

## **Surviving Prison: Exploring prison social life as a determinant of health**

### **NICK DE VIGGIANI**

#### Research Design and Methodology

- in a category C adult male training prison
- held around 500 sentenced prisoners
- Access to research participants was then achieved through non-coercive one-to-one discussions between the researcher and potential participants, and recruitment involved signed informed consent.
- Participants were guaranteed privacy during their participation in interviews and their confidentiality and anonymity were protected during data analysis
- characterized as a reflexive, subtle realist ethnography
- combined three qualitative research methods: participant observation, a group interview and one-to-one, semi-structured interviews with prisoners and prison officers.
- The researcher spent around five months visiting the prison, usually for whole days at a time, meeting prisoners and staff and learning about prison life.
- Two months after the researcher's arrival at the prison, seven prisoners were recruited to participate in a group interview essentially planned to explore collectively the research questions with potential interviewees and gauge their perspectives on health
- In total, thirty-five prisoners and four prison officers participated in the one-to-one semi-structured interviews, which were tape-recorded, carried out in cells or private rooms on the wing and lasted between sixty and ninety minutes. The number of interviews conducted reflected the stage at which data saturation was perceived; in the case of the officers, the number of interviews was small because the wing only employed six permanent staff and two of these were not available to be interviewed.
  
- how they respond to imprisonment is dependent on:
  - how effectively they integrate into an institution's social structure
  - if they learn to fit in with others
  - adapting to/coping with becoming detached from society/community/their family
- environment is an important bearing on health of prisoners > prison health research, policy, and provision should be driven by WHO core principles
- contemporary prison health policy in the UK focuses essentially on providing acute health care services responding to the physical, psychological, emotional, and social needs but it s VERY LIMITED
- needed: expanded notion of deprivation and importation
- "healthy prisons" is ironic, prisoners are likely to suffer regardless because of
  - overcrowding
  - poor facilities
  - few opportunities
  - high levels of stress
  - increased surveillance and control
- risk behavior is symptomatic of individuals personal struggle to cope with prison

- prisoner social relations
  - *TENSION AND TRANSCIENCE* ; close quarters, irritability, aggression, highly sensitive to change, makes social environment fractious and unstable, suspicion, prisoners in a constant state of arousal and stress
  - *FRONT MANAGEMENT*; relationships are usually temporary and tended to be superficial, presenting an acceptable image to others, tension between a true reflection of themselves and projection a false facade, “wearing a mask” “imitation” “mimicking” “seeing the shell of a person” to become socially accepted, one big competition to be individual and to be noticed, be more than number
  - *PRISON TALK*; essentially a superficial and public mode of communication that fostered camaraderie and solidarity, part of front management, both prisoners and prison staff, being crude and humorous banter to suppress negative emotions
  - *ONE-UPMANSHIP* ; physical recreation, sports, weight room, gym ; macho, intimidating, tense, testosterone filled environments
  - *MACHO IMAGE* ; appearing tough, aggressive, as seen as a survival strategy
  - *EMOTIONAL REPRESSION*; avoiding being perceived as weak or vulnerable which necessitated a tough, confident facade that signaled to others that they can cope, listeners and religious folk keeping it quiet to avoid ridicule, releasing their emotions are night in bed
  - *REPUTATION*
  - *HETEROSEXISM*
  - *RACISM*
  - *EXPLOITATION*

## **Pitfalls of TB management in prisons, revisited**

### **HERNÁN REYES**

- Prisons are active pools and reservoirs of TB that need specific attention and management (Maher & Grzemska, 1998)
- “The only way to control TB anywhere, is to control it everywhere.”
- All prisoners should be screened on entry as they constitute a high-risk population group for tuberculosis.
- Four types of problems can be identified in the management of TB and MDR-TB in prisons:
  - Problems related to prisons as a closed (and coercive) environment
  - . Problems related to the prisoners themselves
  - . Specific medical problems encountered in the prisons
  - . Social problems regarding (non) allocation of resources for health in prisons
- Directly observed treatment in a prison should mean directly observed tablet swallowing . . . 2.
- Some prisoners “cheat” on their sputum test to GET IN to a TB programme, giving “positive” sputum from someone else\*whereas they do not have TB\*because the TB programme is seen as advantageous . . . Others, who have been cured, “cheat” on their sputum test by giving someone else’s positive sputum, so as to STAY ON in the programme, for the same perceived (and real) advantages.

- Prisoners need to understand why they suddenly have to be accommodated and kept apart from their fellow inmates. An example of themes that need to be explained in simple terms:
  - . The difference between the first and second phases of the treatment.
  - . What if sputum examination results are negative, but the prisoner is still ill?
  - . End of treatment: information on follow up and maintaining a healthy life style
  - . Information for families and visitors of TB patients concerning contagion, and the dangers of self-medication.
- D.O.T. is absolutely necessary in prisons! directly observed treatment short-course
- The very conditions that lead to high TB rates in prisons may also lead to development of drug-resistant TB and MDR-TB.
- Incoming prisoners may also bring in drug-resistance with them, especially if they have been in prison before or in settings with poorly supervised civilian programs. This is a major problem, for example, in many countries of the former Soviet Union and Eastern Europe.
- Specific medical challenges posed by the treatment of MDR-TB in prisons:
  - .Extremely long duration of therapy (24 months! . . .);
  - . worse side effects with second-line drugs;
  - . a much more challenging monitoring schedule;
  - . need for drug sensitivity testing(with the added difficulties if DST is to include second-line drugs); and
  - . the need for even closer links to the civilian programmes.
- Sources of HIV in prisons:
  - Intravenous drug use
  - Men having sex with men
  - Tattooing
- There should certainly be a careful calculation of risks and benefits before initiating appropriate ARV therapy in prisons.

### **Canada: A land of missed opportunity for addressing the social determinants of health**

- Assuming Canada's public health care insurance system survives attempts to increase its privatization, address- ing the social determinants of health (SDH) and their unequal distribution among the population represent the next frontier for reducing health inequalities, a point long recognized in Canadian governmental and public health institutional document