

2. Good MI, Shader RI. Lethality and behavioral side effects of chloroquine. *J Clin Psychopharmacol* **1982**; 2:40–7.
3. Abdulaziz N, Shah AR, McCune WJ. Hydroxychloroquine: balancing the need to maintain therapeutic levels with ocular safety: an update. *Curr Opin Rheumatol* **2018**; 30:249–55.
4. Ponticelli C, Moroni G. Hydroxychloroquine in systemic lupus erythematosus (SLE). *Expert Opin Drug Saf* **2017**; 16:411–9.
5. Wang M, Cao R, Zhang L, et al. Remdesivir and chloroquine effectively inhibit the recently emerged novel coronavirus (2019-nCoV) in vitro. *Cell Res* **2020**; 30:269–71.
6. Barnard DL, Day CW, Bailey K, et al. Evaluation of immunomodulators, interferons and known in vitro SARS-CoV inhibitors for inhibition of SARS-CoV replication in BALB/c mice. *Antivir Chem Chemother* **2006**; 17:275–84.
7. Channappanavar R, Fehr AR, Vijay R, et al. Dysregulated type I interferon and inflammatory monocyte-macrophage responses cause lethal pneumonia in SARS-CoV-infected mice. *Cell Host Microbe* **2016**; 19:181–93.
8. An J, Woodward JJ, Lai W, et al. Inhibition of cyclic GMP-AMP synthase using a novel antimalarial drug derivative in Treg1-deficient mice. *Arthritis Rheumatol* **2018**; 70:1807–19.

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Spotlight on Jails: COVID-19 Mitigation Policies Needed Now

TO THE EDITOR—In response to the coronavirus disease 2019 (COVID-19) pandemic, healthcare institutions and public health experts are mobilizing to develop mitigation protocols [1] based on the experiences of other countries, including China, South Korea, and Italy. Compared to these countries, the United States has a higher incarceration rate, with 10.6 million people booked into jails each year [2]. Jails pose a unique set of challenges to COVID-19 prevention, detection, and management mitigation that deserves immediate attention.

Social distancing to reduce the rate of disease transmission is not feasible in jails, where people are confined to small living spaces and institutions are often over capacity [3, 4]. Handwashing can be undermined by policies limiting soap access or

requiring individual purchase of soap (at a marked-up price) [5, 6]. Many jails restrict access to hand sanitizer, which contains alcohol, fearing individuals will ingest it. Along with structural barriers to disease prevention, there are administrative challenges—largely driven by lack of financial resources—that impede timely access to healthcare professionals when sick [7]. This is especially concerning because jails have a high proportion of people with underlying health conditions [3, 8], making them more susceptible to severe COVID-19 infection [7]. There are several reasons why people who are infected may be reluctant to self-identify symptoms, including unknown duration of detainment [9], fear of being isolated, or losing privileges (eg, television, phone calls) in a medical unit [10]. Furthermore, increased risk of COVID-19 exposure in jails confers higher risk of transmission in the community upon release, with challenges surrounding then notifying those exposed who have limited access to stable housing or phones [11].

We have developed a list of recommendations to facilitate and augment COVID-19 mitigation policies in jails (Figure 1). At the most basic level, funds should be allocated to purchase soap, hand sanitizer, and personal protective equipment (eg, gloves, masks). Educational materials, in multiple languages, should be disseminated to people who are incarcerated and personnel

designated to address any questions or concerns that arise. All corrections staff should receive training on identifying signs of coronavirus and preventing disease transmission. This starts with updating intake forms in detention settings to screen for people who meet criteria for COVID-19 testing and access to rapid (<24 hours) testing results. Partnership with local academic centers to access rapid testing is encouraged. There should be dedicated spaces within jails for isolation of persons with confirmed or suspected COVID-19 who are not ill enough to warrant hospital transfer, with a plan in place for transporting patients when necessary. Ensuring the well-being of law enforcement and correctional officers is key to any mitigation strategy, and there should be policies that compensate staff who become sick with COVID-19.

An evidence-based approach, grounded in public health principles, is needed to contain the outbreak without further isolating an already vulnerable population. The unintended consequences of these mitigation policies must be considered, for example, the deleterious impact of halting mental health treatment programs in jails. The recent riots in Italy's correctional facilities [12] revealed the potential for negative psychological impact of emergency policies aimed at curtailing the spread of COVID-19 (eg, suspending family visitations). It

Jails should immediately

- Add screening questions for coronavirus (eg, fever, cough) to all medical forms;
- Disseminate timely information about coronavirus to people incarcerated available in multiple languages;
- Develop policies for screening, monitoring, and quarantine of people with suspected or confirmed coronavirus;
- Provide soap, hand sanitizer, and other hygiene products for free;
- Consider allowing additional yard time so people can safely practice social distancing;
- Increase privileges and waive fees to different forms of communication (eg, telephone, email, postal mail) so individuals can maintain contact with their loved ones;
- Suspend co-pays for health visits;
- Ensure ongoing medical, mental, and behavioral healthcare can continue, including the potential use of telehealth;
- Working closely with stakeholders from unions and representatives of jail staff, develop policies regarding home quarantine for illness among correctional and jail health staff.

Jail authorities should work with other criminal justice agencies including the courts, district attorney's office, local law enforcement, and community corrections to

- Deny entrance to low-level offenders and encourage law enforcement to issue summonses for low-level offenses instead of making arrests;
- Release pretrial detainees who do not pose a physical threat to the community;
- Transfer people who are serving sentences and at high risk for severe disease to community supervision; and
- Release people held for technical violations (eg, probation or parole) and encourage community corrections to stop revocations for minor offenses.

Figure 1. Recommendations to local county jails for coronavirus disease 2019 (COVID-19) mitigation response.

is time for reexamination of policies, such as cash bail or holding people pretrial (ie, without a conviction), to decrease the jail population [13, 14].

Thoughtful and deliberate planning for COVID-19 mitigation in corrections institutions—especially jails—is imperative. We need action now, starting with engagement of key stakeholders to identify the current and future needs of jails to combat this pandemic. The health of our communities will only be as good, or as poor, as the health of the most disadvantaged among us. Now is the time to prioritize the health-care of people who are incarcerated.

Notes

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References

1. US Department of Health and Human Services. Secretary Azar declares public health emergency for United States for 2019 novel coronavirus [press release]. 2020. Available at: <https://www.hhs.gov/about/news/2020/01/31/secretary-azar-declares-public-health-emergency-us-2019-novel-coronavirus.html>. Accessed 28 March 2020.
2. Zeng Z. Jail inmates in 2017. Washington, DC: US Bureau of Justice Statistics, 2019.
3. Dumont DM, Brockmann B, Dickman S, Alexander N, Rich JD. Public health and the epidemic of incarceration. *Annu Rev Public Health* 2012; 33:325–39.

4. Maruschak LM, Sabol WJ, Potter RH, Reid LC, Cramer EW. Pandemic influenza and jail facilities and populations. *Am J Public Health* 2009; 99(Suppl 2):S339–44.
5. Prison Policy Initiative. The company store: a deeper look at prison commissaries [press release]. Easthampton, MA: Prison Policy Initiative, 2018.
6. Maree CL, Eells SJ, Tan J, et al. Risk factors for infection and colonization with community-associated methicillin-resistant *Staphylococcus aureus* in the Los Angeles County jail: a case-control study. *Clin Infect Dis* 2010; 51:1248–57.
7. Crowley D, Van Hout MC, Lambert JS, Kelly E, Murphy C, Cullen W. Barriers and facilitators to hepatitis C (HCV) screening and treatment—a description of prisoners' perspective. *Harm Reduct J* 2018; 15:62.
8. Maruschak L, Berzofsky M, Unangst J. Medical problems of state and federal prisoners and jail inmates, 2011–2012. Washington, DC: US Bureau of Justice Statistics, 2015.
9. Meyer CL, Tangney JP, Stuewig J, Moore KE. Why do some jail inmates not engage in treatment and services? *Int J Offender Ther Comp Criminol* 2014; 58:914–30.
10. Pollitt S, Woollard L. Barriers to access and inadequate levels of care in North Carolina jails. *N C Med J* 2019; 80:345–6.
11. Rich JD, Beckwith CG, Macmadu A, et al. Clinical care of incarcerated people with HIV, viral hepatitis, or tuberculosis. *Lancet* 2016; 388:1103–14.
12. Mahbubani R. About 50 inmates escaped from Italian prisons as the coronavirus triggered riots and brought the country's criminal-justice system to a halt. *Business Insider* 2020. Available at: <https://www.businessinsider.com/inmates-riot-escape-from-italian-prisons-amid-coronavirus-restrictions-2020-3>. Accessed 28 March 2020.
13. Sawyer W, Wagner P. Mass incarceration: the whole pie. Easthampton, MA: Prison Policy Initiative, 2019.
14. Woods A; American Civil Liberties Union. Using bail as ransom violates the core tenets of pretrial justice. Available at: <https://www.aclu.org/news/smart-justice/using-bail-as-ransom-violates-the-core-tenets-of-pretrial-justice/>. Accessed 28 March 2020.

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The COVID-19 Pandemic: We Are All in This Together

TO THE EDITOR—A returning student from China is not being truthful around dates of travel because of the fear of being stigmatized in his dormitory. A neighbor stops talking with a family next door because they are originally from France. A patient tells me that coronavirus disease

2019 (COVID-19) was manufactured as a weapon of bioterrorism. These are real stories that have happened before the massive school closures and the travel restrictions. As the spread of COVID-19 increases, I find myself pausing to think: could stigma, discrimination, and misinformation decrease our ability to have an effective response to this pandemic? What makes this novel virus susceptible to conspiracy theories? And what can we do to collectively to fight against stigma and have a unified response, not only in the United States but globally?

The origin of COVID-19 remains unclear. One hypothesis is that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), the virus that causes COVID-19, arose from a cross-species transmission from an animal reservoir (likely bats) and may have involved an intermediary animal host before infecting humans [1, 2]. COVID-19 has a few characteristics that make it particularly attractive to conspiracies: (1) it appeared suddenly and spread rapidly, (2) its origin remains a mystery, (3) it has a relatively high case fatality rate with a rate 5 to 35 times higher than that of influenza, and (4) there are no vaccines and no therapeutics [3]. To make sense of this rapidly evolving pandemic, the Internet is filled with alternative facts that bring social value to a biological mechanism.

To date, COVID-19 has spread across all continents and claimed 25 250 lives [4]. Among the sick, we can only offset the biological damage from the virus by using supportive measures with very little control since we currently do not have a cure. However, what we do have control over is our own behavior. Applying social distancing [5] is key, but relying on factual information to guide public health decisions is also important. Learning from the human immunodeficiency virus (HIV) epidemic we know that communities can contribute to the reinforcement of stigma or we can work actively to break down barriers and together create solutions that can benefit all. We also learned that stigma can be as fatal as the disease