenzione e risposta per:
→ impedire l'introduzione di COVID-19 nelle carceri e in altri luoghi di detenzione;
→ impedire la trasmissione di COVID-19 nelle carceri e in altri luoghi di detenzione;
→ impedire la diffusione di COVID-19 dalle carceri e da altri ambienti chiusi alla comunità.

Obiettivo 3. Delineare un approccio appropriato per collegare il sistema sanitario carcerario e il sistema di pianificazione sanitaria e di emergenza nazionale e locale per:
→ misure preventive, comprese le strutture per l'allontanamento fisico e l'igiene delle mani; → sorveglianza delle malattie;
→ identificazione e diagnosi, inclusa la tracciabilità dei contatti;
→ trattamento e / o rinvio di casi COVID-19 che richiedono cure specialistiche e intensive;
→ impatti di sistema più ampi (incluso l'impatto di altre misure sulla forza lavoro, ad esempio necessità di isolamento domestico, ecc.).

5. DESTINATARI

Questa guida ha lo scopo di aiutare il personale sanitario e di custodia che lavora nelle carceri e in altri luoghi di detenzione per coordinare le azioni di sanità pubblica in tali contesti; fornisce informazioni su:
• il nuovo virus COVID-19;
• come aiutare a prevenire la diffusione di COVID-19; 16
• cosa fare se viene identificata una persona in carcere o in altro luogo di detenzione o un componente del personale con sospetta o confermata infezione da COVID-19;
• quale consiglio dare alle persone in carcere o in un altro luogo di detenzione e ai loro familiari o ai componente del personale che viaggiano da aree colpite negli ultimi 14 giorni.

Le informazioni fornite saranno utili anche per le autorità carcerarie, le autorità e i responsabili delle politiche della sanità pubblica, i governatori e i dirigenti delle carceri, gli operatori sanitari che lavorano in contesti carcerari, i dipendenti dei centri di detenzione, le persone detenute e i contatti sociali delle persone detenute.

I seguenti istituti sono inclusi nella definizione dei luoghi di detenzione utilizzati nella presente guida: carceri (gestite da pubblico e da privati), contesti di detenzione per immigrazione, istituti minorili

6. APPROCCIO GENERALE

Il controllo della diffusione dell'infezione nelle carceri e in altri luoghi di detenzione è essenziale per prevenire le epidemie di COVID-19 in tali contesti, proteggere la salute e il benessere di tutti coloro che vivono e lavorano in essi e coloro che li visitano e proteggere il comunità esterna.

Stabilire tale controllo dipende dagli sforzi coordinati del personale sanitario e di custodia, che lavora con le agenzie sanitarie pubbliche locali e nazionali e con i ministeri della giustizia e degli interni e le loro controparti locali, nell'applicare l'approccio generale di seguito riassunto.

1. È necessario intraprendere azioni per consentire e sostenere gli sforzi coordinati e collaborativi tra le organizzazioni per raggiungere il controllo e la prevenzione dell'infezione (IPC) seguendo gli orientamenti nazionali. Tali azioni dovrebbero essere commisurate al livello di emergenza al momento per evitare il panico e garantire l'attuazione della risposta più appropriata al momento opportuno.

2. Pianificazione congiunta

→ Il personale di custodia / detenzione dovrebbe collaborare con le squadre sanitarie nelle carceri e in altri luoghi di detenzione, secondo i protocolli e le disposizioni nazionali esistenti, per consentire l'identificazione di casi sospetti tra i dipendenti e la loro successiva gestione in conformità con le linee guida nazionali .

→ Il personale di custodia / detenzione dovrebbe collaborare con le squadre sanitarie nelle carceri e in altri luoghi di detenzione per consentire l'identificazione di casi sospetti tra detenuti, il loro successivo isolamento e una successiva valutazione clinica.

3. Valutazione del rischio / gestione del rischio

→ Dovrebbe essere disponibile lo screening al punto di ingresso in carcere: le squadre di assistenza sanitaria e di salute pubblica dovrebbero effettuare una valutazione del rischio di tutte le persone che entrano in carcere, indipendentemente dal fatto che ci siano o meno casi sospetti nella comunità ; dovrebbero essere raccolte informazioni su qualsiasi storia di tosse e / o mancanza di respiro, storia recente di viaggio dei pazienti e possibile contatto con casi confermati negli ultimi 14 giorni.

→ Le persone controllate devono includere prigionieri / detenuti, visitatori e personale carcerario.

→ La comunicazione chiara è importante in modo che il personale con storia di viaggio recente o proveniente da aree interessate che sviluppano sintomi COVID-19 possa isolarsi da casa e che i manager possano fornire un alto livello di vigilanza e supporto al proprio personale. I consigli ai visitatori dovrebbero anche essere forniti con largo anticipo della loro frequentazione delle carceri / altre strutture di detenzione in modo che coloro che devono viaggiare non siano svantaggiati. Coloro che sono sintomatici dovrebbero essere esclusi dalla visita.

→ Per i visitatori asintomatici con storia di viaggio recente o provenienti da aree interessate, dovrebbero essere predisposti protocolli per consentire l'ingresso (ad esempio per i consulenti legali), ma dovrebbero essere prese in considerazione misure aggiuntive, come le visite senza contatto.

→ Le decisioni di limitare o impedire le visite devono tenere conto dell'impatto particolare sul benessere mentale dei detenuti e dei maggiori livelli di ansia che la separazione dai bambini e dal mondo esterno può causare.

→ È necessario mantenere un registro giornaliero dettagliato delle persone che si spostano dentro e fuori la prigione.

→ La gestione delle carceri / detenzioni dovrebbe prendere in considerazione misure di attuazione per limitare la mobilità delle persone all'interno del sistema penitenziario / detentivo e / o limitare l'accesso del personale non essenziale e dei visitatori alle carceri e ad altri luoghi di detenzione, a seconda del livello di rischio nel Paese / area specifici.

L'impatto psicologico di queste misure deve essere considerato e mitigato il più possibile e dovrebbe essere disponibile un supporto emotivo e pratico di base per le persone colpite in carcere.
→ La gestione delle prigioni / detenzione dovrebbe aumentare il livello di informazioni su COVID-19 condivise in modo proattivo con persone in detenzione. Le restrizioni, inclusa una limitazione dei visitatori, devono essere spiegate con attenzione in anticipo e misure alternative per fornire il contatto con la famiglia / amici, ad es. telefonate o chiamate Skype, dovrebbero essere introdotte.

4. Sistema di riferimento e gestione clinica
→ Nel contesto dell'attuale epidemia di COVID-19, la strategia di contenimento include la rapida identificazione di casi confermati in laboratorio e il loro isolamento e gestione in loco o in una struttura medica. Per i contatti di casi confermati in laboratorio, l'OMS raccomanda che tali persone siano messe in quarantena per 14 giorni dall'ultima volta in cui sono state esposte a un paziente COVID-19.
→ Squadre sanitarie, utilizzando i dispositivi di protezione individuale raccomandati (DPI) inclusa la protezione degli occhi (visiera o occhiali protettivi), guanti, maschera e abito, dovrebbero garantire che vengano prelevati campioni biologici adeguati, su consiglio della loro agenzia di sanità pubblica, da eventuali casi sospetti e inviati per l'analisi ai servizi di microbiologia locale secondo i protocolli locali, in modo tempestivo modo e nel rispetto delle procedure cliniche e di governance delle informazioni. Le scorte di DPI devono essere mantenute e protette per garantirne la disponibilità nelle circostanze indicate.
→ Le autorità penitenziarie dovrebbero essere informate e rese consapevoli degli ospedali ai quali possono trasferire coloro che richiedono il ricovero (supporto respiratorio e / o unità di terapia intensiva). È necessario adottare le misure appropriate per tutti i casi confermati, incluso il trasferimento a strutture specializzate per l'isolamento e il trattamento delle vie respiratorie, come richiesto; dovrebbero essere usate le attrezzature appropriate e seguiti i consigli sui trasferimenti sicuri. Tuttavia, è necessario prendere in considerazione protocolli in grado di gestire il paziente in loco con criteri chiari per il trasferimento in ospedale, poiché il trasporto non necessario crea rischi sia per il personale di trasporto che per l'ospedale ricevente.
→ Dovrebbero essere previsti controlli ambientali e ingegneristici intesi a ridurre la diffusione di agenti patogeni e la contaminazione di superfici e oggetti inanimati; ciò dovrebbe includere la disponibilità di uno spazio adeguato tra le persone, un adeguato ricambio d'aria e una disinfezione ordinaria dell'ambiente (preferibilmente almeno una volta al giorno).
→ Dovrebbero essere prese in considerazione misure come la distribuzione di cibo nelle stanze / celle invece di una mensa comune; o ripartire il tempo fuori dalla cella, che potrebbe essere diviso per ala / unità per evitare la concentrazione di prigionieri / personale anche in spazi aperti. Con queste avvertenze, l'accesso dei detenuti all'aria aperta dovrebbe essere mantenuto e non scendere al di sotto di almeno un'ora al giorno.

5. Il personale addetto alla gestione delle carceri / detenzioni dovrebbe collaborare con le agenzie sanitarie pubbliche locali per attuare le raccomandazioni IPC descritte nel presente documento; in ogni momento, devono bilanciare i rischi per la salute pubblica rispetto alle pressioni operative sulle carceri e altri luoghi di detenzione e sui beni immobili e detenuti più ampi.

7caratteristiche del virus
8. PREPARAZIONE, PIANIFICAZIONE DELLA CONTINGENZA E LIVELLO DI RISCHIO
Per gestire un focolaio di COVID-19, è necessario disporre di una pianificazione efficace e di solidi accordi di collaborazione tra i settori (salute e giustizia o interni, a seconda dei casi) che hanno la responsabilità della salute e del benessere delle persone nelle carceri e in altri luoghi di detenzione . Tale collaborazione sarà fondamentale per garantire un sistema di erogazione di assistenza sanitaria sostenibile all'interno delle carceri e dei luoghi di detenzione.
I passi importanti nella creazione di tale pianificazione collaborativa includono quanto segue:

• Dovrebbero essere istituiti piani di emergenza adeguati, incluse check list, per aiutare i sistemi carcerari e di detenzione ad autovalutare e migliorare la loro preparazione per rispondere a COVID-19.

• Dovrebbero essere stabilite strette collaborazioni / collegamenti diretti con le autorità sanitarie pubbliche locali e nazionali e altre agenzie pertinenti (ad esempio unità di crisi locali, protezione civile); è necessario mantenere contatti regolari durante tutto il periodo di pianificazione per condividere informazioni, valutazioni dei rischi e piani.

• Una valutazione dei rischi completa dovrebbe essere effettuata all'inizio della fase di pianificazione e rivista periodicamente; dovrebbe avere input da (o essere guidato da) autorità di sanità pubblica e includere una valutazione aggiornata della situazione epidemiologica. È fondamentale identificare i diversi livelli di rischio e quale impatto possono avere sul sistema carcerario e su altri luoghi di detenzione (ad esempio casi importati nel paese; circolazione locale ma circoscritta nel paese; circolazione locale, anche nell'area in cui il istituzione carceraria situata; circolazione all'interno del sistema carcerario).

• Dovrebbero essere sviluppati piani d'azione in un determinato paese / istituto di custodia per mitigare tutti i rischi identificati nella valutazione. Alcune azioni saranno a carico dell'autorità nazionale della sanità pubblica; alcuni saranno di responsabilità del fornitore di servizi sanitari locali; e le prigioni e altri luoghi di detenzione saranno responsabili per gli altri. Ogni piano d'azione dovrebbe specificare chi è responsabile della realizzazione di una determinata azione, i tempi di consegna e come e da chi sarà garantita la consegna. I piani d'azione dovrebbero includere:

→ integrazione con la pianificazione nazionale di emergenza e piani di risposta per le malattie infettive;

→ disposizioni di comando e controllo per facilitare la comunicazione rapida di informazioni e analisi e processi decisionali efficienti;

→ sorveglianza e individuazione della malattia (ad esempio, chi sarà sottoposto a screening per i sintomi COVID-19? Ci sarà uno screening iniziale per i sintomi per tutti i pazienti in entrata (personale / visitatori)? Come verranno diagnosticati e confermati i casi? Come saranno i casi e i contatti dei casi confermati devono essere gestiti?);

→ gestione dei casi (ad esempio, come verranno trattati i casi sospetti di COVID-19 nella popolazione detenuta? Esiste un luogo adeguato per una rapida valutazione della salute e isolamento, in caso di rilevamento di un potenziale caso COVID-19? Possono le unità alloggiare sospetti casi o contatti creati? Esiste un meccanismo per il trasporto sicuro di viaggiatori malati negli ospedali designati, compresa l'identificazione di adeguati servizi di ambulanza? Quale risposta sarà disponibile in caso di emergenza sanitaria che coinvolge persone nelle carceri e in altri luoghi di detenzione ? Esistono procedure operative standard per la pulizia e la disinfezione ambientale, anche per biancheria e utensili?);

→ pianificazione dell'emergenza del personale con particolare attenzione a

(a) disponibilità del personale e continuità aziendale, compreso il servizio minimo locale (ad es. Farmaci essenziali, controlli diabetici, medicazioni per ferite, ecc.); e

(b) le esigenze e le prestazioni di assistenza sanitaria - discutere la possibilità / fattibilità di fornire assistenza in carcere rispetto alla necessità di trasferire i pazienti ai servizi sanitari della comunità per cure specialistiche / intensive, nonché l'impatto previsto sulla pianificazione di emergenza del personale di custodia .

Un elemento essenziale da considerare attentamente in qualsiasi piano di preparazione per malattie infettive respiratorie come COVID-19 è la disponibilità e la fornitura di forniture essenziali, compresi DPI e prodotti per l'igiene delle mani e l'igiene ambientale e la disinfezione.

Si raccomanda pertanto ai governatori delle carceri, in collaborazione con gli operatori sanitari nelle carceri e in altri luoghi di detenzione, di valutare la necessità di DPI e altre forniture essenziali al fine di garantire la continuità della fornitura e la disponibilità immediata. Va notato che, al fine di evitare l'uso improprio e l'abuso dei DPI, personale e persone in carcere devono essere adeguatamente formati (per ulteriori informazioni sulla formazione, vedere la sezione 9 di seguito). In alcuni paesi, la percentuale della popolazione detenuta che soddisfa i criteri per la vaccinazione antinfluenzale è stata utilizzata come misura di base di base della potenziale domanda di servizi sanitari in caso di epidemia di COVID-19 nelle strutture di detenzione. Data la possibilità che alcuni disinfettanti comuni, come quelli contenenti alcol, possano essere usati in modo improprio, acqua e sapone, insieme ad asciugamani personali, dovrebbero essere considerati come la prima opzione per l'igiene delle mani. Questi dovrebbero essere forniti in stanze / celle giorno e notte. I gel a base di cloro possono essere usati dalle guardie carcerarie e dalle persone in carcere o in altri luoghi di detenzione in spazi comuni e / o se sapone e acqua non sono disponibili. Nel caso della disinfezione ambientale, tuttavia, è necessario garantire che i prodotti a base di cloro siano tenuti chiusi a chiave quando non vengono utilizzati dai fornitori di servizi.

La **formazione del personale** è un elemento chiave di qualsiasi piano di preparazione per le carceri e altri luoghi di detenzione.
Le attività di formazione dovrebbero essere opportunamente programmate e indirizzate al personale di custodia e sanitario che opera in contesti carcerari. Tali attività dovrebbero almeno coprire le seguenti aree:
• conoscenza di base della malattia, inclusi patogeni, via di trasmissione, segni e progressione della malattia clinica
• pratica di igiene delle mani ed etichetta respiratoria
• uso appropriato e requisiti di DPI
• misure di prevenzione ambientale , compresi pulizia e disinfezione.

In risposta all'epidemia di COVID-19, l'OMS ha sviluppato diverse risorse che potrebbero essere utili nelle carceri e in altri luoghi di detenzione.
• Corsi di formazione online su IPC e gestione clinica delle infezioni respiratorie acute acute (SARI) sono disponibili gratuitamente da OpenWHO, la piattaforma di conoscenza basata sul Web dell'OMS. Questi corsi di base forniscono un'introduzione generale a COVID-19 e ai virus respiratori emergenti; sono destinati ai professionisti della sanità pubblica, ai gestori degli incidenti e al personale che lavora per le Nazioni Unite, le organizzazioni internazionali e le organizzazioni non governative.
• Un pacchetto di comunicazione del rischio per le strutture sanitarie fornisce le informazioni agli operatori sanitari e alla gestione delle strutture sanitarie, procedure e strumenti necessari per lavorare in modo sicuro ed efficace. Il pacchetto contiene una serie di messaggi e promemoria semplificati basati sulla guida tecnica più approfondita dell'OMS sull'IPC nelle strutture sanitarie nel contesto di COVID-19 e può essere adattato al contesto locale.
• Inoltre, esiste una gamma di assistenza tecnica su molti argomenti, quali gestione dei casi, supporto operativo e consulenza logistica sull'uso delle maschere.

Infine, prima di intraprendere qualsiasi iniziativa, è assolutamente essenziale coinvolgere la popolazione carceraria in attività di informazione e sensibilizzazione diffuse, in modo che le persone in carcere / detenzione e i visitatori siano informati in anticipo e comprendano le procedure da adottare, perché sono necessario e come devono essere eseguiti. È particolarmente importante che vengano spiegate eventuali misure restrittive potenziali e che venga sottolineata la loro natura temporanea.
Purtroppo, a causa della stigmatizzazione o della paura, alcuni operatori sanitari che rispondono al COVID-19 nei luoghi di detenzione possono sperimentare l'evitamento da parte della famiglia o della comunità. Ciò può rendere molto più difficile una situazione già impegnativa. Il personale sanitario dovrebbe essere informato di rimanere in contatto con i propri cari e avere accesso alla salute mentale e al supporto psicosociale.

10. COMUNICAZIONE DEL RISCHIO
In un evento come l'epidemia di COVID-19, è fondamentale un buon coordinamento tra le squadre a livello nazionale e subnazionale coinvolte nella comunicazione del rischio. È necessario stabilire stretti contatti per

garantire la rapida eliminazione di messaggi e materiali di comunicazione, tempestivi e trasparenti, in tali situazioni di crisi.
I messaggi chiave per le persone in carcere e altri luoghi di detenzione, personale di custodia, operatori sanitari e visitatori devono essere coordinati e coerenti.
Per affrontare le barriere linguistiche, potrebbe essere necessario il materiale di traduzione o visivo.
Le risorse informative per il personale di custodia e assistenza sanitaria, i visitatori, i venditori e le persone detenute, quali brevi fogli informativi, volantini, poster, video interni e qualsiasi altro mezzo di comunicazione, dovrebbero essere sviluppate e collocate nelle aree comuni del carcere e nelle aree designate per visite legali e visite familiari.
Si dovrebbe prendere in considerazione il modo in cui i messaggi sul rischio possono essere consegnati rapidamente; ciò dovrebbe includere:
1) una valutazione globale del rischio locale (rischio comunitario e rischio all'interno della prigione);
(2) consulenza su misure preventive, in particolare pratiche di igiene delle mani e etichetta respiratoria;
(3) consulenza su quali misure adottare se si manifestano i sintomi;
(4) informazioni sui segni e sintomi della malattia, compresi i segnali di allarme di malattia grave che richiedono cure mediche immediate;
(5) consulenza sull'auto-monitoraggio di sintomi e segni per coloro che viaggiano o vivono in aree colpite, compreso il controllo della loro temperatura;
(6) consigli su come accedere all'assistenza sanitaria locale, se necessario, incluso come farlo senza creare un rischio per gli operatori sanitari;
(7) informazioni che si consiglia di indossare una maschera per le persone che hanno sintomi respiratori (ad esempio una tosse); non è raccomandato per le persone sane.

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

12. PREVENTION MEASURES
12.1 Personal protection measures
12.2 Use of masks
12.3 Environmental measures
12.4 Physical distancing measures
12.5 Consideration of access restriction and movement limitation

Una valutazione di ciascun caso e impostazione dovrebbe essere effettuata dal personale penitenziario in collaborazione con l'agenzia sanitaria pubblica locale. I consigli sulla gestione del personale o delle persone in carcere o sui luoghi di detenzione si baseranno su questa valutazione.
Una sospensione temporanea delle visite in carcere in loco dovrà essere attentamente considerata in linea con le valutazioni dei rischi locali e in collaborazione con i colleghi della sanità pubblica e dovrebbe includere misure per mitigare l'impatto negativo che tale misura potrebbe avere sulla popolazione carceraria. Deve essere preso in considerazione l'impatto specifico e sproporzionato sui diversi tipi di prigionieri, nonché sui bambini che vivono con il genitore in carcere.

Le misure per limitare i movimenti di persone in entrata e in uscita dall'area di detenzione, tra cui la limitazione dei trasferimenti all'interno del sistema di detenzione / detenzione e la limitazione dell'accesso al personale non essenziale e ai visitatori, devono essere considerate attentamente in linea con adeguate valutazioni del rischio, poiché tali restrizioni avranno un impatto più ampio sul funzionamento del sistema di detenzione.
Le misure che possono essere prese in considerazione comprendono, se del caso, la limitazione delle visite della famiglia, la riduzione del numero dei visitatori e / o la durata e la frequenza delle visite e l'introduzione di videoconferenze (ad esempio Skype) per i familiari e i rappresentanti del sistema giudiziario, come i consulenti legali .

In particolare:

• lo screening può essere preso in considerazione all'ingresso con un questionario di auto-segnalazione per escludere quelli con sintomi;
• i visitatori che non si sentono bene dovrebbero rimanere a casa e non frequentare la struttura;
• il personale deve rimanere a casa e consultare un medico se dovesse sviluppare segni e sintomi rilevanti.
Dovrebbe essere predisposto un protocollo sul luogo di lavoro su come gestire tali situazioni, incluso un caso COVID-19 sospetto o confermato o i loro contatti.

12.6 Staff returning to work following travel to affected areas or with a history of potential exposure
12.7 What to do if a member of staff becomes unwell and believes they have been exposed to COVID-19

13. VALUTAZIONE DEI CASI SOSPETTATI DI COVID-19 NELLE PERSONE IN PRIGIONE / DETENZIONE
L'identificazione del caso deve essere eseguita in conformità con le linee guida nazionali / sovranazionali disponibili per le cure primarie e le impostazioni della comunità.
I casi sospetti tra le persone in carcere possono essere identificati dalle notifiche ricevute dal personale di custodia / detenzione, altri prigionieri / detenuti, autoreferenziazione e screening alla reception o con altri mezzi. Per le definizioni dei casi, vedere la sezione 11 sopra.

A seconda del livello locale di rischio, potrebbero essere necessarie procedure aggiuntive per valutare i nuovi arrivati in carcere.
Le misure da considerare sono:
• creazione di un'area di screening dedicata all'ingresso della struttura
• definizione di una procedura per l'isolamento immediato dei casi sospetti.

13.1 Consigli sull'uso di DPI e altre precauzioni standard per il personale sanitario e il personale di custodia con ruoli rivolti ai pazienti
Gli operatori sanitari nelle carceri e altre strutture di detenzione hanno più probabilità di lavorare direttamente con i pazienti con una possibile diagnosi di COVID-19, ma possono anche essere coinvolti personale di custodia e servizi di trasporto, specialmente alla presentazione iniziale. Ciò significa che tutto il personale (operatori di custodia e sanitari) dovrebbe essere istruito sulle precauzioni standard come l'igiene personale, le misure di base IPC e su come trattare una persona sospettata di avere COVID-19 nel modo più sicuro possibile per prevenire la diffusione dell'infezione .
La gestione dell'IPC comprende indossare il livello adeguato di DPI in base alla valutazione del rischio e garantire una gestione dei rifiuti sicura, biancheria adeguata, pulizia ambientale e sterilizzazione delle attrezzature per la cura del paziente.
DPI per il personale di custodia Per le attività che comportano uno stretto contatto con un caso sospetto o confermato di COVID-19, come intervistare persone a una distanza inferiore a 1 metro, o arresto e repressione, si consiglia che il livello minimo di DPI che custodisce / il personale di scorta dovrebbe indossare è:

• guanti monouso
• mascherina medica
• se disponibile, un abito monouso completo e una protezione monouso per gli occhi (ad es. Visiera o occhiali protettivi).

DPI per il personale sanitario Si consiglia che il livello minimo di DPI per il personale sanitario richiesto quando si tratta di un caso sospetto o confermato COVID-19 è:
• mascherina medica
• abito completo
• guanti
• protezione degli occhi (ad es. Monouso occhiali di protezione o visiera)
• sacchetti per rifiuti clinici
• prodotti per l'igiene delle mani
• soluzioni detergenti e disinfettanti per uso generale che sono virucide e che sono state approvate per l'uso dalle autorità penitenziarie.

Il personale sanitario dovrebbe usare i respiratori solo per le procedure che generano aerosol; per ulteriori dettagli sull'uso dei respiratori, vedere la sezione 14 di seguito e la guida dell'OMS sull'uso dei DPI.

Per tutto il personale, i DPI devono essere cambiati dopo ogni interazione con un caso sospetto o confermato.
La rimozione dei DPI deve essere rimossa in un ordine che minimizzi il potenziale di contaminazione incrociata. Prima di lasciare la stanza in cui è tenuto il paziente, guanti, camice / grembiule, protezione per gli occhi e maschera devono essere rimossi (in questo ordine, se indossati) e smaltiti come rifiuti clinici. Dopo aver lasciato l'area, la maschera facciale può essere rimossa e smaltita come rifiuto clinico in un apposito contenitore.
La procedura corretta per la rimozione dei DPI è la seguente:
(1) togliere i guanti e smaltirli come rifiuto clinico
(2) eseguire l'igiene delle mani, lavandosi le mani o usando gel alcol
(3) rimuovere il grembiule / abito piegandosi su se stesso e posizionandolo in cestino per rifiuti clinici
(4) rimuovere occhiali / maschera facciale solo dall'archetto o dai lati e smaltire come rifiuto clinico
(5) rimuovere la mascherina medica da dietro e smaltire mentre i rifiuti clinici
(6) eseguono l'igiene delle mani.

Tutti i DPI usati devono essere smaltiti come rifiuti clinici.

Igiene delle mani
Una scrupolosa igiene delle mani è essenziale per ridurre la contaminazione incrociata.
Va notato che:
• l'igiene delle mani comporta la pulizia delle mani con uno strofinamento a base di alcool o con acqua e sapone;
• si preferiscono sfregamenti delle mani a base di alcol se le mani non sono visibilmente sporche;
• se si utilizza un massaggio a base di alcol, dovrebbe essere almeno il 60% di alcol;
• lavarsi sempre le mani con acqua e sapone quando sono visibilmente sporche.
Tutto il personale dovrebbe applicare l'approccio "I miei cinque momenti per l'igiene delle mani" alla pulizia delle mani:
(1) prima di toccare un paziente
(2) prima di eseguire qualsiasi procedura pulita o asettica
(3) dopo l'esposizione al fluido corporeo
(4) dopo aver toccato un paziente
(5) dopo aver toccato l'ambiente circostante.

Maggiori informazioni su come lavarsi le mani correttamente, sotto forma di un poster che può essere adattato alla struttura carceraria, sono disponibili sul sito Web dell'OMS.

13.2 Consigli per attività di polizia, forze di frontiera e attività di controllo dell'immigrazione
Per polizia, forze di frontiera e immigrazione agenti di controllo, potrebbero esserci situazioni in cui un individuo che deve essere arrestato o in custodia è identificato come potenzialmente a rischio di COVID-19. Se è necessaria assistenza per un individuo che è sintomatico e identificato come un possibile caso COVID-19, la persona dovrebbe, ove possibile, essere collocata in un luogo lontano dagli altri. Se non esiste una stanza fisicamente separata, alle persone che non sono coinvolte nella fornitura di assistenza dovrebbe essere chiesto di stare lontano dall'individuo. Se sono disponibili barriere o schermi, possono anche essere utilizzati.
È necessario attuare misure IPC adeguate. Nelle attività che comportano uno stretto contatto con una persona sintomatica sospettata di avere COVID-19 (come interviste a una distanza inferiore a 1 metro o arresto e contenzione), il personale deve indossare:

• guanti monouso

• mascherina medica

• camice con maniche lunghe

• protezione degli occhi (ad es. visiera o occhiali).

14. GESTIONE DEI CASI
La gestione dei casi deve essere eseguita in conformità con le linee guida nazionali / sovranazionali disponibili per le cure primarie e le impostazioni comunitarie.

14.1 Gestione clinica di infezione respiratoria acuta grave (SARI) quando si sospetta COVID-19
L'OMS ha pubblicato una guida destinata ai medici coinvolti nella gestione clinica e nella cura di pazienti adulti, in gravidanza e pediatrici con o a rischio di SARI in caso di infezione da COVID- Si sospetta che 19 virus. Non intende sostituire il giudizio clinico o la consultazione specialistica, ma piuttosto rafforzare la gestione clinica di questi pazienti e fornire una guida aggiornata. Sono incluse le migliori pratiche per IPC, triage e terapia di supporto ottimizzata.

14.2 Precauzioni aggiuntive I pazienti devono essere collocati in uno spazio adeguatamente ventilato. Se vengono rilevati più casi sospetti e se non sono disponibili spazi individuali, i pazienti sospettati di essere infettati da COVID-19 devono essere raggruppati. Tuttavia, tutti i letti dei pazienti devono essere posizionati ad almeno 1 metro di distanza indipendentemente dal fatto che si sospetti o meno di avere l'infezione da COVID-19.
Una squadra di operatori sanitari e personale di custodia / detenzione dovrebbe essere designata per occuparsi esclusivamente di casi sospetti o confermati per ridurre il rischio di trasmissione.

14.3 Come eseguire la pulizia ambientale a seguito di un caso sospetto in un luogo di detenzione
Una volta che un caso sospetto di COVID-19 è stato trasferito fuori dal carcere o da un altro luogo di detenzione in una struttura ospedaliera, la stanza in cui è stato sistemato il paziente e la stanza dove il paziente risiedeva non deve essere usato fino a quando non viene opportunamente decontaminato; le porte dovrebbero rimanere chiuse, con le finestre aperte e l'eventuale aria condizionata spenta, fino a quando le stanze non saranno state pulite con un detergente e un disinfettante virucida e approvato per l'uso in ambito carcerario.
Una volta completato il processo di pulizia, la stanza può essere rimessa immediatamente in uso. I dispositivi e le attrezzature mediche, la lavanderia, gli utensili per la ristorazione e i rifiuti sanitari devono essere gestiti in conformità con la politica sui rifiuti medici presso la struttura.
Un pacchetto di prodotti per malattie per COVID-19 delinea le forniture necessarie per sorveglianza, analisi di laboratorio, gestione clinica e IPC.

14.4 Dimissione di persone provenienti da carceri e altri luoghi di detenzione Se una persona che ha scontato la pena è un caso COVID-19 attivo al momento della sua liberazione, o è il contatto di un caso COVID-19 ed è ancora entro 14 giorni periodo di quarantena, le autorità sanitarie della prigione dovrebbero garantire che la persona dimessa abbia un posto dove poter mantenere la quarantena, che l'autorità locale sia informata che la persona è stata dimessa e che quindi il follow-up è trasferito dalle autorità carcerarie a le autorità locali.
Se una persona dimessa viene trasferita in un ospedale o in un'altra struttura medica al termine del periodo di detenzione, ma è ancora in quarantena / cure mediche per la sua infezione da COVID-19, la struttura ricevente deve essere informata dello stato COVID-19 della persona (confermato o sospettato) in modo che sia pronto a fornire un adeguato isolamento.

World Health Organization

REGIONAL OFFICE FOR Europe

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

Interim guidance

15 March 2020

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This document is based on the latest available evidence on the COVID-19 outbreak as of 15 March 2020. The World Health Organization (WHO) continues to monitor the situation closely for any changes that may affect this interim guidance. Should any factors change, WHO will issue a further update.

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ABBREVIATIONS

ARDS	acute respiratory distress syndrome
COVID-19	coronavirus disease 2019
ECDC	European Centre for Disease Prevention and Control
HCID	high-consequence infectious disease
IPC	infection prevention and control
MERS	Middle East respiratory syndrome
nCoV	novel coronavirus
PHE	Public Health England
PPE	personal protective equipment
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
WHO	World Health Organization

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 the coronavirus disease (COVID-19) outbreak 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 close proximity may act as a source of infection, amplification and spread of infectious diseases within and beyond prisons. Prison health is therefore widely considered as public health. 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:[2,3]

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 as well.
3. In many countries, responsibility for health-care provision in prisons and other places of detention lies with the Ministry of Justice/Internal Affairs. Even if this responsibility is held by the Ministry of Health, coordination and collaboration between health and justice sectors are paramount if the health of people in prisons and other places of detention and the wider community is to be protected.
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.

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[1] Places of detention, as defined for the purposes of these guidelines, include prisons, justice-related detention settings and immigration removal centres.

[2] 2019 Novel Coronavirus (2019-nCOV): Strategic Preparedness and Response Plan. Geneva: World Health Organization; 2020 (https://www.who.int/docs/default-source/coronaviruse/srp-04022020.pdf?sfvrsn=7ff55ec0_4&download=true).

[3] Good governance for prison health in the 21st century: a policy brief on the organization of prison health. Copenhagen: WHO Regional Office for Europe/Vienna: United Nations Office on Drugs and Crime; 2013 (http://www.euro.who.int/__data/assets/pdf_file/0017/231506/Good-governance-for-prison-health-in-the-21st-century.pdf).

2. RATIONALE

People deprived of their liberty, such as people in prisons, are likely to be more vulnerable to various diseases and conditions. The very fact of being deprived of liberty generally implies that people in prisons and other places of detention live in close proximity with one another, which is likely to result in a heightened risk of person-to-person and droplet transmission of pathogens like COVID-19. In addition to demographic characteristics, people in prisons typically have a greater underlying burden of disease and worse health conditions than the general population, and 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, and on 12 March 2020 the COVID-19 outbreak was declared a pandemic.[4]

In these circumstances, prevention of importation 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 COVID-19 situation of the specific country, the risk of introducing COVID-19 into prisons and other places of detention may vary. In areas with no local virus circulation, the risk of virus introduction into closed settings may be associated with prison staff or newly admitted individuals who have recently stayed in affected countries or areas or who have been in contact with people returning from affected countries or areas. However, as several countries in Europe are now experiencing widespread sustained community transmission, the risk of transmission has substantially increased.

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 with more intense transmission.

Prisons and other places of detention are enclosed environments where people (including staff) live in close proximity. Every country has a responsibility to increase their 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 the subnational level have been defined for COVID-19, and countries should therefore adjust and tailor their approach to the local context.[5]

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[4] WHO Director-General's opening remarks at the mission briefing on COVID-19 (12 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-mission-briefing-on-covid-19---12-march-2020).

[5] Critical preparedness, readiness and response actions for COVID-19: interim guidance (16 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/critical-preparedness-readiness-and-response-actions-for-covid-19).

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:[6]

- 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.
- Adequate measures should be in place to ensure a gender-responsive approach in addressing the COVID-19 emergency in prisons and other places of detention.
- 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 healthcare provision.[7]

[6] Cf. CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12). Adopted at the Twenty-second Session of the Committee on Economic, Social and Cultural Rights, on 11 August 2000 (Contained in Document E/C.12/2000/4) (https://www.refworld.org/pdfid/4538838d0.pdf); United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations General Assembly Resolution A/RES/70/175, adopted 17 December 2015 (https://undocs.org/A/RES/70/175); High Commissioner updates the Human Rights Council on human rights concerns, and progress, across the world. Human Rights Council 43rd Session, Item 2, Geneva, 27 February 2020. United Nations Human Rights Office of the High Commissioner (https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=25621&LangID=E); Advice from the SPT [Subcommittee on Prevention of Torture] to the UK NPM [National Preventive Mechanism] regarding compulsory quarantine for Coronavirus (https://s3-eu-west-2.amazonaws.com/npm-prod-storage-19n0nag2nk8xk/uploads/2020/02/2020.02.25-Annexed-Advice.pdf).

[7] Coronavirus: healthcare and human rights of people in prison. London: Penal Reform International; 2020 (https://www.penalreform.org/resource/coronavirus-healthcare-and-human-rights-of-people-in).

- Enhanced consideration should be given to resorting to non-custodial measures at all stages of the administration of criminal justice, including at the pre-trial, trial and sentencing as well as post-sentencing stages. Priority should be given to non-custodial measures for alleged offenders and prisoners 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 prisoners at highest risk to be separated 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.
- Upon admission to prisons and other places of detention, all individuals should be screened for fever and lower respiratory tract symptoms; particular attention should be paid to persons with contagious diseases. If they have symptoms compatible with COVID-19, or if they have a prior COVID-19 diagnosis and are still symptomatic, they should be put into medical isolation until there can be further medical evaluation and testing.

- The psychological and behavioural reactions of prisoners 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 prevent stigmatization or marginalization of individuals or groups who are considered to be potential carriers of viruses.
- Any decision to place people in prisons and other places of detention in conditions of medical isolation should always be based on medical necessity as a result of a clinical decision and subject to authorization by law or by the regulation of the competent administrative authority.
- People subjected to 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 isolation, and given the possibility to have a third party notified.
- Adequate measures should be in place to protect persons in isolation from any form of ill treatment and to facilitate human contact as appropriate and possible in the given circumstances (e.g. by audiovisual means of communication).
- The COVID-19 outbreak 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.[8]
- The COVID-19 outbreak 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,[9] the Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment,[10] and the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment.[11]
- Even in the circumstances of the COVID-19 outbreak, 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 isolation, in accordance with the provisions of the respective body's mandate.

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[8] United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules). United Nations General Assembly Resolution A/RES/70/175, adopted 17 December 2015 (https://undocs.org/A/RES/70/175).

[9] Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment. United Nations General Assembly Resolution A/RES/57/199, adopted 18 December 2002 (https://www.ohchr.org/EN/ProfessionalInterest/Pages/OPCAT.aspx).

[10] Optional Protocol to the Convention against Torture (OPCAT) Subcommittee on Prevention of Torture. The SPT in Brief (https://www.ohchr.org/EN/HRBodies/OPCAT/Pages/Brief.aspx).

[11] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment [website]. Strasbourg: Council of Europe (https://www.coe.int/en/web/cpt).

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),[8] the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules),[12] the Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules),[13] the United Nations Standard Minimum Rules for Non-custodial Measures (the Tokyo Rules),[14] and WHO guidance on *Prisons and health* (2014).[15] 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 international COVID-19 outbreak, 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 outbreak 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 prisoners, etc.);
   - → 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 likelihood that COVID-19 will 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 considered in national and local health and emergency planning.

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[12] United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders. United Nations General Assembly Resolution A/RES/65/229, adopted 21 December 2010 (https://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/UN_Rules_Treatment_Women_Prisoners_Bangkok_Rules.pdf).

[13] Standard Minimum Rules for the Administration of Juvenile Justice. United Nations General Assembly Resolution A/RES/40/33, adopted 29 November 1985 (https://www.ohchr.org/Documents/ProfessionalInterest/beijingrules.pdf).

[14] United Nations Standard Minimum Rules for Non-custodial Measures. United Nations General Assembly Resolution A/RES/45/110, adopted 14 December 1990 (https://www.ohchr.org/Documents/ProfessionalInterest/tokyorules.pdf).

[15] Prisons and health. Copenhagen: WHO Regional Office for Europe; 2014 (http://www.euro.who.int/__data/assets/pdf_file/0009/99018/E90174.pdf).

2. To present effective preventive and response mechanisms for:
   → preventing the introduction of COVID-19 into prisons and other places of detention;
   → preventing the transmission of COVID-19 in prisons and other places of detention;
   → preventing the spread of COVID-19 from prisons and other closed settings to the community.
3. To outline an appropriate approach to dovetailing the prison health system and the national and local health and emergency planning system for:
   → preventive measures, including physical distancing and hand hygiene facilities;
   → disease surveillance;
   → identification and diagnosis, including contact tracing;
   → treatment and/or referral of COVID-19 cases requiring specialized and intensive care;
   → 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:

- the novel COVID-19 virus;
- how to help prevent spread of COVID-19;[16]
- what to do if a person in prison/other place of detention or a staff member with suspected or confirmed COVID-19 infection is identified;
- what advice to give to people in prison or in another place of detention and their family members, or to staff members, travelling from affected areas within the last 14 days.

The information given here will also be useful for prison authorities, public health authorities and policy-makers, 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.

The following large, institutional, residential establishments are included within the definition of places of detention used in this guidance:

- prisons (public and privately managed)
- immigration detention settings
- the children and young people's detention estate.

[16] This applies to respiratory infections that are transmitted mainly via droplets. For aerosol-transmitted diseases such as tuberculosis, refer to: WHO guidelines on tuberculosis infection prevention and control. Geneva: World Health Organization; 2019 (https://www.who.int/tb/publications/2019/guidelines-tuberculosis-infection-prevention-2019/en).

6. GENERAL APPROACH

Controlling the spread of infection in prisons and other places of detention is essential to preventing outbreaks of COVID-19 in such settings, protecting the health and well-being of all those who live and work in them and those who visit them, and protecting the outside community. 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 prisoners/detainees, their subsequent isolation in single accommodation and a subsequent clinical assessment.
3. Risk assessment/risk management
   - → Screening at point of entry to prison should be available: health-care and public health teams should undertake a risk assessment of all people entering the prison, irrespective of whether or not there are suspected cases in the community; information should be collected on any history of cough and/or shortness of breath, patients' recent travel history and possible contact with confirmed cases in the last 14 days.
   - → Persons checked should include prisoners/detainees, visitors and prison staff.
   - → Clear messaging is important so that staff with recent travel history or coming from affected areas who develop COVID-19 symptoms can home-isolate and managers can provide a high level of vigilance and support of their staff. Advice to visitors should also be provided well in advance of their attending the prisons/other detention facilities so that those who have to travel are not disadvantaged. Those who are symptomatic should be excluded from visiting.
   - → For asymptomatic visitors with recent travel history or coming from affected areas, there should be protocols in place to permit entry (e.g. for legal advisers), but additional measures, such as non-contact visits, should be considered.
   - → Decisions to limit or restrict visits need to consider the particular impact on the mental well-being of prisoners and the increased levels of anxiety that separation from children and the outside world may cause.
   - → A detailed daily registry of people moving in and out of the prison should be maintained.

- → 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. The psychological impact of these measures needs to be considered and mitigated as much as possible, and basic emotional and practical support for affected people in prison should be available.[17]
- → 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, e.g. phone or Skype calls, should be introduced.

4. Referral system and clinical management
   - → In the context of the current COVID-19 outbreak, the containment strategy includes the rapid identification of laboratory-confirmed cases, and their isolation and management either on site or in a medical facility. For contacts of laboratory-confirmed cases, WHO recommends that such persons be quarantined for 14 days from the last time they were exposed to a COVID-19 patient.[18]
   - → Health-care teams, using recommended personal protective equipment (PPE) including eye protection (face shield or goggles), gloves, mask and gown, should ensure that appropriate biological samples are taken, on advice from their public health agency, from any suspected cases and sent for analysis to local microbiology services as per local protocols, in a timely manner and in compliance with clinical and information governance procedures. PPE stocks should be maintained and kept secure to ensure their availability under the indicated circumstances.
   - → Prison authorities should be informed and made aware of the hospitals to which they can transfer those requiring admission (respiratory support and/or intensive care units). Appropriate actions need to be taken for any confirmed cases, including transfer to specialist facilities for respiratory 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.
   - → Environmental and engineering controls intended to reduce the spread of pathogens and contamination of surfaces and inanimate objects should be in place; this should include provision of adequate space between people,[19] adequate air exchange, and routine disinfection of the environment (preferably at least once daily).
   - → Consideration should be given to measures such as distributing food in rooms/cells instead of a common canteen; or splitting out-of-cell time, which could be divided by wing/unit to avoid concentration of prisoners/staff even in open spaces. With these caveats, access of prisoners to the open air should be maintained and not fall below a minimum of one hour per day.

5. 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.

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[17] Psychological first aid: guide for field workers. Geneva: World Health Organization; 2011 (https://www.who.int/mental_health/publications/guide_field_workers/en).

[18] Considerations for quarantine of individuals in the context of coronavirus disease (COVID-19): interim guidance (29 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/considerations-for-quarantine-of-individuals-in-the-context-of-containment-for-coronavirus-disease-(covid-19)).

[19] A minimum space of 1 metre is recommended.

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

7.1 Pathogen characteristics

Coronaviruses are a large family of viruses found in both animals and humans. Some infect people and are known to cause illnesses ranging from the common cold to more severe diseases, such as severe acute respiratory syndrome (SARS) and Middle East respiratory syndrome (MERS). A novel coronavirus is a new strain of coronavirus that has not previously been identified in humans. The latest novel coronavirus, now called COVID-19 virus, had not been detected before the outbreak reported in Wuhan, China, in December 2019. So far, the main clinical signs and symptoms reported in people during this outbreak include fever, coughing, difficulty in breathing, and chest radiographs showing bilateral lung infiltrates.

Although the current outbreak of COVID-19 is still evolving, infection may present with mild, moderate or severe illness and can be passed from human to human, primarily (as in other respiratory viruses) by droplet spread. While about 80% of cases manifest as a mild illness (i.e. non-pneumonia or mild pneumonia), approximately 20% progress to a more severe illness, with 6% requiring specialist medical care, including mechanical ventilation. Situation reports on the outbreak, updated daily, are available on the WHO website.[20]

Most estimates of the incubation period of COVID-19 range from 1 to 14 days, with a median of 5–6 days.[21] 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. However, these estimates may be updated as more data become available.

7.2 Signs and symptoms of COVID-19

The most common symptoms of COVID-19 are fever, tiredness and dry cough. Some patients may have aches and pains, nasal congestion, runny nose, sore throat or diarrhoea. These symptoms are usually mild and begin gradually. Some people become infected but do not develop any symptoms and do not feel unwell. Most people (about 80%) recover from the disease without needing special treatment. Around one out of every five people who are infected with COVID-19 becomes seriously ill and develops difficulty breathing. Older people, and those with underlying medical problems such as high blood pressure, heart problems or diabetes, are more likely to develop serious illness. Based on the latest data, about 3–4% of reported cases globally have died, but mortality varies according to location, age and existence of underlying conditions.[22] People with fever, cough and difficulty breathing should seek medical attention.[23]

7.3 Transmission of COVID-19

Respiratory secretions, formed as droplets and produced when an infected person coughs, sneezes or talks, contain the virus and are the main means of transmission.

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[20] Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

[21] Coronavirus disease 2019 (COVID-19): situation report 30. 19 February 2020. Geneva: World Health Organization; 2020 (https://www.who.int/docs/default-source/coronaviruse/situation-reports/20200219-sitrep-30-covid-19.pdf?sfvrsn=3346b04f_2).

[22] WHO Director-General's opening remarks at the media briefing on COVID-19. 3 March 2020. Geneva: World Health Organization; 2020 (https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-covid-19---3-march-2020).

[23] Q&A on coronaviruses (COVID-19). 23 February 2020. Geneva: World Health Organization; 2020 (https://www.who.int/news-room/q-a-detail/q-a-coronaviruses).

There are two main routes by which people can spread COVID-19:

- infection can be spread to people who are nearby (within 1 metre) by breathing in droplets coughed out or exhaled by a person with the COVID-19 virus; or
- people may become infected by touching contaminated surfaces or objects (fomites) and then touching their eyes, nose or mouth (e.g. a person may touch a doorknob or shake hands and then touch their own face). This is why environmental disinfection is so important.

According to current evidence, transmission may start just before symptoms become visible. However, many people infected with COVID-19 experience only mild symptoms. This is particularly true at the early stages of the disease. It is therefore possible to catch COVID-19 from someone who has, for example, just a mild cough and does not feel ill. WHO is assessing ongoing research on the period of transmission of COVID-19 and will continue to share updated findings.

7.4 How long can the virus survive on surfaces?

How long any respiratory virus survives will depend on a number of factors, including:

- the type of surface the virus is on
- whether it is exposed to sunlight
- differences in temperature and humidity
- exposure to cleaning products.

Under most circumstances, the amount of infectious virus on any contaminated surface is likely to have decreased significantly within 48 hours.

Once such viruses are transferred to hands, they survive for very short lengths of time. Regular cleaning of hands and frequently touched hard surfaces with disinfectants will therefore help to reduce the risk of infection.

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,[24] including checklists,[25] should be established to help prison and detention systems to self-assess and improve their preparedness for responding to COVID-19.
- 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. imported cases in the country; local but circumscribed circulation in the country; local circulation, including in the area where the prison institution is located; circulation within the prison system).
- Action plans in a given 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:[26]
  - → 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 (for example, who will be screened for COVID-19 symptoms? Will there be an initial screening for symptoms for all on entry (staff/visitors)? How will the disease be diagnosed and confirmed? How will cases and contacts of confirmed cases be managed?);
  - → case management (for example, how will suspected cases of COVID-19 within the detained population be treated? Is there an appropriate place for rapid health assessment and isolation, in the event of detecting a potential COVID-19 case? Can units to house suspected cases or contacts be created? Is there a mechanism for safely transporting ill travellers to designated hospitals, including identification of adequate ambulance services? What response will be available in the event of

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[24] Multi-agency contingency plan for the management of outbreaks of communicable diseases or other health protection incidents in prisons and other places of detention in England. Second edition. London: Public Health England; 2017 (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/585671/multi_agency_prison_outbreak_plan.pdf).

[25] Correctional facilities pandemic influenza planning checklist. Atlanta (GA): Centers for Disease Control and Prevention; 2007 (https://www.cdc.gov/flu/pandemic-resources/pdf/correctionchecklist.pdf).

[26] Adapted from: Key planning recommendations for mass gatherings in the context of the current COVID-19 outbreak: interim guidance (14 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/key-planning-recommendations-for-mass-gatherings-in-the-context-of-the-current-covid-19-outbreak).

a health-care emergency involving people in prisons and other places of detention? Are there standard operating procedures in place for environmental cleaning and disinfection, including for linens and utensils?);

→ 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,[27] staff and people in prison should be adequately trained (for further information on training, see section 9 below). In some countries, the proportion of the population in detention that meets the criteria for influenza vaccination has been used as a basic proxy measure of the potential demand on health-care services in the case of COVID-19 outbreak in detention settings.

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. Chlorine-based gels may be used by prison guards and by people in prison or in other places of detention in common spaces and/or if soap and water are not available. In the case of environmental disinfection, however, it is necessary to ensure that chlorine-based products are kept locked up when not being used by service providers.

[27] Rational use of personal protective equipment for coronavirus disease 2019 (COVID-19): interim guidance (27 February 2020). Geneva: World Health Organization; 2020 (https://apps.who.int/iris/bitstream/handle/10665/331215/WHO-2019-nCov-IPCPPE_use-2020.1-eng.pdf).

9. TRAINING

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 outbreak, WHO has developed several resources that may be useful in prisons and other places of detention.

- Online training courses on IPC and clinical management of severe acute respiratory infection (SARI) are available, free of charge, from OpenWHO, WHO's web-based knowledge platform. These basic courses give a general introduction to COVID-19 and emerging respiratory viruses; they are intended for public health professionals, incident managers and personnel working for the United Nations, international organizations and nongovernmental organizations.[28]
- 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.[29]
- In addition, there is a range of technical guidance covering many topics, such as case management, operational support and logistics advice on use of masks.[30]

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, why they are necessary, and how they are to be carried out. It is especially important that any potential restrictive measures are explained and their temporary nature emphasized.

Regrettably, as a consequence 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.

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[28] Emerging respiratory viruses, including COVID-19: methods for detection, prevention, response and control [OpenWHO online course]. Geneva: World Health Organization; 2020 (https://openwho.org/courses/introduction-to-ncov).

[29] The COVID-19 risk communication package for healthcare facilities. Manila: WHO Regional Office for the Western Pacific; 2020 (https://iris.wpro.who.int/handle/10665.1/14482).

[30] Country and technical guidance: coronavirus disease (COVID-19) [resource portal]. Geneva: World Health Organization (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance).

10. RISK COMMUNICATION

In an event such as the COVID-19 outbreak, 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 prison and other places of detention, custodial staff, health-care providers and visitors must be coordinated and consistent. To address language barriers, translation or visual material 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 and respiratory etiquette;
(3) advice on what measures to adopt if symptoms develop;
(4) information about disease signs and symptoms, including warning signs of severe disease that require immediate medical attention;
(5) advice on self-monitoring for symptoms and signs for those travelling from or living in affected areas, including checking their temperature;
(6) advice about how to access local health care if necessary, including how to do so without creating a risk to health-care workers;
(7) information that wearing a face mask is recommended for people who have respiratory symptoms (e.g. a cough); it is not recommended for healthy people.[31]

WHO's advice for the public about COVID-19, including information about the myths that surround it, may also be consulted.[32,33]

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[31] 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. 29 January 2020. Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/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).

[32] Coronavirus disease (COVID-19) advice for the public [website/portal]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public).

[33] Coronavirus disease (COVID-19) advice for the public: myth busters [website]. Geneva: World Health Organization; 2019 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters).

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

WHO guidance for global surveillance of COVID-19 disease should be consulted for updated definitions. The WHO case definitions given below are based on information available as of 27 February 2020 and are being revised as new information accumulates.[34] Countries may need to adapt these case definitions depending on their own epidemiological situation.

[34] Global surveillance for human infection with coronavirus disease (COVID-19): interim guidance (27 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/global-surveillance-for-human-infection-with-novel-coronavirus-(2019-ncov)).

11.1 Definition of a suspect case

A suspect case is:

(A) a patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g. cough, shortness of breath) AND no other aetiology that fully explains the clinical presentation AND a history of travel to or residence in a country/area or territory reporting local transmission of COVID-19 during the 14 days prior to onset of symptoms;[35] OR

(B) a patient with any acute respiratory illness AND who has been in contact with a probable or confirmed COVID-19 case (see 11.2 and 11.3 below) in the last 14 days prior to onset of symptoms; OR

(C) a patient with severe acute respiratory infection (fever and at least one sign/symptom of respiratory disease, e.g. cough, shortness of breath) AND who requires hospitalization AND who has no other aetiology that fully explains the clinical presentation.

If it is determined that there is a suspect case of COVID-19, the local prison outbreak management plan should be activated. The suspect case should be immediately instructed to wear a medical mask and follow respiratory etiquette and hand hygiene practices. IPC measures, such as medical isolation, should be applied.

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 suspect cases or confirmed cases not requiring hospitalization can be placed in medical isolation.[34,36] The creation of housing units may also be considered, as not everyone who is a suspect case, a probable case or a contact requires hospitalization.

11.2 Definition of a probable case

A probable case is a suspect case for whom testing for COVID-19 is inconclusive (that is, if the result of the test reported by the laboratory is inconclusive).

11.3 Definition of a confirmed case

A confirmed case is a patient with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms. Laboratory confirmation needs to be made according to an appropriate method.[37]

11.4 Definition of a contact

A contact is a person who is involved in any of the following:

- providing direct care without proper PPE for a COVID-19 patient;
- staying in the same closed environment (e.g. a detention room) as a COVID-19 patient;
- travelling together in close proximity (within 1 metre) with a COVID-19 patient in any kind of conveyance within a 14-day period after the onset of symptoms in the case under consideration.

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[35] For update on latest situation refer to: Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

[36] Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected: interim guidance (25 January 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125).

[37] Laboratory testing for coronavirus disease 2019 (COVID-19) in suspected human cases: interim guidance (2 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/laboratory-testing-for-2019-novel-coronavirus-in-suspected-human-cases-20200117).

18 Monitoring of contacts of suspect, probable and confirmed cases

- Contacts should be monitored for 14 days from the last unprotected contact.
- External contacts should self-limit travel and movements. In prison settings, monitoring should be done by prison health-care or custodial staff with regular visits to see if symptoms have developed (this is important as people in prison may have a disincentive to admit to developing symptoms as they could be put in isolation).
- Any contact who becomes ill and meets the case definition becomes a suspect case and should be tested.
- Any newly identified probable or confirmed cases should have their own contacts identified and monitored.

Contact tracing should begin immediately after a suspect case has been identified in a prison or detention facility, without waiting for the 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 competent national health authority and according to national preparedness plans. Every effort should be made to minimize exposure of the suspect case to other people and the environment and to separate contacts from others as soon as possible.[38] Contacts outside the prison (visitors, etc.) should be followed up by the health authorities.

11.5 Case reporting

COVID-19 has been added to the list of notifiable diseases that doctors have a duty to report to public health authorities. COVID-19 is a high-consequence infectious disease (HCID) with outbreak potential in prisons and other detention settings; possible cases in such settings should therefore be notified straightaway to responsible public health authorities, who will then report to national and international authorities.

[38] Operational considerations for managing COVID-19 cases/outbreak on board ships: interim guidance (24 February 2020). Geneva: World Health Organization; 2020 (https://apps.who.int/iris/handle/10665/331164).

12. PREVENTION MEASURES

There is currently no vaccine to prevent COVID-19. 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.

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; alcohol hand sanitizer containing at least 60% alcohol is also an option if available (for further guidance on hand hygiene, see section 13.1 below);
- physical distancing 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;
- 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

It is important to create a general understanding of what measures should be taken by, and on behalf of, each person in prison when infection by COVID-19 is suspected. 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 hand hygiene and other IPC measures to prevent human-to-human transmission of COVID-19.

Patient use of a medical mask is one of the prevention measures that can be taken to limit spread of certain respiratory diseases, including COVID-19, in affected areas. However, use of a mask alone is insufficient to provide an adequate level of protection and other equally relevant measures should also be adopted.

WHO has developed guidance for home-care and health-care settings on IPC strategies for use when infection with COVID-19 is suspected.[36] WHO has also issued guidance on the use of masks in the community, during home care and in health-care settings in the context of the COVID-19 outbreak.[31]

Wearing medical masks when not indicated may incur unnecessary cost, cause procurement burden and create a false sense of security that can lead to neglecting other essential measures such as hand hygiene practices. Furthermore, using a mask incorrectly may hamper its effectiveness in reducing the risk of transmission.[27]

Management of masks

If medical masks are worn, appropriate use and disposal are essential to ensure that they are effective and to avoid any increase in risk of transmission associated with incorrect use and disposal. The following advice on correct use of medical masks is based on standard practice in health-care settings:[31]

- place mask carefully to cover mouth and nose and tie securely to minimize any gaps between face and mask;
- while in use, avoid touching the mask;
- remove the mask by using an appropriate technique (i.e. do not touch the front but remove by the headband from behind);
- after removal or whenever you inadvertently touch a used mask, clean hands by using an alcohol-based hand rub (if available) or soap and water;
- replace masks with a new clean, dry mask as soon as they become damp/humid;
- do not reuse single-use masks;
- discard single-use masks after each use and dispose of them immediately upon removal (consider a central place in the ward/cell block where used masks can be discarded).

Cloth (e.g. cotton or gauze) masks are not recommended under any circumstances.

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.

As the COVID-19 virus has the potential to survive in the environment for several days, premises and areas that may have been contaminated should be cleaned and disinfected before they are reused, with regular household detergent followed by disinfectant containing a diluted bleach solution (e.g. one part liquid bleach, at an original concentration of 5.25%, to 49 parts water for a final concentration of about 1000 ppm or 0.1%). For surfaces that do not tolerate bleach, 70% ethanol can be used. If bleach or ethanol cannot be used in the prison for security reasons, ensure that the disinfectant used for cleaning is able to inactivate enveloped viruses. Prison authorities may have to consult disinfectant manufacturers to ensure that their products are active against coronaviruses.

To ensure adequate disinfection, janitorial and housekeeping personnel should take care to first clean surfaces with a mix of soap and water, or a detergent. Then they should apply the disinfectant for the required contact time, as per the manufacturer's recommendations. The disinfectant may be rinsed off with clean water after the contact time has elapsed.

Clothes, bedclothes, bath and hand towels, etc. can be cleaned using regular laundry soap and water or machine-washed at 60–90 °C with common laundry detergent. Waste should be treated as infectious clinical waste and handled according to local regulation. Guidance on environmental cleaning in the context of the COVID-19 outbreak is available from the European Centre for Disease Prevention and Control (ECDC);[39] see also Annex 1 below.

12.4 Physical distancing measures

All staff should be alert to the enhanced risk of COVID-19 infection in people in prisons and other places of detention who have a history of potential exposure, having travelled to, transited through or lived in high-risk areas in the last 14 days.

Any detainee who has (a) travelled from or lived in an identified high-risk area,[40] or (b) had contact with a known case of COVID-19, should be placed in quarantine, in single accommodation, for 14 days from the date of travel or last possible day of contact.[18] If it is not possible to house the detainee in medical isolation, then detainees with similar risk factors and exposures may be housed together while they undergo quarantine. The patient should wear a medical face mask while being transferred to an isolation room. During isolation, the isolated person should be under medical observation at least twice a day, including taking body temperature and checking for symptoms of COVID-19 infection.

An assessment of any language or communication issues should be made and access to a language interpretation/translation service must be provided as soon as a possible case enters the facility so that an accurate history can be taken.

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. The specific and disproportionate impact on different types of prisoners, as well as on children living with their parent in prison, must 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

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[39] Interim guidance for environmental cleaning in non-healthcare facilities exposed to SARS-CoV-2. ECDC technical report. 18 February 2020. Stockholm: European Centre for Disease Prevention and Control; 2020 (https://www.ecdc.europa.eu/sites/default/files/documents/coronavirus-SARS-CoV-2-guidance-environmental-cleaning-non-healthcare-facilities.pdf).

[40] Situation updates are available at: Coronavirus disease (COVID-19) situation reports. Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports).

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 (e.g. Skype) for family members and representatives of the judicial system, such as legal advisers.

In particular:

- screening may be considered at entrance with self-reporting questionnaire to exclude those with symptoms;
- visitors who feel unwell should stay at home and not attend the establishment;
- staff must stay at home and seek medical attention should they develop any relevant 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.

12.6 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 also keep up to date on the latest information on the COVID-19 outbreak, available on the WHO website[40] 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.

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 staff becomes unwell in the prison and has travelled to an affected area or lives in an area where COVID-19 is spreading, they should be removed to a location which is at least 1 metre away from other people. If possible, a room or place where they can be isolated behind a closed door, such as a staff office, should be made available. If it is possible to open a window for ventilation, do so.

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 (this may not be necessary if the prison is located in affected area). If the person affected is not able for any reason to call a doctor themselves, then another staff member should call on their behalf.

While the unwell individual waits for advice or an ambulance to arrive, they should remain at least 1 metre from other people, and if possible be isolated behind a closed door. They should avoid touching people, surfaces and objects, and they should be provided with a medical mask. If a medical mask is not available, they should be advised to cover their mouth and nose with a disposable tissue when they cough or sneeze, then put the tissue in a bag and throw it in a bin. If they do not have any tissues available, they should cough and sneeze into the crook of their elbow.

If the unwell individual needs to go to the bathroom while waiting for medical assistance, they should use a separate bathroom, if available. This will apply only to the period of time while they wait for transport to hospital. Given the possible risk of environmental contamination, it is important to ensure that the bathroom is properly cleaned and disinfected after the suspected case has used it; the area where they were sitting should also 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 prisoners/detainees, self-referral, and screening at reception, or by other means. For case definitions, see section 11 above.

Depending on the local level of risk, additional procedures to assess new arrivals in prison may be needed. Measures to consider are:

- creating a dedicated screening area at the facility entrance
- establishing a procedure for immediate isolation of suspected cases.

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 such as personal hygiene, 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.

IPC management includes wearing the appropriate level of PPE according to risk assessment, and ensuring safe waste management, proper linens, environmental cleaning, and sterilization of patient-care equipment.

PPE for custodial staff

For activities that involve close contact with a suspected or confirmed case of COVID-19, such as interviewing people at a distance of less than 1 metre, or arrest and restraint, it is advised that the minimum level of PPE that custodial/escort staff should wear is:

- disposable gloves
- medical mask
- if available, a disposable full gown and disposable eye protection (e.g. face shield or goggles).

PPE for health-care staff

It is advised that the minimum level of PPE for health-care staff required when dealing with a suspected or confirmed COVID-19 case is:

- medical mask
- full gown
- gloves
- eye protection (e.g. single-use goggles or face shield)
- clinical waste bags
- hand hygiene supplies
- general-purpose detergent and disinfectant solutions that are virucidal and have been approved for use by the prison authorities.

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.[27]

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

Removal of PPE

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 as follows:

(1) peel off gloves and dispose of as clinical waste
(2) perform hand hygiene, by handwashing or using alcohol gel
(3) remove apron/gown by folding in on itself and place in clinical waste bin
(4) remove goggles/face shield only by the headband or sides and dispose of as clinical waste
(5) remove medical mask from behind and dispose of as clinical waste
(6) perform hand hygiene.

Further WHO guidance, with illustrations, on putting on and taking off PPE is available online.[41,42]

All used PPE must be disposed of as clinical waste.

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[41] How to put on and take off personal protective equipment (PPE) [information sheet]. Geneva: World Health Organization; 2008 (https://www.who.int/csr/resources/publications/PPE_EN_A1sl.pdf).

[42] Steps to put on personal protective equipment (PPE) [poster]. Geneva: World Health Organization (https://www.who.int/csr/disease/ebola/put_on_ppequipment.pdf).

Hand hygiene

Scrupulous hand hygiene is essential to reduce cross-contamination. It should be noted that:

- hand hygiene involves cleansing 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 at least 60% 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, in the form of a poster that can be adapted to the prison facility, is available on the WHO website.[43]

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.[44]

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 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:

- disposable gloves
- medical mask
- long-sleeved gown
- eye protection (e.g. face shield or goggles).

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[43] How to handwash? [poster]. Geneva: World Health Organization; 2009 (https://www.who.int/gpsc/5may/How_To_HandWash_Poster.pdf).

[44] For further information, see: Guidance for first responders and others in close contact with symptomatic people with potential COVID-19. London: Public Health England; 2020 (https://www.gov.uk/government/publications/novel-coronavirus-2019-ncov-interim-guidance-for-first-responders/interim-guidance-for-first-responders-and-others-in-close-contact-with-symptomatic-people-with-potential-2019-ncov).

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 the COVID-19 virus is suspected.[45] 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.

The WHO guidance is organized in the following sections:

1. Background
2. Screening and triage: early recognition of patients with SARI associated with COVID-19
3. Immediate implementation of appropriate IPC measures
4. Collection of specimens for laboratory diagnosis
5. Management of mild COVID-19: symptomatic treatment and monitoring
6. Management of severe COVID-19: oxygen therapy and monitoring
7. Management of severe COVID-19: treatment of coinfections
8. Management of critical COVID-19: acute respiratory distress syndrome (ARDS)
9. Management of critical illness and COVID-19: prevention of complications
10. Management of critical illness and COVID-19: septic shock
11. Adjunctive therapies for COVID-19: corticosteroids
12. Caring for pregnant women with COVID-19
13. Caring for infants and mothers with COVID-19: IPC and breastfeeding
14. Care for older persons with COVID-19
15. Clinical research and specific anti-COVID-19 treatments.

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[45] Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected: interim guidance (13 March 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/clinical-management-of-severe-acute-respiratory-infection-when-novel-coronavirus-(ncov)-infection-is-suspected).

14.2 Additional precautions

Patients should be placed in adequately ventilated space. 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. However, all patients' beds should be placed at least 1 metre apart whether or not they are suspected of having COVID-19 infection.

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 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 decontaminated; the doors should remain shut, with windows open and any air conditioning switched off, until the rooms have been cleaned with detergent and disinfectant that is virucidal and approved for use in the prison setting. Detailed information on cleaning and disinfection is provided on the WHO website [46] and in Annex 1.

Once the cleaning process has been completed, the room can be put back in use immediately. Medical devices and equipment, laundry, food service utensils and medical waste should be managed in accordance with the medical waste policy at the facility.

A disease commodity package for COVID-19 outlines the supplies needed for surveillance, laboratory analysis, clinical management and IPC.[47]

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 quarantine period, the prison health authorities should ensure that the person discharged has a place to go where they can maintain quarantine, 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 isolation.

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[46] Home care for patients with suspected novel coronavirus (nCoV) infection presenting with mild symptoms and management of contacts: interim guidance (4 February 2020). Geneva: World Health Organization; 2020 (https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts).

[47] Disease commodity package: novel coronavirus (COVID-19). Geneva: World Health Organization; 2020 (https://www.who.int/emergencies/what-we-do/prevention-readiness/disease-commodity-packages/dcp-ncov.pdf).

15. 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

Mental health and social issues

Coping with stress during the COVID-19 outbreak
https://www.who.int/docs/default-source/coronaviruse/coping-with-stress.pdf?sfvrsn=9845bc3a_2

Helping children cope with stress during the COVID-19 outbreak

https://www.who.int/docs/default-source/coronaviruse/helping-children-cope-with-stress-print.pdf?sfvrsn=f3a063ff_2

Mental health considerations for different groups (including health workers) during the COVID-19 outbreak

https://www.who.int/docs/default-source/coronaviruse/mental-health-considerations.pdf?sfvrsn=6d3578af_10

Addressing social stigma associated with COVID-19

https://www.epi-win.com/sites/epiwin/files/content/attachments/2020-02-24/COVID19%20Stigma%20Guide%2024022020_1.pdf

IASC briefing note on mental health and psychosocial support (MHPSS) aspects of COVID-19
https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/briefing-note-about

European Centre for Disease Prevention and Control

COVID-19 information portal: https://www.ecdc.europa.eu/en/novel-coronavirus-china

United Nations Office on Drugs and Crime

Assessing compliance with the Nelson Mandela Rules: a checklist for internal inspection mechanisms (2017)
https://www.unodc.org/documents/justice-and-prison-reform/17-04946_E_ebook_rev.pdf

Handbook on strategies to reduce overcrowding in prisons (2013)

https://www.unodc.org/documents/justice-and-prison-reform/Overcrowding_in_prisons_Ebook.pdf

Policy brief on HIV prevention, treatment and care in prisons and other closed settings (2013)
https://www.unodc.org/documents/hiv-aids/HIV_comprehensive_package_prison_2013_eBook.pdf

Handbook on prisoners with special needs (2009)
https://www.unodc.org/pdf/criminal_justice/Handbook_on_Prisoners_with_Special_Needs.pdf

Public Health England

Public Health England (PHE) – Public health in prisons and secure settings (collection of resources)
https://www.gov.uk/government/collections/public-health-in-prisons

COVID-19: prisons and other prescribed places of detention
https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

Robert Koch Institute
Information portal (in German)
https://www.rki.de/DE/Home/homepage_node.html

National Commission on Correctional Health Care
What you need to know about COVID-19
https://www.ncchc.org/blog/covid-19-coronavirus-what-you-need-to-know-in-corrections

Penal Reform International
Briefing note on COVID-19, health care, and the human rights of people in prison
https://www.penalreform.org/resource/coronavirus-healthcare-and-human-rights-of-people-in

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 enable 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, with windows opened and the air conditioning switched off (if relevant), until it has been cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back in use immediately.

Preparation

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

- collect all cleaning equipment and clinical waste bags before entering the room
- dispose of any cloths and mop heads as single-use items
- perform hand hygiene, then put on a disposable plastic apron and gloves.

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.

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.

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* COVID-19: interim guidance for primary care (updated 25 February 2020). London: Public Health England; 2020 (https://www.gov.uk/government/publications/wn-cov-guidance-for-primary-care/wn-cov-interim-guidance-for-primary-care).

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 personal protective equipment (PPE) as medical waste
- perform hand hygiene.

Cleaning of communal areas

If a suspected case spent time in a communal area, then these 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 in 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

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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