Preparing prisons for the next pandemic: Lessons from COVID-19 in Malaysia, Thailand, and the Philippines

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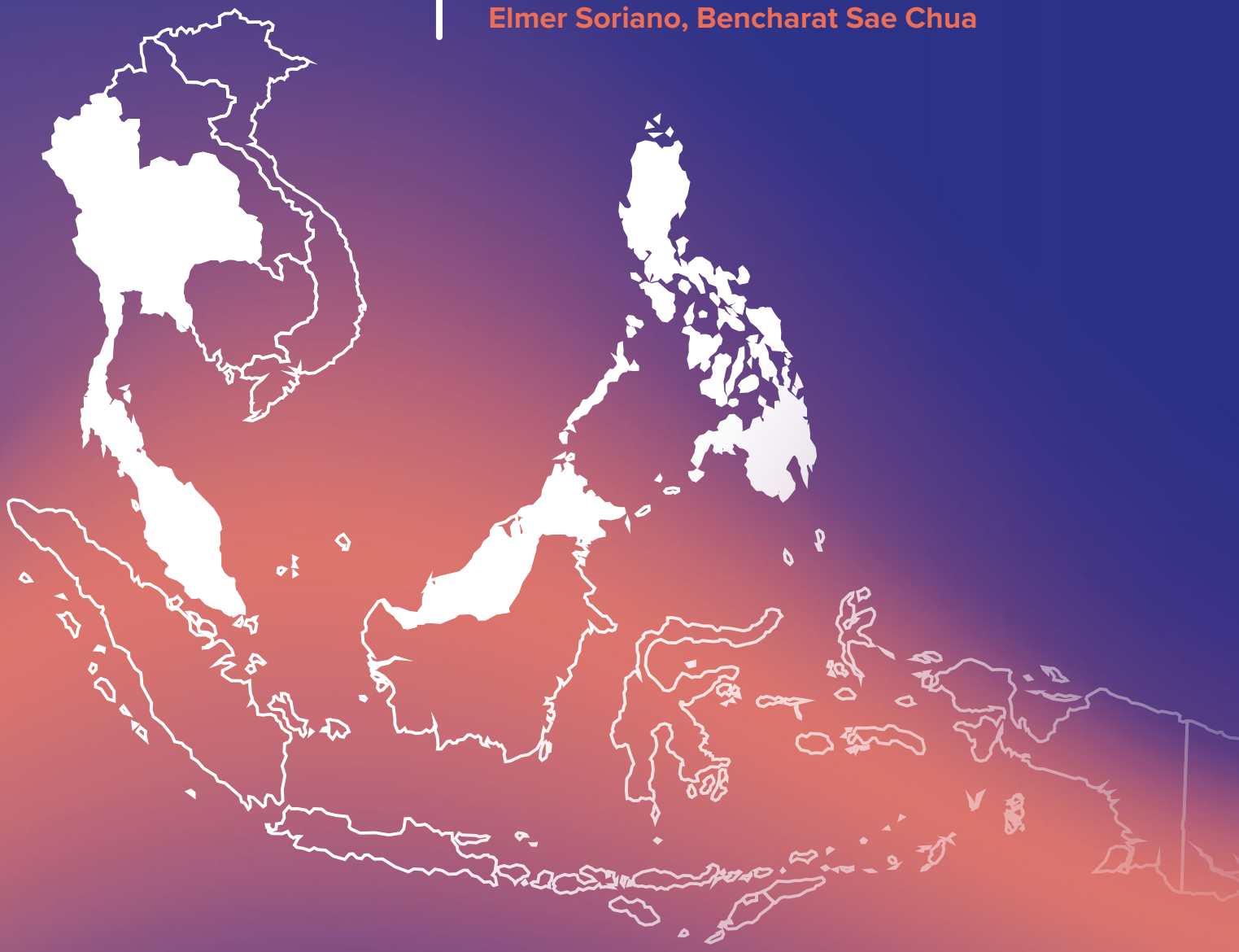

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Citation

Ismail, N., Kananatu, T., Soriano, E. and Sae Chua, B. (2026) Preparing Prisons for the Next Pandemic: Lessons from COVID-19 in Malaysia, Thailand, and the Philippines. University of Bristol: Bristol.

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Acknowledgment

We are grateful to the many individuals and organisations who contributed to this research and supported the project at different stages of its development.

We would like to thank Professor Patricia Kennett of the School for Policy Studies, University of Bristol, for her generous mentoring and intellectual guidance throughout the project. Her expertise in comparative social policy and global governance was invaluable in shaping the study's conceptual framing and comparative approach.

We would also like to acknowledge Pitch Pongsawat of Chulalongkorn University, Thailand, for his initial assistance with the early stages of the policy analysis.

We are deeply grateful to the members of our International Advisory Board for their expertise, insight, and sustained engagement throughout the project. Professor Emma Plugge (University of Southampton) provided leadership on prison health research and health equity; Dr Claire Blackmore (World Health Organization) offered guidance on emergency response and pandemic preparedness; Olivia Rope (Penal Reform International) contributed expertise on human rights, detention reform, and gender-responsive justice; Dr Andrew M. Jefferson (Danish Institute Against Torture, DIGNITY) shared critical perspectives grounded in long-standing scholarship on prisons and reform in the Global South; and Chontit Chuenurah (Thailand Institute of Justice) supported the project through her leadership in justice reform research and evidence-based policy development across Thailand and the ASEAN region.

We would also like to extend our sincere gratitude to all participants who took part in the interviews, including policymakers, practitioners, civil society actors, and representatives of international organisations. Their time, candour, and reflections were essential to the depth and integrity of this research. We are grateful to national stakeholders who reviewed factual elements of the report and provided updated administrative data where available.

Finally, we gratefully acknowledge the support of our funder, the British Academy, and in particular Erwin Yin, Sheneika Smith, and Olivia Walker, for their guidance and support throughout the application and implementation of this project under the ISPF ODA Challenge-Oriented Research Grants scheme.

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Contents

How to read this report

This report is designed for policymakers, prison administrators, health agencies, monitoring bodies, civil society organisations, and international partners working on prison health and pandemic preparedness. It has three main purposes:

1. To explain what COVID-19 revealed

The report identifies how overcrowding, prison health governance, staffing, transparency, and crisis decision-making shaped pandemic responses in prisons across Malaysia, Thailand, and the Philippines.

2. To distinguish emergency response from preparedness

Many systems improvised under pressure during COVID-19. This report examines which measures were temporary crisis responses and which changes may be capable of strengthening preparedness before the next outbreak.

3. To support practical action

The report proposes a minimum preparedness package and country-specific priorities that can be used to inform policy discussion, technical review, and future collaboration.

How evidence is used

The report combines policy and documentary analysis, expenditure analysis, and interview evidence.

- Administrative figures reflect official or institutional data sources.
- Interview quotations reflect the perspectives of participants involved in prison governance, health response, or oversight.
- Comparative tables and summary assessments represent the authors' synthesis of multiple forms of evidence and are intended to support structured cross-country comparison.

How to use the report

Readers may wish to approach the report in different ways:

- For headline messages and recommendations, read the Executive Summary.
- For comparative analysis, read Sections 3 and 4.
- For practical policy implications, read Section 5.
- For methodological detail, read Section 2.

The report is intended to support constructive discussion on future preparedness. It does not rank prison systems, but seeks to identify where institutional strengthening is most needed before the next public health emergency.

Executive summary and recommendations

This report presents findings from a British Academy–funded comparative study of COVID-19 pandemic experiences in prisons in Malaysia, Thailand, and the Philippines (2024 – 2026), designed to inform future pandemic preparedness in custodial settings. It is written for prison and health policymakers, as well as multilateral partners such as UNODC, WHO, ICRC, advocates, and NGOs.

We combine three strands of evidence:

1. A systematic policy and documentary analysis (154 documents, 2019–2023)
2. A first-of-its-kind econometric analysis of prison spending trends (2010–2023)
3. A total of 31 interview sessions with 37 policymakers and system actors across the three countries (prison policymakers, health agencies, human rights institutions, civil society, faith groups, and international organisations) capturing the “hidden transcripts” (the unofficial and often undocumented realities) of crisis management.

The core finding is clear and urgent: Prisons were consistently treated as high-risk sites to be controlled during COVID-19, but rarely as health systems to be strengthened. As a result, the region’s dominant preparedness response became biosecurity-led containment (relying principally on lockdowns and restriction) in overcrowded institutions, rather than prevention through structural risk reduction.

This exclusion matters because prisons function as epidemic amplifiers, with consequences that extend well beyond prison walls. During COVID-19, outbreaks in places of detention repeatedly threatened the health and safety of people who live and work in prisons, and community transmission. Across all three countries, preparedness was constrained by:

- Systemic overcrowding that rendered standard clinical protocols (like social distancing) physically impossible;
- Institutional silos where prison health remained divorced from national health bureaucracies;
- Limited prison health infrastructure; and
- Variable transparency and accountability mechanisms (varying by governance context).

As future pandemics and recurrent outbreaks emerge, there is a clear opportunity to build on COVID-19 lessons by developing preparedness frameworks that are explicitly designed for custodial environments.

Headline findings

1 COVID response reflected how the state governs, not only what it knows. Across the three countries, prison pandemic governance followed distinct political and institutional logics:

- Philippines: a pattern described by interviewees as punitive and securitised crisis governance, where enforcement practices (arrests/detention for public health violations) blended into existing drug-war approaches and produced severe overcrowding pressures and restricted access.
- Malaysia: a technocratic public health response at national level, but prisons remained politically marginal and structurally under-resourced. Prison health was frequently characterised as receiving a comparatively low share of resources, highlighting the need for clearer prioritisation within preparedness planning.
- Thailand: the strongest examples of centralised command and rapid operational measures (war rooms, classification systems, and field hospital models), paired with concerns about transparency and independent monitoring space.

Across all three, the pandemic did not automatically produce sustained prisoner welfare prioritisation; it magnified longstanding patterns of carceral governance.

2 Overcrowding was the central limiting condition. Interview and policy documentary evidence converge on one point: overcrowding made standard public health measures (distancing, isolation, and quarantine) only partially effective and often socially damaging when implemented as prolonged lockdown. Where systems innovated (field hospitals, quarantine blocks, mass testing, and digital hearings), these were frequently viewed as procedural workarounds rather than structural fixes. Overcrowding remained the core risk multiplier.

3 Spending increased during COVID but largely as containment, not care. The econometric analysis indicates an increase in prison spending as a share of GDP during pandemic years, but the broader pattern is consistent with a containment response: governments mobilised resources when prisons posed a visible risk to public health beyond prison walls, without a clear shift toward durable welfare-oriented investment. This matters for preparedness: it suggests capacity exists, but is activated selectively. Preparedness planning must therefore change incentives and institutional responsibilities, not only write better protocols.

4 Multilateral actors were essential but played different roles depending on state capacity and politics. Across cases, the World Health Organization (WHO), the International Committee of the Red Cross (ICRC), and the United Nations Office on Drugs and Crime (UNODC) were repeatedly described as crucial in filling gaps in personal protective equipment, training, communications access, and technical guidance. But multilateral cooperation functioned differently:

- As supplementation in Malaysia where the country had systems but lacked resources or prioritisation;
- As institutional reinforcement in Thailand where bureaucratic capacity was high; and
- As compensatory substitution in the Philippines where domestic systems could not meet basic needs consistently.

Preparedness cannot rely on external partners to substitute for core state functions; but neither can it be realistic without them.

5 COVID left legacies. Positive legacies include:

- A stronger intake screening and outbreak SOPs;
- Digital and remote systems (hearings and visits);
- Emerging integration attempts between detention health and national health systems; and
- New policy frameworks (e.g., Philippines' "Healthy Places of Detention" policy referenced by interviewees as a post-COVID milestone).

Risks include:

- Normalisation of prolonged lockdown regimes;
- Weakened transparency norms (including stopping or limiting routine reporting); and
- The tendency for systems to "move on" without embedding reforms.

From findings to action: A minimum preparedness package for prisons

Across all three countries, the evidence supports a pragmatic minimum package that should exist *before* the next outbreak:

1. Population management triggers (decarceration options, pretrial review, and non-custodial pathways)

2. Custodial outbreak standard operating procedures that are operationally realistic (intake screening, cohorting, isolation, and referral pathways)

3. Health system integration (clear responsibility lines, referral, and financing mechanisms)

4. Workforce protection (staff health, allowances, mental health, duty rosters, personal protective equipment fit and supply chain)

5. Data and reporting (routine and standardised reporting of key indicators)

6. Rights and communication continuity (family contact, legal access, monitoring, and complaint mechanisms)

7. Standing multilateral coordination (pre-agreed modalities for WHO/ICRC/UNODC support)

Together, these findings point to a preparedness gap that is institutional rather than technical; one that can be addressed through clearer mandates, incentives, and coordination across justice, health, and oversight systems.

Recommendations for justice and/or home affairs ministries

These recommendations are grounded in international standards, specifically the Nelson Mandela Rules and the Bangkok Rules, ensuring that future pandemic responses respecting the principles of necessity, proportionality, and non-discrimination. The goal is to not merely recover, but to build back better by addressing the root causes of health inequity.

1. Treat population reduction as a preparedness tool, not a political concession. Establish pre-defined triggers and procedures for release mechanisms during outbreaks (prioritising vulnerability and low-risk categories) and build judicial/administrative capacity to implement quickly.

2. Institutionalise outbreak governance. Create permanent prison outbreak units and drills, not ad hoc crisis teams. Keep protocols “live” through annual exercises and after-action reviews.

3. Build infrastructure for separation without isolation-as-punishment. Quarantine and medical isolation must be clinically justified, time-limited, and subject to strict external oversight. To prevent psychological harm, isolation protocols must ensure meaningful human contact (beyond 1 hour) and access to mental health support, ensuring regimes do not become de facto solitary confinement.

4. Protect and stabilise the workforce. Ensure staff have equal access to risk allowances, personal protective equipment, safe rosters, and psychosocial support.

Recommendations for health ministries and public health agencies

1. Make detention health part of national preparedness architecture. Assign clear responsibility for detention settings in national pandemic plans and surveillance systems, including referral pathways and minimum service standards.

2. Integrate financing and access mechanisms. Expand health coverage arrangements for people in detention and ensure continuity for chronic disease, TB, HIV, and mental health. Crucially, mental health support must be scaled up to address the severe psychological toll of prolonged lockdowns and restricted family contact.

Recommendations for national human rights institutions and oversight bodies

1. Codify access and monitoring continuity during outbreaks. Oversight should be classed as essential, with protocols for safe access or remote monitoring that preserve independence and confidentiality.

2. Strengthen transparency norms as preparedness infrastructure. Regular publication of standard indicators (cases, deaths, testing, vaccination, occupancy, and healthcare staffing) should be routine, not discretionary.

3. Institutionalise the voice of lived experience. Include people with lived experience of imprisonment in the design and monitoring of preparedness plans, recognising their unique insight into the operational reality of outbreaks.

Recommendations for intergovernmental organisations, such as UNODC, WHO, ICRC, donors, and regional actors, such as ASEAN

1. Integrate prison health into wider systemic capacity building. Move beyond ad hoc emergency support by embedding prison health into broader health system strengthening. Specifically, include prisons in national digitalisation of health records and integrated disease surveillance systems. Use pandemic preparedness principles to test responses to other infectious diseases (TB, HIV), ensuring prisons are not left behind in broader health emergencies.

2. Support cross-country learning focused on implementation. Regional exchange should prioritise what is operationally replicable: staffing models, triage systems, quarantine design, data templates, and continuity-of-contact safeguards.

Section 1: Why prisons must be part of pandemic preparedness

1.1 Prisons are not peripheral to public health risk

Pandemics do not stop at prison walls. During COVID-19, prisons across Malaysia, Thailand, and the Philippines functioned as high-risk sites for infectious disease amplification, with consequences extending well beyond incarcerated populations [1].

Three features make prisons structurally vulnerable during outbreaks:

- High population density and chronic overcrowding, often far exceeding design capacity
- Constant population turnover, including admissions, releases, court transfers, staff movement, and service providers
- Limited health infrastructure, particularly for isolation, respiratory care, and continuity of treatment for chronic conditions [1]

These conditions are not exceptional; they are routine features of custodial systems in the region. Prior to the pandemic, Malaysian prisons were operating at approximately 107–137% of official capacity, Thailand held more than 370,000 incarcerated individuals nationwide, and occupancy levels in Philippine jails exceeded 300% in some facilities [2–4]. Under these conditions, physical distancing and home-style isolation were structurally impossible at scale [1]. As a result, once COVID-19 entered a facility, rapid spread was often unavoidable without drastic restrictions on movement and contact. Across all three countries, interviewees consistently described outbreaks in prisons as posing risks not only to imprisoned populations, but to staff, surrounding communities, and already stretched public hospitals.

The implication for preparedness is clear: excluding prisons from pandemic planning creates blind spots that undermine wider public health strategies.

1.2 COVID-19 exposed long-standing structural weaknesses

The pandemic did not create the vulnerabilities observed in prisons; it revealed and intensified pre-existing ones.

Overcrowding as the central constraint

Across Malaysia, Thailand, and the Philippines, overcrowding emerged as the single most important factor shaping pandemic outcomes in prisons [1,5]. Interviewees repeatedly linked high infection rates and prolonged lockdowns to dense sleeping arrangements, shared sanitation, and limited ventilation.

In Malaysia, the prison population increased from approximately 71,898 in 2019 to around 84,143 by 2025, even though early release and non-custodial measures were introduced during the COVID-19 pandemic period [2,3]. In Thailand, the prison system entered COVID-19 with tens of thousands of people in pre-trial detention, many for non-violent and bailable offences. In the Philippines, overcrowding extended beyond prisons to police lockups and precincts, compounding risks at the earliest stages of detention [4].

These structural conditions meant that:

- Isolation frequently became collective isolation;
- Quarantine became prolonged lockdown; and
- Infection control relied heavily on restriction rather than prevention.

Fragmented responsibility for prison health

COVID-19 also exposed the consequences of fragmented responsibility for prison health. In all three countries, prisons relied heavily on external health systems that were already under pressure during the pandemic [1].

Despite national COVID-19 responses involving large-scale mobilisation of testing, treatment, and vaccination resources, prison health services were often under-resourced and peripheral. Econometric analysis of prison expenditure between 2010 and 2023 shows that while governments increased prison-related spending during the pandemic years, baseline investment levels remained comparatively low relative to the scale of custodial systems, around 0.01% of GDP on average across the three countries. This systemic underfunding meant that even technically advanced health protocols failed due to a lack of basic supplies, such as paracetamol or personal protective equipment.

This pattern indicates that fiscal capacity existed, but that prison health was typically prioritised only when outbreaks posed visible risks beyond prison walls.

The human cost of containment. Beyond the epidemiological data, the pandemic imposed severe human rights costs on people in prison. The suspension of family visits, legal counsel, and rehabilitation activities exacerbated the ‘pains of imprisonment,’ creating a mental health crisis alongside the viral one. Preparedness must therefore account for the protection of fundamental rights, ensuring that public health measures do not inadvertently result in cruel or degrading treatment.

Staff welfare and system resilience

COVID-19 further highlighted the central role of prison staff in system resilience. Across the three countries, staff-to-prisoner ratios were already stretched before the pandemic [3]. In Thailand, for example, there were approximately 10,000 prison staff for just under 370,000 prisoners. During COVID-19, staff shortages were exacerbated by illness, quarantine requirements, and extended on-site deployments.

Unequal access to risk allowances, personal protective equipment, and psychosocial support weakened morale and, in some cases, contributed to burnout and severe distress. Preparedness planning that does not explicitly address staff welfare and retention risks failure at the point of implementation.

1.3 Emergency responses are not the same as preparedness

During COVID-19, all three prison systems demonstrated the ability to improvise under pressure. Measures included:

- Internal lockdowns and suspension of visits;
- Creation of quarantine and isolation blocks;
- Field hospitals or prison-based treatment facilities;
- Mass testing and vaccination campaigns; and
- Temporary population reduction measures.

These interventions often limited immediate harm and reduced pressure on external hospitals. However, they were largely reactive, assembled under crisis conditions, and dependent on extraordinary effort from staff and external partners.

Analysis of policy responses and spending trends indicates that many of these measures were time-limited. While prison expenditure increased during the pandemic period, there is limited evidence of sustained post-pandemic budgetary reorientation toward prison health or decarceration. This distinction matters: emergency response capacity is not the same as preparedness.

Preparedness requires:

- Pre-defined decision pathways for outbreaks;
- Clear institutional responsibility for detention health;
- Standing agreements with health authorities;
- Baseline infrastructure and staffing; and
- Mechanisms to reduce population pressure before crisis peaks.

Without these elements, restrictive emergency measures risk becoming normalised forms of prison governance rather than temporary public health interventions.

1.4 Pandemic preparedness is a governance issue

COVID-19 demonstrated that preparedness requires more than just state capacity, understood here as the tangible hardware of budgets, infrastructure, and staff. It relies equally on institutional capability, defined as the "software" or organisational agility required to mobilise those resources effectively under pressure. Ultimately, both are shaped by governance, which we view here not merely as administration, but as the broader interplay of political incentives, institutional design, and trust.

Across the three countries, prisons entered national COVID-19 agendas primarily when framed as risks to public health, rather than as sites of vulnerable populations requiring protection. Transparency around infections, deaths, and conditions varied, and access for oversight bodies, NGOs, and international partners was often restricted during periods of acute outbreak.

These governance dynamics mattered in practice. Limited transparency reduced trust among families of people in prison and civil society, while constrained oversight made it harder to identify problems early or correct harmful practices. In several instances, systems relied heavily on prolonged lockdowns in the absence of alternative tools for risk reduction.

For future preparedness, this experience underscores that trust, communication, and accountability are operational assets, not optional extras.

1.5 Why preparedness must start before the next crisis

The evidence from Malaysia, Thailand, and the Philippines points to a shared lesson: waiting until a pandemic arrives is too late to design effective prison responses.

Preparedness must be built into:

- Penal policy (population management and use of custody);
- Health system planning (surveillance, referral, and financing);
- Workforce policy (staff protection and retention); and
- Governance arrangements (oversight, transparency, and cooperation).

The next sections of this report examine how different governance contexts shaped pandemic responses in practice, what capacities were mobilised, and what legacies COVID-19 has left behind, both positive and problematic.

Section 2. How this study was conducted

2.1 Study design and purpose

This study adopted a systematic, comparative, mixed-methods design to examine 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.

The study was designed to answer three interrelated questions:

1. How did different political and democratic systems shape prison governance, agenda-setting, and resource allocation during the COVID-19 pandemic?
2. In what ways did state capacity and institutional resilience influence the management of COVID-19 in prisons, including engagement with international and multilateral partners?
3. What institutional, policy, and governance legacies has the COVID-19 pandemic left within prison systems, and how do these shape future pandemic preparedness?

Given the opacity, securitisation, and political sensitivity of prison systems—particularly during emergencies—no single method could adequately capture these dynamics. The study therefore combined documentary analysis, fiscal analysis, and elite interviews to triangulate evidence, distinguish between formal policy commitments and operational practice, and identify gaps between stated priorities and actual governance outcomes.

The analysis covers the period 2010–2024, with particular attention to the pandemic years 2020–2023, allowing both pre-pandemic baselines and post-pandemic legacies to be assessed.

2.2 Country selection and comparative approach

Malaysia, Thailand, and the Philippines were purposively selected to reflect maximum variation across:

- Political regimes and democratic practice;
- State capacity and bureaucratic organisation;
- Prison system scale and overcrowding levels; and
- Approaches to public health governance.

While all three are middle-income Southeast Asian states with long-standing prison overcrowding, they differ markedly in how authority is exercised, how crises are governed, and how prisons are positioned within national policy agendas.

The study does not assume equivalence between prison systems. Instead, it adopts a structured, context-sensitive comparative approach, asking the same core analytical questions of each case while remaining attentive to institutional and political differences. This enables identification of both shared regional constraints and regime-specific governance pathways.

2.3 Data sources and analytical strands

The study draws on three complementary strands of evidence, each designed to capture a distinct dimension of prison pandemic governance.

Strand 1: Policy and documentary analysis (priority-setting)

A total of 154 policy and institutional documents were analysed across the three countries, including:

- Government regulations, circulars, and ministerial guidance;
- Prison and corrections directives;
- National COVID-19 taskforce materials;
- Court rulings and legal instruments;
- Reports from national human rights institutions;
- Publications by civil society organisations; and
- Guidance and assessments from international and regional bodies.

Documents were included if they related to COVID-19, prisons, and governance or implementation, and were produced between December 2019 and December 2023.

The analysis was guided by an adapted priority-setting framework, drawing in particular on the work of Kapiriri and Martin [10], which examines how priorities are set under conditions of constraint, uncertainty, and political pressure. Rather than treating policies as neutral records, documents were analysed to identify:

- How problems were framed;
- Whose risks and interests were prioritised;
- How responsibility and authority were allocated; and
- Where implementation responsibilities were specified, deferred, or obscured.

This approach enabled the study to trace how and when prisons entered national pandemic agendas, and whether they were framed primarily as sites of public health risk, security concern, or welfare responsibility.

Strand 2: Analysis of prison expenditure (2010–2023)

To assess whether pandemic governance translated into material investment, the study analysed government spending on prisons from 2010 to 2023 in Malaysia, Thailand, and the Philippines.

Prison expenditure was measured as a share of GDP, enabling comparison across countries and over time while controlling for macroeconomic fluctuations. This approach focuses on relative political prioritisation, rather than absolute budget size.

The analysis employed pooled Ordinary Least Squares (OLS) regression, including time trends, country indicators, and a COVID-period dummy variable [11], to test whether:

- Prison spending increased during the COVID-19 period;
- Higher-income contexts invested proportionally more in prisons; and
- Pandemic-related spending was associated with durable welfare investment or short-term containment responses.

Where official budget data were incomplete, expenditure estimates were constructed using prisoner population figures and per diem cost data. All assumptions and transformations were applied consistently across countries.

This strand provides a quantitative anchor for the governance analysis, allowing comparison between rhetorical commitment and fiscal behaviour. While data limitations remain, these are analytically meaningful, reflecting the structural opacity of prison finance and the low visibility of detention within public budgeting processes.

Strand 3: Interviews with policymakers and system actors (elite interviewing)

The study conducted 31 interview sessions with 37 participants across the three countries. Participants included:

- Senior prison officials;
- Public health policymakers;
- National human rights institutions;
- Civil society and faith-based organisations;
- International and regional organisations; and
- Policy advisors.

Interviews were informed by an elite interviewing approach, recognising that prison governance decisions during crises are highly centralised, politically sensitive, and often undocumented. Interviews were treated not as neutral fact-finding exercises, but as interpretive accounts that illuminate how policies were understood, negotiated, constrained, and enacted in practice [12,13].

Interviews focused on pandemic preparedness, crisis decision-making, implementation challenges, multilateral cooperation, and institutional legacies. All interviews were transcribed, anonymised, and analysed thematically. Quotations are used throughout the report to illustrate patterns and tensions, rather than to attribute responsibility to individuals or institutions.

2.4 Analytical framework and triangulation

The overall analysis integrates the three strands through a governance-focused analytical framework, examining:

- Political and democratic context;
- Institutional capacity and authority;
- Priority-setting processes;
- Implementation and enforcement; and
- Outcomes and longer-term legacies.

This framework was explicitly adapted to the distinctive features of prison systems, including securitised governance, limited transparency, fragmented accountability, and constrained participation by affected populations.

Findings from documents, expenditure data, and interviews were systematically triangulated. Claims were assessed based on the convergence of multiple sources and characterised as strong, moderate, or limited evidence. This enabled the study to distinguish between:

- Policy intention and implementation;
- National narratives and institutional practice; and
- Crisis-driven adaptation and durable reform.

2.5 Ethical approval and research rigour

This study was conducted in full compliance with international standards for ethical research involving human participants, particularly in sensitive policy domains such as prisons, public health, and governance.

Ethical approval for primary data collection was obtained from multiple institutions to reflect the multi-country nature of the research. Approval to conduct interviews in Malaysia and Thailand was granted by Monash University in March and July 2025 respectively (Reference: 2025-46237-128362). Ethical clearance for fieldwork in the Philippines was provided by the Philippine Social Science Council – Social Science Ethics Review Board (PSSC-SSERB; Reference: CE-25-17). Approval for secondary data analysis was granted by the University of Bristol in October 2025 (Reference: 27629).

All interviews were conducted on the basis of informed consent. Participants were provided with detailed information about the study's purpose, voluntary nature, confidentiality safeguards, and their right to withdraw at any stage. Given the political sensitivity of prison governance and the small number of senior actors involved, particular care was taken to minimise risks of identification, including through anonymisation of roles and institutions where necessary. These safeguards were especially important in contexts where disclosure could carry professional, political, or personal risk.

Rigour was ensured through multiple, complementary strategies designed to strengthen credibility, transparency, and analytical robustness. First, iterative validation ("member checking") was undertaken through the presentation of preliminary findings at academic and policy-relevant forums. These included the University of Bristol Criminology Conference (Bristol, United Kingdom, December 2024), the European Group for the Study of Deviance and Social Control Conference (Malmö, Sweden, August 2025), and the European Society of Criminology Conference (Athens, Greece, September 2025). Presenting findings in these settings enabled critical scrutiny from scholars, policymakers and advocates working on prisons, public health, and governance, and informed subsequent refinement of the analysis.

Second, the project benefited from ongoing engagement with an International Advisory Board, whose members brought expertise in prison health, human rights, pandemic preparedness, and international policy. Advisory Board members were invited to review and comment on emerging findings, helping to test interpretations against comparative experience and policy realities.

Third, participants themselves were invited to provide feedback on preliminary analysis where appropriate. This helped ensure that findings accurately reflected institutional practices and constraints, while also identifying areas requiring clarification or contextualisation. This approach was particularly valuable in a study of crisis governance, where official records are often incomplete and decision-making processes are rarely fully documented.

Finally, to strengthen trustworthiness in a politically sensitive setting, the research team used reflexive documentation of refusals and non-recording requests, careful anonymisation to reduce deductive disclosure, and triangulation across sectors and roles. This aligns with methodological evidence that elite interviews can be powerful yet precarious encounters where authority and vulnerability are co-produced, and where what cannot be said can be as revealing as what is disclosed [13].

Taken together, these ethical safeguards and quality assurance processes underpin the robustness of the report's findings. They demonstrate that the analysis is grounded not only in extensive empirical evidence, but also in careful ethical practice, transparency, and engagement with those directly involved in prison and public health governance during the COVID-19 pandemic.

2.6 Data sources and interpretation

This report draws on multiple forms of evidence, including policy documents, administrative data, expenditure analysis, and interviews with policymakers and system actors. The analysis distinguishes between three types of information presented throughout the report:

1. Administrative data (for example prison population figures, capacity estimates, and official policy documents) reflect information produced by government agencies and other formal institutions.

2. Interview evidence reflects the perspectives and experiences of participants who were directly involved in prison governance, public health response, or oversight during the COVID-19 pandemic. These quotations illustrate how policies were interpreted and implemented in practice.

3. Comparative analytical assessments (for example in summary tables) represent the authors' synthesis of multiple sources of evidence. These assessments are intended to support cross-country comparison and should not be interpreted as official ratings of national prison systems.

Where administrative figures were updated or clarified following institutional review, the revised figures have been incorporated and cited accordingly.

Section 3. Country profiles and governance context

Across Southeast Asia, prison systems are shaped by layered historical trajectories—colonial-era carceral logics, post-independence state-building, and contemporary punitive policy pressures—creating "hybrid" governance arrangements where formal rules coexist with informal practices [6,7]. These legacies help explain why overcrowding, underinvestment, and uneven accountability persist across the region, and why technical public health guidance often collides with custodial realities.

Across the three cases, differences in regime type, institutional design, and civil society space influenced:

- Whether prisons entered national COVID-19 agendas early or late;
- How transparent prison responses were;
- How receptive systems were to oversight and multilateral support; and
- Whether emergency measures translated into longer-term reform.

3.1 Malaysia: Semi-democratic governance and institutional marginality

Malaysia is best characterised as a semi-democratic system with strong central bureaucracy and periodic electoral competition [8]. Prisons sit at the tail end of the criminal justice system, both politically and institutionally. Interviewees consistently described them as structurally marginal: prisons are not salient in electoral politics, the prison population does not vote, and detention rarely features in public debate outside moments of crisis. As a result, prison conditions tend to receive attention only when they intersect with broader public health or security concerns.

During COVID-19, Malaysia demonstrated high national public health capacity, including mass testing, vaccination, and centralised outbreak management. Prisons were eventually incorporated into these efforts, particularly once confined settings were recognised as transmission hotspots. However, prison health remained dependent on the Ministry of Health, with no fully autonomous prison health system.

This governance context produced a paradoxical outcome: strong technical capacity to respond to outbreaks, but chronic under-prioritisation of prison health outside crisis moments. COVID-19 prompted improvements in screening, outbreak SOPs, and some early release mechanisms, yet overcrowding continued to rise, underscoring the limits of emergency-driven attention. This marginalisation is compounded by the 'war on drugs' framing, where the majority of the prison population is incarcerated for drug-related offences, reducing political will for welfare-oriented reform.

3.2 Thailand: Authoritarian stability and centralised capacity

Thailand operates under a military-influenced constitutional monarchy, which during the COVID-19 period exercised strong centralised control over the prison system [8]. The Department of Corrections is highly bureaucratised and capable of rapid operational coordination.

This governance model shaped a COVID-19 response in prisons that prioritised command-and-control measures: daily reporting systems, internal "war rooms," triage classifications, field hospitals within prison compounds, and rapid mobilisation of resources, including through royal projects. These measures demonstrated substantial state capacity to manage outbreaks internally and reduce pressure on external hospitals.

However, this capacity coexisted with limited transparency and constrained external oversight. Civil society organisations and international actors reported restricted access during the pandemic, and independent verification of official data was often difficult. While Thailand invested in medical infrastructure and procedures, decarceration remained minimal. Official corrections statistics indicate that the total prison population remained consistently high throughout the pandemic phases, and pre-trial detention continued to drive overcrowding.

In this context, preparedness took the form of internal system strengthening rather than population reduction or rights-based reform. The result was a system better equipped to manage outbreaks within existing carceral structures, but less responsive to calls for structural change.

3.3 Philippines: Electoral democracy and punitive populism

The Philippines is an electoral democracy with a highly decentralised governance structure and a strong civil society presence. During the pandemic period studied, however, prison governance was profoundly shaped by the legacy of the "war on drugs", which normalised mass incarceration and aggressive enforcement practices [9].

COVID-19 governance in prisons unfolded alongside this punitive context. Public health regulations were often enforced through arrest and detention, further exacerbating overcrowding in prisons. Interviewees described pandemic policing as blurring into existing punitive practices, producing a sharp increase in detention at precisely the moment when density posed the greatest health risk.

At the same time, democratic institutions provided countervailing channels. Human rights institutions, faith-based organisations, non-governmental organisations, and some health agencies acted as advocates for detention health, transparency, and alternatives to incarceration. These actors played a critical role in elevating prison health onto the national agenda and facilitating engagement with WHO and other multilateral partners.

The Philippine case thus illustrates a dual dynamic: highly politicised punitive governance, combined with active civil society and international engagement, which together shaped both the harms experienced during COVID-19 and the reform-oriented legacies that followed.

3.4 Why governance context matters for preparedness

The comparative evidence from these three countries demonstrates that pandemic preparedness in prisons is not determined by technical knowledge alone. It is shaped by:

- Political incentives (whether people in prison are visible or marginal to decision-makers);
- Institutional design (centralised versus fragmented responsibility for prison health);
- Civil society space (capacity for advocacy, oversight, and service provision); and
- Attitudes toward external scrutiny (receptivity to multilateral actors).

These factors influenced not only how COVID-19 was managed in prisons, but also what kinds of legacies were left behind, whether in the form of stronger internal capacity, new health-rights frameworks, or missed opportunities for decarceration.

Table 1. Governance and prison system context (comparative snapshot)

Dimension	Malaysia	Thailand	Philippines
Political system	Semi-democratic	Authoritarian / military-influenced	Electoral democracy
Prison political salience	Low	Moderate (security-focused)	High (punitive populism)
Overcrowding (pre-/during COVID) [2,3]	High (119%)	Very high (144%)	Extreme (362%)
Pre-trial detention	Significant	Very high	High
Prison health governance	MOH-dependent	DOC-run health system	Fragmented / devolved
Civil society and national human rights institutions access	Moderate	Restricted	Active but contested
Multilateral engagement	Technocratic	Selective	Strong but politicised
Dominant COVID prison logic	Containment and marginality	Centralised control	Punitive enforcement and advocacy

Section 4: Pandemic preparedness gaps and stress tests

4.1 COVID-19 as a stress test of prison systems

The COVID-19 pandemic functioned as a system-wide stress test for prison systems in Malaysia, Thailand, and the Philippines. Prisons are structurally vulnerable to infectious disease outbreaks due to overcrowding, limited ventilation, constrained healthcare capacity, and high population turnover [1]. These risks were well documented prior to 2020. What COVID-19 revealed was not a lack of awareness or guidance, but the limits of prison systems operating under chronic structural strain.

At the onset of the pandemic, prisons in all three countries were operating far beyond safe capacity. Malaysian prisons were operating at approximately 119% of official capacity, Thailand's prison population exceeded 350,000 people, and occupancy levels in Philippine jails exceeded 300% in some facilities [2–4]. Under these conditions, physical distancing, isolation, and quarantine were structurally unattainable.

As a Thai human rights advocate noted:

> **When you have to keep distance as part of the COVID measures, it was impossible. There was simply no space. (Human Rights Advocate, Thailand)**

Similarly, a Malaysian pandemic taskforce member reflected:

> **Any location where you had people who were confined was a hotspot… if you don't have the space, quarantine becomes meaningless. (Senior Official, Malaysia)**

COVID-19 therefore did not create new weaknesses in prison systems; it magnified existing vulnerabilities, transforming overcrowding into an acute public health risk that extended beyond prison walls.

4.2 Shared preparedness gaps across all three countries

Despite differences in governance and administrative capacity, the pandemic exposed four preparedness gaps common to all three prison systems.

4.2.1 Overcrowding as the core structural vulnerability

Overcrowding emerged as the most significant barrier to effective pandemic management. In all three countries, infection spread rapidly once COVID-19 entered a facility, overwhelming containment measures.

A senior public health official in the Philippines explained:

> **I haven't seen any jail that is spacious, even police precincts. If one person gets COVID, everyone gets it. (Senior Public Health Official, Philippines)**

In Malaysia, overcrowding was described in operational terms:

> **Cells designed for two people were housing up to six. Triple-decker beds. There was no way to separate people. (Senior Official, Malaysia)**

In Thailand, participants linked overcrowding directly to penal policy and pre-trial detention:

> **These people should be presumed innocent, but they had to stay in prison... about 70,000 people faced increased health risks because of pre-trial detention. (Justice Sector Programme Director, Thailand)**

Across the three systems, overcrowding was not an incidental problem but the structural condition that undermined all other preparedness measures.

4.2.2 Insufficient prison healthcare capacity

All three countries entered the pandemic with limited medical staffing and weak health infrastructure inside prisons. Typical staffing ratios included one nurse for thousands of prisoners, irregular access to doctors, and heavy reliance on external hospitals.

A Thai human rights commissioner described the situation bluntly:

> **We do not have regular doctors in most prisons. Sometimes only overtime doctors or nurses. (Human Rights Commissioner, Thailand)**

In Malaysia, resource constraints were stark:

> **The annual prison health budget wouldn't even have covered testing. (Medical Official, Malaysia)**

In the Philippines, health officials emphasised the epidemiological consequences:

> **Our jails are really very cramped. Once COVID entered, it was almost impossible to stop transmission. (Senior Public Health Official, Philippines)**

These limitations reflected not a lack of technical knowledge, but long-term underinvestment and institutional marginalisation of prison healthcare systems.

4.2.3 Staff shortages, burnout, and uneven protection

Prison staff were central to pandemic response yet often poorly protected. Across all three countries, staff shortages intensified as officers fell ill, were quarantined, or worked extended shifts under difficult conditions.

In the Philippines, prolonged confinement of staff inside facilities contributed to severe distress:

> **You are already stressed from guarding, then you can't go home to your family... the stress is really double. (Civil Society Leader, Philippines)**

In Malaysia, officers worked long hours in full PPE, sometimes without adequate ventilation:

> **Even the prison personnel themselves were at risk of heat stroke and dehydration. (Senior Official, Malaysia)**

In Thailand, inequities between prison health staff and other frontline workers were a source of frustration:

> **Prison medical personnel worked under the same risk, but they were not entitled to special allowances. (Human Rights Commissioner, Thailand)**

There were also 'internal lockdowns' where staff were required to stay within prison premises for weeks at a time, separating them from their own families. These pressures weakened institutional resilience and contributed to burnout, absenteeism, and declining morale.

4.2.4 Separation between prison and public health systems

Before COVID-19, detention health in all three countries was institutionally separated from mainstream health systems, limiting preparedness and coordination.

In the Philippines, a national health official described detention health as effectively "divorced" from the health system prior to the pandemic. Malaysia relied on Ministry of Health support without a dedicated detention health unit, while Thailand operated prison hospitals within the correctional system, complicating financing and referrals.

As one Malaysian human rights official explained:

> **Prison health followed Ministry of Health policies, but prisons were never a priority. (Human Rights Official, Malaysia)**

The pandemic forced closer collaboration, but these interfaces remained fragile and unevenly institutionalised.

4.2.5 The gendered burden of containment

While women constitute a minority of the prison population in all three countries, the pandemic response revealed a "gender blindness" in preparedness planning. Facilities designed for men struggled to accommodate the specific needs of women during lockdowns.

Health and hygiene: Supply chain disruptions frequently led to shortages of gender-specific essentials, including sanitary products, which were often deprioritised compared to general PPE.

- Maternal health: Access to pre-natal and post-natal care was severely restricted as transfers to external hospitals were curtailed to prevent infection.
- The caregiver gap: The suspension of family visits took a disproportionate psychological toll on women, who are frequently primary caregivers. Interviewees in the Philippines noted that the inability to contact children was a primary source of acute distress.

Table 2: Shared pandemic preparedness gaps in Southeast Asian Prisons

Dimension	Malaysia	Thailand	Philippines
Chronic overcrowding	High (119%)	Very high (144%)	Extreme (362%)
Prison healthcare capacity	Low	Low–moderate	Very low
Staff protection and welfare	Limited	Uneven	Severely strained
Integration with health system	Weak	Partial	Previously minimal
Feasibility of distancing	Low	Very low	Near impossible

Note: Categories represent the authors' comparative assessment based on triangulated evidence from policy documents, administrative data, and interview findings. They do not represent official ratings of national prison systems.

4.3 Divergent stress responses under pressure

Although the preparedness gaps were shared, responses under pressure diverged.

- Malaysia prioritised procedural adaptation, including testing regimes, quarantine blocks, and temporary satellite facilities.

- Thailand mobilised centralised authority rapidly, deploying field hospitals and mass screening, but restricted external scrutiny.
- The Philippines relied heavily on civil society and international partners to compensate for structural deficits.

A Thai civil liberties advocate captured the tension between capacity and transparency:

> **The ability to process data is there, but we cannot cross-check it. In the end, we doubt the information. (Human Rights Advocate, Thailand)**

In the Philippines, civil society actors described filling gaps left by the state:

> **When visits were cut, NGOs had to raise funds for medicine, masks, vitamins. The collaboration was strong, but it was improvisation. (Faith-Based Organisation Leader, Philippines)**

These differences reflect how authority, accountability, and resource mobilisation shaped crisis response.

4.4 Where preparedness failed most severely

Across all three countries, several critical gaps persisted:

- Decarceration remained limited and exceptional;
- Mental health and psychosocial support were marginal;
- Transparency and communication were inconsistent;
- Family contact and complaints mechanisms were curtailed.

A Thai advocate emphasised the rights dimension:

> **Health care is important, but the right to information, to register complaint, to contact the outside world should not disappear just because there is a pandemic.**

In Malaysia, oversight bodies argued that trust depended on independent verification:

> **If an independent body says it is safe inside, people will believe it more than the prison authorities. (Human Rights Commissioner, Malaysia)**

In the Philippines, prolonged isolation took a severe psychosocial toll:

> **Some women were isolated for almost a year. They worried about their children every day. (Civil Society Leader, Philippines)**

4.5 Stress test outcomes: What changed and what did not

The pandemic generated significant short-term adaptation, such as field hospitals, digital hearings, virtual visits, and emergency protocols. However, many reforms remain contingent and vulnerable to reversal.

As one Malaysian pandemic advisor reflected:

> **Governments just want to forget about COVID. I don't see real reforms being put in. (COVID-19 Taskforce Member, Malaysia)**

COVID-19 also accelerated incremental institutional change. Like the "Ship of Theseus"—where a vessel is gradually transformed as parts are replaced—prisons may appear stable, yet crisis adaptations can quietly reconfigure governance over time [14]. This makes it especially important to identify which pandemic-era changes should be retained (e.g., surveillance, health integration, and continuity systems) and which should be actively rolled back (e.g., prolonged isolation as routine control).

The central lesson of this stress test is clear: without addressing overcrowding, health system integration, staff welfare, and trust, future pandemics will reproduce the same vulnerabilities regardless of how comprehensive preparedness plans appear on paper.

Section 5. Lessons for future pandemic preparedness in prisons

These lessons translate the comparative evidence from Malaysia, Thailand, and the Philippines into clear, implementable guidance for future pandemic preparedness in custodial settings. They focus on measures that are feasible within existing institutional structures, while also identifying where sustained political commitment is required.

Lesson 1: Treat overcrowding as a core preparedness risk that must be actively managed

Governments should formally recognise overcrowding as a public health and emergency preparedness risk, and integrate population reduction targets into pandemic preparedness planning. Preparedness plans that assume existing population levels are structurally unworkable. Without population reduction, infection control measures will fail regardless of technical sophistication.

Priority actions

- Establish maximum emergency occupancy thresholds for prisons and jails, beyond which automatic population reduction measures are triggered.
- Mandate the use of non-custodial measures (bail, probation, electronic monitoring, and community-based sanctions) during public health emergencies.
- Reduce reliance on pre-trial detention, particularly for minor, non-violent, and drug-related offences.

Lesson 2: Make decarceration a standing public health tool, not an exceptional response

Prioritise release pathways based on risk, not just offence category. This includes people with short remaining sentences (e.g., <1 year), those who have served the majority of their time, and vulnerable cohorts. Crucially, ensure preparedness plans include provisions for unconditional early release to rapidly reduce density, noting that evidence from the COVID-19 period suggests such measures did not lead to spikes in community offending.

Priority actions

Develop pre-approved decarceration protocols for public health emergencies, including clear eligibility criteria.

- Prioritise release or alternatives for:
  - » Older prisoners;
  - » Those with chronic illness or disability;

- » Pregnant women; and
- » People held for bailable or minor offences.

- Ensure that release mechanisms are paired with community health and social support, including housing, healthcare access, and continuity of medication.

Lesson 3: Integrate prison health fully into national health preparedness systems

Prison health services should be structurally integrated into national public health systems, with clear mandates, budgets, and accountability. Institutional integration improves speed, prioritisation, and continuity of care.

Priority actions

- Assign formal responsibility for detention health to Ministries of Health, not only Ministries of Justice or Interior.
- Establish dedicated detention health units within health ministries.
- Ensure people in prison are automatically enrolled in national health insurance or equivalent schemes.
- Include prisons explicitly in:
  - » National pandemic preparedness plans;
  - » Surveillance systems;
  - » Vaccination strategies; and
  - » Supply chains for PPE and medicines.

Lesson 4: Recognise and support prison staff as frontline emergency responders

Prison staff should be formally recognised as frontline emergency workers, with commensurate protection and support. Institutional resilience depends on staff capacity and morale. Burnout and distress undermine preparedness and increase long-term costs.

Priority actions

- Extend risk allowances, insurance coverage, and occupational protections to prison medical and custodial staff during health emergencies.
- Incorporate mental health and psychosocial support into preparedness plans for staff.
- Ensure staffing contingency plans address:
  - » Illness and quarantine;
  - » Burnout and fatigue; and
  - » Prolonged confinement within facilities.

Lesson 5: Build transparency, oversight, and communication into preparedness frameworks

Preparedness frameworks should explicitly protect transparency, communication, and oversight, even under emergency conditions. Trust and compliance are essential to effective containment. Independent oversight strengthens legitimacy and public confidence.

Priority actions

- Guarantee continued access for national human rights institutions and independent monitors during emergencies.
- Maintain minimum standards of prisoner communication, including family contact and access to information.
- Publish regular, disaggregated data on:
  - » Infections;
  - » Deaths;
  - » Testing and vaccination; and
  - » Population movements.

Lesson 6: Formalise multilateral cooperation before the next crisis

Governments should institutionalise cooperation with WHO, UNODC, ICRC, and regional partners such as ASEAN within standing preparedness frameworks. Multilateral partners proved most effective where engagement was sustained and politically supported. Preparedness should not depend on personal relationships or crisis improvisation.

Priority actions

- Develop pre-negotiated protocols for technical assistance, equipment provision, and emergency funding.
- Insulate health cooperation from political volatility by anchoring it in technical and administrative agreements.
- Strengthen regional coordination, including information-sharing and joint training across Southeast Asia.

5.1 Country-specific priorities

Malaysia

- Scale up early release and non-custodial measures beyond pilot scope.
- Strengthen the new Ministry of Health detention health unit with a clear mandate and budget.
- Expand the role of SUHAKAM as a recognised partner in emergency response.

Thailand

- Reduce reliance on pre-trial detention and imprisonment for minor offences.
- Improve transparency and independent monitoring during emergencies.
- Integrate prison healthcare more fully into national health financing systems.

Philippines

- Operationalise the “Healthy Places of Detention” policy across all detention facilities.
- Address extreme overcrowding in police jails and precincts as a preparedness priority.
- Institutionalise civil society participation in detention health planning.

5.2 Roles for regional and international actors

WHO

- Support integration of prison health into national pandemic preparedness plans.
- Develop regional guidance on decarceration and emergency population management.

UNODC

- Support alternatives to incarceration and sentencing reform.
- Provide technical assistance for prison health governance.

ICRC

- Continue support for detention health, PPE, and independent monitoring.
- Advocate for minimum humanitarian standards during emergencies.

ASEAN and regional bodies

- Facilitate regional dialogue on prison preparedness.
- Support cross-border learning and joint capacity-building.

The COVID-19 pandemic demonstrated that prison preparedness is achievable when political attention and resources are mobilised. The challenge is to sustain that commitment outside moments of crisis.

Finally, prison systems must move from reactive crisis management to long-term adaptive governance. The stressors facing prisons—pandemics, climate-induced heat, and migration shifts—will only intensify. Governance systems must therefore be designed for adaptation, capable of proactively adjusting population levels and operational routines before the next crisis hits.

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