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Preparing prisons for the next pandemic: Why COVID-19 showed that containment is not preparedness

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COVID-19 exposed a critical preparedness gap in prisons across Southeast Asia. During the pandemic, prisons in Malaysia, Thailand, and the Philippines were treated primarily as biosecurity risks to be contained rather than as health systems to be prepared.

Overcrowding, fragmented prison health governance, and weak integration with national health systems meant that emergency responses relied heavily on prolonged lockdowns, carrying severe human rights and mental health costs. Future pandemics can be managed more safely and proportionately if prisons are embedded within national pandemics can be managed more safely and proportionally.

About the research

This policy briefing draws on a British Academy–funded comparative study examining how prisons in Malaysia, Thailand, and the Philippines were governed during the COVID-19 pandemic, and what this reveals about future pandemic preparedness in custodial settings.

While pandemic preparedness planning has expanded significantly since COVID-19, prisons remain marginal to national health preparedness despite the risk they pose. Decisions taken in prisons during COVID-19 had consequences not only for people in custody, but also for staff, surrounding communities, and already stretched public hospitals.

Our research combined a systematic analysis of national and institutional COVID-19 policies affecting prisons (2019–2023); an econometric assessment of prison spending trends over time (2010–2023); and interviews with senior prison officials, health policymakers, national human rights institutions, civil society organisations, and international actors.

This range of evidence allowed us to distinguish between formal policy commitments and operational realities, and to identify where preparedness failures were institutional rather than technical. Importantly for policymakers, the findings highlight not only what went wrong during COVID-19, but which governance reforms are most likely to reduce harm in future outbreaks.

Recommendations

Justice or interior ministries

- Treat population reduction as a preparedness tool, not a political concession: establish emergency occupancy thresholds that automatically trigger release or diversion mechanisms.
- Institutionalise outbreak governance through permanent prison outbreak units, annual drills, and after action reviews.
- Ensure quarantine and medical isolation are clinically justified, time limited, and subject to independent oversight to prevent de facto solitary confinement.

Health ministries and public health agencies

- Assign explicit responsibility for detention settings within national pandemic preparedness plans and surveillance systems.
- Integrate prison health into national financing and insurance schemes to ensure continuity of care for chronic disease, TB, HIV, and mental health.
- Include prisons in national supply chains for medicines, PPE, testing, and vaccination.

National human rights institutions and oversight bodies

- Codify monitoring continuity during emergencies, including safe in person or remote access that preserves independence and confidentiality.
- Strengthen transparency as preparedness infrastructure through routine publication of standard indicators.
- Institutionalise the voice of lived experience in preparedness planning and review.

Civil society organisations, NGOs, and advocates

- Support independent oversight by documenting conditions, raising concerns, and contributing evidence to national and international accountability mechanisms.
- Act as trusted intermediaries between prison authorities, people in custody, families, and communities, particularly when official communication is constrained.
- Assist with health education, continuity of care, and psychosocial support in ways that complement, rather than replace, state provision.
- Use evidence to sustain attention on prison health and preparedness beyond crisis moments, including engagement with legislatures and international bodies.

Intergovernmental and regional actors (WHO, UNODC, ICRC, ASEAN)

- Embed prison health within broader health system strengthening and preparedness programmes, moving beyond ad hoc emergency support.
- Support cross country learning focused on implementation (staffing models, triage systems, quarantine design, and data templates).
- Develop and disseminate regional guidance on emergency population management and decarceration.

Research findings

Why prisons must be part of pandemic preparedness

Pandemics do not stop at prison walls. Prisons are structurally vulnerable to infectious disease because of chronic overcrowding, high population turnover (admissions, releases, transfers, staff movement), and limited health infrastructure. During COVID 19, these features turned prisons into epidemiological amplification sites, with consequences for people in custody, staff, surrounding communities, and already stretched hospitals.

COVID-19 functioned as a system-wide stress test. International standards and public health guidance were widely available, but the pandemic exposed the limits of prison systems operating under longstanding structural strain. Where distancing and isolation were physically impossible, emergency responses defaulted to prolonged lockdowns, carrying severe mental health and human rights costs. Preparedness is therefore not a technical checklist to be activated during emergencies. It is a governance challenge that must be addressed in advance through population management, institutional integration, workforce policy, and accountability mechanisms.

What COVID 19 revealed

1) Overcrowding as the central risk multiplier

Across Malaysia, Thailand and the Philippines, overcrowding undermined every other preparedness measure. Cells and dormitories far exceeded design capacity, turning isolation into collective confinement and quarantine into prolonged lockdown. Innovations such as field hospitals, quarantine blocks, and mass testing helped limit immediate harm but functioned as procedural workarounds rather than structural fixes.

2) Prison health remained marginal to national health systems

Despite large scale mobilisation of national testing, treatment, and vaccination, prison health services were peripheral and under resourced. Spending rose during COVID 19, but largely for containment once prisons posed visible risks beyond their walls. Baseline investment in prison health remained extremely low, limiting preparedness outside crisis moments.

3) Workforce fragility undermined resilience

Prison staff were essential to outbreak management yet often lacked equal access to risk allowances, adequate PPE, safe rosters, and psychosocial support. Illness, quarantine, and burnout reduced operational capacity precisely when it was most needed.

4) Governance context shaped responses

Malaysia combined strong national public health capacity with political and institutional marginality of prisons.

Thailand demonstrated rapid, centralised operational control but limited transparency and minimal decarceration.

The Philippines combined punitive enforcement dynamics with active civil society and multilateral engagement that helped compensate for structural deficits.

Across contexts, the pandemic magnified existing patterns of carceral governance rather than transforming them.

5) Legacies are contested

Positive legacies include improved intake screening, outbreak SOPs, digital hearings and visits, and initial steps toward health system integration. Risks include the normalisation of prolonged lockdowns, weakened transparency norms, and the tendency to move on without embedding reforms.

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Before the next outbreak, prison systems should be able to demonstrate the following baseline preparedness package:

- Population management triggers: pre defined decarceration options, pre trial review mechanisms, and non custodial pathways that can be activated rapidly.
- Operationally realistic outbreak SOPs: intake screening, cohorting, isolation, referral pathways, and continuity of essential services.
- Health system integration: clear lines of responsibility, referral, financing, surveillance, and supply chains linking prisons to national health systems.
- Workforce protection: staff health and safety, risk allowances, mental health support, safe rosters, and secure PPE supply.
- Data and reporting: routine, standardised reporting of key indicators (occupancy, testing, cases, deaths, vaccination, staffing).
- Rights and communication continuity: guaranteed family contact, legal access, monitoring, and complaints mechanisms during emergencies.
- Standing multilateral coordination: pre agreed modalities for technical assistance and support from WHO, UNODC, ICRC, and regional partners.

This package emphasises readiness in advance, not reactive crisis response.

Further information

This briefing draws on a British Academy–funded comparative study (2024–2026) combining policy analysis, econometric assessment of prison spending (2010–2023), and interviews with policymakers and system actors across Malaysia, Thailand, and the Philippines.

The full report provides detailed country analysis, methods, and references and is intended to support evidence-based preparedness planning. Read the report here.

Image credit: Photo by Christian Lue on Unsplash

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