Harm Reduction Behind Bars: Prison Worker Perspectives

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Abstract

We aimed to identify how strategies to reduce the risk of hepatitis C virus (HCV) in prisons could be implemented in a way that is acceptable to those with the responsibility for implementing them. Prison officer and nurse perceptions of HCV and attitudes toward a range of harm reduction interventions, including clean needle and bleach provision, were explored. In the context of highly prevalent feelings of resentment, most of the proposed strategies were perceived by all staff as a threat for officers and a privilege for prisoners. Addressing the underlying concerns of prison staff is essential in achieving a fully collaborative harm reduction effort. Ongoing resistance to proposed harm reduction strategies underscores the relevance of these findings for prison settings in Australia and elsewhere.

Keywords

prison studies, health communication, correctional institutions, policies, alcohol, drugs, tobacco

Introduction

With an estimated prevalence of up to 1.5% (Alter, 2007; Hellard, Horyniak, & Aitken, 2009), hepatitis C virus (HCV) infection is one of the most commonly notified communicable diseases in Australia. While the risk is greatest in people with a history of injection drug use (National Centre for HIV Epidemiological and Clinical Research, 2010), history of imprisonment has long been independently associated with HCV (Crofts et al., 1996; Dolan, 2000a; Stark et al., 1997). HCV transmission has proven to be difficult to study in prison populations, primarily due to rapid population turnover, but rates are thought to be high relative to the general community (Miller, Bi, & Ryan, 2009) and direct evidence of transmission within Australian prisons has been reported (Haber et al., 1999; Post et al., 2001).

In 1993, the World Health Organization (WHO) published guidelines on the management of HIV in prisons (WHO Global Programme on AIDS, 1993). A major principle of the document was to provide prisoners with the same standard of health care (including access to preventive resources such as condoms, bleach, and sterile injecting equipment) available to the communities from which the prisoners were sourced. While focused on HIV, the guidelines are applicable to HCV as has been reflected in subsequent WHO documents (WHO, 2007; WHO and Joint United Nation Programme on AIDS, 2006). Evaluations of the extent to which the international guidelines have been adopted over the ensuing two decades, however, have yielded disappointing results—particularly with respect to the provision of syringes and bleach (Bollini, Laporte, & Harding, 2002). This is despite strong evidence from around the world for the effectiveness of needle and syringe programs in the community (Commonwealth Department of Health and Ageing, 2002) and their successful implementation in a growing number of prisons in Switzerland, Germany, Romania, Belgium, Scotland, and elsewhere (Chu & Elliott, 2009). Although many of the reasons for this are related to legislative and administrative restrictions, a number of authors have also described a lack of acceptance among prison officers and other correctional staff to the introduction of particular harm reduction strategies (Cregan, 1998; Dolan, Wodak, & Hall, 1998; Godin et al., 2001; Leh, 1999; Levy, 1999; Niveau, 2006). In Australia, proposals for new harm reduction strategies within prisons, including access to clean injecting equipment, have also been met with various levels of resistance from prison staff (Dolan, 2001). Efforts to understand the attitudes and beliefs of prison staff could promote a more collaborative approach to introducing effective strategies in the future (Gollop et al., 2004; Grol & Wensing, 2004; Mogg & Levy, 2009).

During 2005 and 2006, a study of HCV infection in prisoners was conducted in the South Australian (SA) system.

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This study (Miller et al. 2009) estimated an overall HCV seroprevalence in prison entrants of around 42%—similar to the 37% to 58% reported by studies in other Australian prisons (Butler, Boonwaat, & Hailstone, 2005; Butler et al., 1999; Crofts et al., 1995; Hellard, Hocking, & Crofts, 2004). The study confirmed that those already infected with HCV at prison entry were significantly more likely to continue injecting while incarcerated. It was concluded that the few needles in circulation in the prison were almost certainly contaminated with HCV and represent an unacceptable risk for susceptible prisoners and prison staff. With the exception of an established opioid replacement program (Cowie & Alberti, 2001), no practical preventive resources aimed at reducing the harms associated with injecting have been provided to SA prisoners to date.

During this study, prison officers and health staff working in the SA prison system took part in small group interviews and a focus group. The rationale for the interviews was to assist in the development of recommendations for harm reduction strategies that would be acceptable to those responsible for implementing them. In this article, we explore their perceptions and views about hepatitis C and a range of harm reduction strategies to identify future directions for minimizing transmission risks within prison. In addition to ethical approvals obtained for the original project (Miller et al., 2009), this secondary analysis was specifically approved by the SA Department of Health Human Research Ethics Committee and the Deakin University Human Research Ethics Committee.

**Method**

In late 2005, three small group interviews with correctional officers and one focus group with prison health staff were held at two metropolitan prisons in Adelaide. The included participants were 18 years of age or older, employed in the prison system at the time of the interview, and actively working in or as in the SA prison system during the period of the larger study in which this research arm was embedded.

In each semistructured interview, participants were invited to talk about the importance of HCV as a workplace issue for them and the adequacy of any infection control measures then in place. They were then provided with a brief text paragraph summarizing statistics on the prevalence of HCV in SA prisons, and asked whether that information changed their assessment of HCV as a priority issue. Following this, participants were invited to raise any issues of interest in relation to communicable disease in general, before being canvassed for their views on a range of specific prevention strategies, including increasing education, bleach provision, clean needle provision—which have been among the most commonly proposed strategies for prison systems (Dolan, 2000b).

Prison officer participants responded to posters and flyers that were placed around the institutions by making contact directly with the researcher on-site. Nursing staff participants responded to invitations provided directly to them via nursing education workshops and through reminders at handover meetings. Responders were provided with an information sheet and signed a consent form several days prior to the interviews but no participants withdrew. All interviews were held in private rooms on-site during work time, were audiotape recorded, and then transcribed verbatim at which time the tapes were destroyed. Initially, some of the data were descriptively analyzed and reported to the primary stakeholders (including the SA Prison Health Service, SA Department of Health, and SA Department for Correctional Services) along with the larger study findings, but they were not comprehensively analyzed or published at that time.

Further analysis involved a recursive cycle of inductive and deductive reasoning that included descriptive coding, to highlight emergent themes; determining a point of reference for examining each theme to interpret key categories; a mapping exercise to illustrate and question the information emerging and to assess what we already know about the topic; and interpreting and presenting findings (Daly, 2007). The analysis was undertaken by a researcher who was not involved in the data collection and without previous experience in the context or the content area of the study. Although previously held attitudes to prisoners, prison staff, and communicable diseases would remain, it is likely that their impact on the analytic process may not have been as great as the potentially more strongly established attitudes held by persons with expert knowledge of the field.

**Participants**

Eight prison officers (two females and six males) and seven prison health service nurses (four females and three males) were interviewed in their work time within the grounds of two high security metropolitan male-only prisons in Adelaide, South Australia. One prison accommodated sentenced prisoners and the other a mixture of sentenced and unsentenced prisoners. The eight prison officers took part in one of three small group interviews (one group of two participants, and two groups of three participants) and had levels of experience ranging from what might be described as ‘early career’ to ‘veteran.’ The seven nurses participated in a single focus group session that was held in a prison infirmary. Their level of experience in prison health also ranged from relative newcomer to extensive.

**Results**

The interviews covered three main discussion points and uncovered a number of associated issues: working in an environment with a high prevalence of HCV (including attitudes toward HCV, awareness of prisoner HCV status, and knowledge about HCV), existing strategies to minimize HCV transmission (including formal protocols and
individual protection), and specific staff responses to the proposed strategies.

The findings are presented according to the discussion points and themes emerging from the analytical process, with verbatim quotes provided to exemplify key points. Interpretive discussion is presented along with each theme and final implications are discussed separately.

**Working in a High HCV Prevalence Environment**

Risk of transmission was the most dominant consideration in prison officer discussions of working in an environment with high background prevalence of HCV infection. Transmission risk was also a major theme in nurse discussions and, for both groups, all discussion was located within the discourse of personal risk rather than that of susceptible prisoners or other prison staff.

**Attitudes to HCV: The ever present threat.** HCV was considered an important issue by prison officers and nursing staff. While both groups indicated some understanding of the infection risk, harm reduction activities initiated by officers were primarily focused on the potential threat of prisoner-to-staff transmission. No officers commented on the risk for prisoners, with one officer explaining that prisoner safety was assumed to be the responsibility of health staff. Reinforced during their initial training, officers considered all inmates to be infected and employed self-protective strategies to reduce disease transmission. While not part of formal protocol, for example, officers reported routinely wearing three or four pairs of gloves and protective goggles for cell inspections, when ‘patting down’ prisoners (undertaking personal security searches) or when attending crisis situations involving blood exposure—such as self-harm incidents and altercations.

Yes, [you] assume that everybody, absolutely everybody has hep C, and AIDS and everything else . . . you just assume everybody’s got it.

It’s more about precautions for ourselves than it is about concern for prisoners, because I think, there is an assumption that the prisoner health services educates them . . . about that . . . my focus isn’t really on them it’s more on universal precautions for ourselves.

**Awareness of inmate HCV status: Knowing the enemy.** The requirement to maintain confidentiality necessarily restricts the relaying of prisoner health information, yet the self-defense approach of officers to HCV harm reduction was further reinforced by officers not feeling fully informed about the infection status of prisoners. Some officers relied on individual prisoners informing them of their status with respect to blood-borne viruses, sometimes in a manner that potentially reinforced their fears, or legitimized their cautious approach:

I’ve actually found prisoners are pretty upfront about it . . . [they tell us] “you’d better watch yourself, I’ve got hep C” . . . especially on escorts when we’re handcuffed to them . . . I’ve had a couple of guys say “you might want to put a towel there” because I’ve got exposed arms . . . They’re like “you might want to put something between us because I’ve got hep C.”

Conversely, others suggested they did receive informal advice about prisoner serostatus from nursing staff—often occurring when they were present at prisoner entrant health assessments. For example, one officer stated:

Every time we do look up the inductions [admitting prisoners], it’s hep C, hep C, hep C—the majority of them [have] hep C . . . The nurses, when they [prisoners] come through . . . they just sort of say he’s got . . . you know . . . we can be aware that they’ve got it.

The seroconversion window is known to be long in HCV, with the appearance of measurable antibodies in the blood being delayed for up to 6 months following exposure (Pawlotsky, 2002; Widell et al., 2002). Furthermore, circulating HCV antibodies may remain after the viral infection has resolved (Pawlotsky, 2003). The risk posed by a given prisoner was determined by HCV antibody assay, the test offered to prisoners at entry. The possibility of infection (and therefore transmission risk) in the absence of a positive antibody test was not raised by either group, nor was the potential for overstating the transmission risk posed by prisoners a proportion of whom may have cleared the virus.

**Knowledge about HCV: The ‘known unknowns.’** Although officers took precautionary measures when working with prisoners (i.e., treating all situations as high risk situations), most were unclear about the proportion of prisoners infected with HCV and the precise nature of the risk this posed. When presented with recent HCV statistics collected from SA prisons, many of the officers indicated their surprise that prevalence of HCV in prisoners was as high (40% of males and 66% of females—Miller et al., 2006).

I didn’t realise it was that high. I knew it was fairly high, but I didn’t think it would be that high.

It is a little bit surprising, exactly why are the females, especially when our prison population of females, not here at the [male only prison] but . . . females are so low in our population stats, I mean I’m thinking, I’m surprised that they are a lot higher—I mean they are twenty percent higher.

For some, however, the information confirmed their impressions and served to reinforce their perceptions of risk. It doesn’t surprise me . . . So it doesn’t surprise me that those numbers or percentages . . . because we, every time we do look up at the inductions, it’s hep C, hep C, hep C—the majority of them hep C, that come through or infectious disease.
We all look at the case files and we actually get the prisoner list and we can see by the prisoners whose got contagious disease, so I actually knew it was going to be high.

Because we don’t need it [the information]. Cause we assume everyone’s got everything.

Notably absent from officer interviews was discussion of the implications for prisoner health and welfare despite the high prevalence of HCV in the prison setting. There was no discussion about the increased risk for susceptible (HCV negative) prisoners.

Given their professional education and workplace setting, prison nurses were confident in their knowledge of HCV and other communicable disease. They stated they were not surprised by the provided statistics proposing around a 40-fold increase of HCV in prison populations relative to the general population. They were also aware of the heightened transmission risk in the context of high background prevalence:

We’ve been aware of hep B and hep C for a long time now, so it’s just been a further extension of the awareness threat we’ve already had I guess.

Everyone . . . [is] high risk . . . even if someone comes in and has a negative screening that could change at any time during their stay here.

While HCV was the main focus of this investigation, other communicable diseases were seen as a more important issue. Concern was expressed about a range of parasitical, fungal, and bacterial infections (including scabies and gastrointestinal infections) in prisoners—particularly the transmission risk posed to officers. The possibility of passing on influenza to family and friends was frequently raised.

Officers discussed recent changes to the hepatitis B and influenza vaccination entitlements for correctional staff, which were no longer offered routinely in the workplace. Hepatitis B vaccinations were reimbursed by the Department, but officers needed to arrange the three required vaccinations from their own general practitioners (GPs), which was seen as substantial barrier to complete vaccination:

People don’t have time to do that . . . we had a . . . system in place before that was very effective . . . and the staff were actually, were very proactive with it. Now I would say that there are people who wouldn’t even know where they are up with, with their actual inoculation with hepatitis B.

I mean . . . you know to me, it’s almost like “Well, we don’t care about you officers. Our main concern is the prisoners, but we don’t care about the people looking after the prisoners.”

Officers expressed resentment about changes to the influenza vaccination schedule which meant that officers not meeting priority vaccination criteria would have to contribute to their cost.

Why can’t the officers get the influenza shots for free, or their hep B? Why do we have to pay for it? . . . We are just as vulnerable here for that. And . . . the other thing that’s on all the officer’s minds at the moment is the bird flu. Now . . . are we going . . . to be inoculated for it? If prisoners are all going to get it, what about the officers? You know, these things are running across our minds.

While nurses did not express concern about communicable diseases in general, the prison officers appeared to be highly concerned about this issue, with many expressing their fears about contracting an infection of some type along with what they perceived as limited education and insufficient hand washing facilities for staff.

The provision of an alcohol-based hand gel was frequently proposed as a solution to a problem that appeared to represent a source of ongoing resentment:

I also think around prison . . . there’s a definite lack of hand washing facilities . . . So you just end up, you just don’t wash your hands half the time. Whereas if it was there [hand gel], I know damn well I’d wash my hands a lot more.

Hepatitis C is not really that contagious—it’s blood-to-blood, right? So . . . I’m more concerned around here with other skin diseases and things like that and I’d like to see . . . like all medical sectors have that . . . like the gel.

Update on training . . . I think that’s a huge thing that we don’t get here. And . . . some more, easy, convenient way of washing your hands. So . . . that’s always been an issue for me . . . go downstairs and hold onto a stair rail and then you get to the bottom and think “oh, how many hands have been on that rail,” you know?

**Existing Strategies to Minimize HCV Transmission**

Prison officers and nursing staff described a limited set of strategies they used to minimize HCV transmission. In all cases, these were barrier strategies aimed at self-protection and no strategies for minimizing transmission among the prison population were nominated by either group.

**Formal Protocols and Individual Protection: Fear, Power, and Resentment**

Officers were typically confident in the efficacy of the authorized and voluntary preventive measures routinely used as part of their operative duties, yet noted that occasionally the urgency of a situation increased their risk of exposure to HCV and other diseases. It was acknowledged that in such cases, officers were obliged to respond to the emergent situations with less caution:

I think that we have the ‘blood protocol’ in place and we all know what we have to do. The only problem is we have . . .
instances where you don’t have time to put the gloves on . . . I had an instance where a guy came out of the cell from an unlock [formal time for unlocking cells] and he slashed up [cut himself deliberately] whilst doing the unlock. He then took the blade and went for his neck. Now I thought “I’m not going to run away and go and get gloves on so I can grab him” . . . if he actually cuts the neck and blood spurts everywhere its . . . more danger anyway—so I literally grabbed him [without protective gloves].

In the event of such situations, prison officers might follow the ‘blood protocol’ set out to establish disease transmission and serostatus. On exposure to blood or other bodily fluids, serology tests are immediately conducted and then followed up with further tests at 3-month intervals. As the protocol is initiated on slightest suspicion, almost all of the officers had some direct experience of the process and suggested that they were clear on procedure and held it in serious regard. As stated by the officer involved in the above incident:

I did the blood protocol . . . I had the blood tests . . . and that was that . . . it definitely put a different perspective on my sex life at home.

Some of the officers stated they felt unsupported in such circumstances when experiencing anxiety associated with the prospect of being infected. The testing schedule takes 6 months to rule out transmission, leaving officers feeling ‘in limbo’ before being ‘cleared,’ as described by one officer:

I had blood protocol . . . there was no counselling support . . . no intervention from management, no nothing. It was just ‘well, take time off, come back when you’re ready’ . . . I think to send somebody away from work for a period of time and not provide them with any support in the meantime, then all you’re going to do is go home and think about it.

Nursing staff were also cautious when treating and screening prisoners, and discussed their strict adherence to ‘universal’ precautions (the guidelines also known as ‘standard’ precautions) as the main strategy used to reduce the possibility of HCV transmission.

Well it’s [universal precautions] something . . . that’s drummed into you at training, you know, from day “dot” really.

The previous statement suggests early legitimizing of their subsequent concerns and fears. Similar to prison officers, nurses focused their discussion about HCV transmission on self-protection, with no reference to harm reduction principles in relation to prisoner welfare. There did not seem to be a sense of coordinated effort in regard to prison-wide infection control, as the following conversation highlights:

We don’t know what happens [with laundry stained with bodily fluids]. We’ve got those big blue bags haven’t we?

The yellow ones, yes. Anything with blood or anything like that is bagged into a yellow bag automatically . . . they dissolve in the laundry, so the guys over there don’t have to touch it.

Yeah, I’m not familiar with what they do . . . only our side.

All SA prisoners were required to undertake a health assessment on entry to prison at the time of the study. The assessment, which was predominantly conducted by nursing staff, was designed to identify most physical and mental health problems (as well as drug dependency) and included referral to the prison opioid replacement program where indicated. During the assessment, nurses provided information pertaining to HCV and other blood-borne viruses, highlighting the heightened risk of HCV in the prison setting and providing information on minimizing transmission risks. This essentially consisted of advising prisoners not to inject while in prison. Nursing staff suggested, however, that the importance of any information provided at this time was likely to be overlooked by prison entrants given the competing priorities of the admissions process and the emotional trauma associated with being newly incarcerated. As one nurse commented:

From the moment they hit the place they’re actually being confronted with information. But, sadly, that’s not the best time, because they’re stressed, they’re frightened . . . sometimes they’re just too concerned with their drug withdrawals at that stage to listen to anything you’re saying anyway.

Despite the high HCV prevalence in their working setting, the nurses provided little insight about their knowledge of, and practice related to, HCV-infected prisoners. Neither did they comment on strategies used to reduce transmission of HCV among prisoners other than the information they provided at entry. Prison officers and nurses did not appear to regard each other as theoretical ‘co-workers’ in relation to prisoner management. They did, however, appear to share a similar sense of detachment from prisoner welfare in relation to HCV.

Response to Proposed Harm Reduction Strategies

Discussion on the proposed harm reduction strategies focused entirely on their impact on officers rather than the broader aim of reducing HCV transmission in prisons. In all cases, the strategies were considered in terms of the risk they might pose to officers (including loss of power and control) weighted against the privilege they might represent for prisoners.

Overwhelmingly, the officers expressed a feeling of being threatened by any action that would provide prisoners with an opportunity to challenge the hierarchical structure
within the prison setting. Once more, there was little consideration about broader harm reduction aims which might provide prisoners with an environment that demonstrated welfare concerns for their physical, emotional, and mental health.

Despite their level of education and attainment of competencies required for professional practice, nurses did not refer to their ‘duty of care’ toward prisoners or to the human rights of prisoners through ethical practice (Fry, 2007). In this sense, there was little to separate the dialogue of nurses and prison officers.

**Strategy 1: Bleach provision.** The provision of household bleach to prisoners to clean syringes and other injecting paraphernalia has been introduced in a number of prisons in the world, with no documented safety issues so far arising (Jürgens, Ball, & Verster, 2009). The idea of making bleach available in SA prisons, however, was not received favorably by prison officers. Officers perceived bleach as a potential weapon that could provide inmates with an advantage in the prison environment. The key concern lay with the potential transfer of power from officers to prisoners, by means of presenting various opportunities for exploiting the intended uses for the chemical. Providing bleach to help reduce HCV transmission left officers feeling compromised:

I don’t particularly like the idea of giving them any sort of chemical. Bleach is a pretty strong chemical . . . I don’t want to wear it in the face. Anything you give to prisoners can become a weapon.

The odour of bleach will actually mask so many other things . . . I think it would be very detrimental to the whole environment here in prison.

The potential benefits of the strategy for minimizing hepatitis C transmission were not explored. Proposing provision of bleach to prisoners, despite the aim of the strategy, could be rejected on the grounds that it was against the rules—which seemed to underscore the apparently inherent legitimacy of the current position:

One of the substances is bleach, they can’t have because it’s not allowed.

It still would not be allowed even then because of the chance that it can be used against the officers.

Nurses also viewed bleaching agents negatively, suggesting that chemicals had the potential to be misused by the inmates to gain power:

I think they would be more likely to use bleach as a weapon . . . They can use it as a weapon . . . throw it in the eyes.

**Strategy 2: Safe tattooing programs.** In an inquiry into HCV-related discrimination in New South Wales (NSW), the NSW Anti-Discrimination Board (2004) specifically recommended that the means for sterile tattoo application be provided to prisoners. This could be accomplished by allowing visits from commercial tattooists, or by providing adequate infection control education to prisoners and supplying single-use ink ampoules and access to autoclaves. In describing a successful pilot for a safe tattooing scheme in a Canadian prison, Levy et al. (2007) stated that, in addition to improved infection control, the program benefits included “better control of tattooing equipment and enhanced education opportunities for both inmates and staff.” Neither commercial tattooing sessions nor training of prisoners was supported by prison officers. These strategies represented a test of power relations within a context of almost universal feelings of being undervalued within their workplace and by the broader society (as exemplified in the first of the following quotes):

And I think if . . . you speak to anyone out of our unit . . . you’ll find . . . that you have, at the same time as you have police, teachers, people who are always getting pay rises . . . when it came to us no one wants to know us.

We subsidise their drugs, we subsidise their living . . . Tattooing is a recreational thing—why should we subsidise, why should we? They’re in jail for what they do to society.

It just seems . . . they want, want, want and we give, give, give. There’s no stopping it.

This strategy was again interpreted as presenting opportunities for abuse and providing prisoners with weapons to gain power over the prison staff. The resentment also extended to the proposition of providing training opportunities for prisoners and allowing them to apply tattoos to other inmates. Officers strongly opposed the provision of any prisoner ‘liberties,’ as this strategy was widely perceived.

You’ll generally find the Department’s easier to say “Yes” and “let’s show them how to do it,” right? Because that’s the easy way around, instead of saying “no, this is not acceptable behaviour.” So instead of rewarding by giving and encouraging it, do their bloody job and say “no.”

The training of prisoners to improve vocational skills and development was also not accepted by the nursing staff who perceived a greater risk to other inmates through being tattooed by unskilled and (potentially) unsupervised trainee tattooists. Nurses did not draw on prisoner privilege as a reason for dismissing this strategy, presenting here a point of difference in attitude to prison officers. Overall, the notion of having prisoners conducting tattooing was principally rejected on the basis of increased risk for skin infection:
Prison officers strongly rejected any provision of needles and syringes, whether on request, as part of an exchange program or through the establishment of a safe injecting room. Again, the officers identified concerns regarding inmate privileges and widespread concerns about providing prisoners with potential weapons. Discussion of this strategy highlighted officer fears of being undermined by inmates, and again underscored how such harm reduction strategies were viewed exclusively from a power paradigm. A safe injecting strategy raised additional issues for officers in regard to the moral appropriateness of this intervention, particularly as they perceived their role to be a role that supported the punishment of illicit drug users:

The system works for us . . . at least while we [can] say “No” . . . we rarely find a needle—very rarely . . . [it is because] they are hard to get in. If you had them on exchange—God knows where they would hide them.

That means we are condoning drugs within the system. And I am totally against that.

At the moment needles are like gold. If they start getting needles, that becomes a weapon. That’s straight away giving them weapons.

Safe injecting programs in the prison system, of any type, were also firmly rejected by the nursing staff. Rather, strong support was expressed for the opioid replacement program (the only established harm reduction program in place in the SA prison system at that time), as an alternative to continued illicit drug use.

But then when we’ve got other programs in place to take away that whole needle problem. You know we’ve got methadone, and your [buprenorphine], I think we should be pushing that.

In contrast, prison officers commonly expressed significant doubts about the usefulness of the opioid replacement program, with suggestions that the program was being in appropriately targeted and monitored:

I don’t agree with . . . the methadone program . . . Cause there’s too many on it. We had our count the other day—you know there’s nearly four hundred prisoners here and eighty five or something, ninety of them . . . on methadone.

Methadone, no I don’t [agree] either . . . You know, we’ve got crims coming in clean, coming into the jail clean, and I know this is happening . . . They’re coming in totally clean. Other crims are saying “this is good shit, let’s sign up.”

They cough it [methadone or buprenorphine] into their clothing or their hands . . . there’s lots of ways they can . . . go through a lot of trouble to get good at, you know.

That’s what I think is our big problem with our . . . methadone program. If the methadone program was actually run and backed up with . . . full on support and education I think we’d have a lot more success than what it does . . . as it is now . . . they’re just getting a buzz throughout the day.

According to the nurses, the magnitude of this problem was greatly overestimated by prison officers, as one nurse explained:

You hear those stories all the time at all the prisons and I guess it all boils down to they don’t just go straight on. They’re assessed, and they’re very thoroughly assessed. Certainly there’s some get through the net . . . And there’d be very, very few—I’m not saying there’s none, but there would be very few.

In agreement with the officers on providing injecting equipment—and in strikingly similar language—nurses were concerned about the possibility of condoning drug use and suggested the provision of any needles might compromise prison officer safety.

Well the main issue becomes a safety issue for officers. At the moment . . . needles and syringes that are around are worth their weight in gold, because there are so few of them . . . so there’s no way they’re gonna be wasted by threatening you . . . and if all of a sudden you can get your hands on them relatively easily, they’re not worth that much more, so they might be used as a [weapon].

It’s more or less condoning drug use . . . So it’s banned on the outside, you come to prison . . . It’s almost like . . . we’re saying what you’re doing is OK.

Strategy 4: Education programs on HCV and other communicable diseases. Overall, there was a more positive reaction to the strategy of providing improved education programs and training around HCV and other communicable disease, particularly for prison officers. Officers and nurses, however, lacked a shared understanding of what educational opportunities were already in place for prison staff. Perceptions of what regulatory steps were required to protect staff and inmates in promoting harm reduction were unclear across the two operational sectors. Similarly, nursing staff and prison officers were not aware of the procedures each group implemented to reduce HCV transmission risk.
Officers suggested that, beyond their initial orientation training, little continued education on HCV and other communicable diseases was provided. Opportunity to attend professional development sessions was apparently restricted due to a shortage of staff to cover prison operations at any one time. Thus, attendance was subject to staffing rosters and prison regulations regarding staff prisoner ratios:

You get [staff education] when you first come into the job and . . . you’ve got these blue gloves about the place reminding you all the time . . . it’s just an automatic reaction that you reach and put gloves on. You’re grabbing gloves and items to make sure you’re hopefully protecting yourself. It’s always there . . . so you tend to be educated all the time.

The problem is we’ve got is we have such a turnover [of staff]. And we have training days every four weeks, and in six years I’ve had three days of training.

The provision of education to prisoners was discussed briefly, particularly in reference to prisoner literacy, but not otherwise in depth. It is possible that this was due to a general belief that the provision of such education was primarily the role of health staff, as well as a lack of clarity about the information that was or should be provided to prisoners.

I think it [further education] would be very good, because my understanding is what prisoners get in the way of education now is only when they go and see a nurse or doctor here. They’re not given any literature as far as I’m aware.

I don’t know what the doctor or the nurses tell them, but on their induction interview the last thing that they sign is a form saying that they won’t share needles, syringes, toothbrushes and razors . . . shaving equipment. And we tell them to assume everyone’s got hep C . . . but I don’t know what happens on the . . . medical side.

Raising awareness of HCV and other communicable diseases was the one strategy accepted by officers to reduce harm in the prison environment. As identified previously, however, responses to the strategy tended to focus on ways in which the strategy worked toward the protection of correctional staff, with little attention given to reducing HCV transmission in general.

Education and information sessions were welcomed by nursing staff as an important strategy to raise awareness of HCV among prison officers and inmates. There was agreement among nurses that health staff were adequately informed and routinely updated on HCV and other communicable diseases. As noted previously, nurses questioned the approaches used to disseminate HCV information on admission to prisoners. While the officers clearly saw information provision as the role of health staff, there was evidence that some nurses assigned that responsibility to the prisoners themselves:

There’s plenty of literature around and things like that . . . but I suppose it’s the enthusiasm of individual prisoners. If they want to seek it, they’ll seek it—they’ve certainly got access to it.

It’s discussed on admission with each prisoner . . . generally when we talk to them they’re pretty au fait on what you’re supposed to do . . . they know, it’s whether or not they stick to it.

But they’re all made aware. They all know when they come in . . . they’re all adults, at the end of the day they’ve got to be responsible for what they do when they get in here . . . to put themselves at risk . . . well that’s a choice.

There were few formal structures described to provide ongoing education or HCV information to inmates. Nursing practice was apparently restricted to the provision of clinical care in the infirmary with little if any responsibility for health promotion within the broader prison environment. With the exception of routine information provided at the initial assessment, discussion about HCV-related issues occurred primarily when initiated by the prisoner themselves. Nurses attributed a lack of knowledge among prison officers with respect to HCV and other communicable diseases, which they believed was expressed in a tendency to overreact to assumed risks associated with some situations:

Obviously, we’re not getting enough of their story . . . saying these things, [there is a] misunderstanding of infectious diseases.

They’re almost at the opposite extreme . . . we had that one last week when a fellow slashed up and they came in with the white suits.

Discussion

The interviews raised many concerns about the prison work environment, roles and responsibilities of staff members. The topic of HCV harm reduction was overshadowed by what appeared to be deep rooted societal values and attitudes of prisoners and punishment. Thus, the notion of power and privilege was threaded throughout the statements and conversational exchanges within the transcripts. Such ideals essentially frame the context in which HCV harm reduction strategies are potentially implemented, yet prison staff (prison officers in particular) appeared loathe to present views on such matters. Where prisoner duty of care is positioned by prison staff should be understood in this context.

The prison officer interviews revealed widespread feelings of being undervalued and resentment about increased pressures in the workplace, combined with perceptions of inadequate resources and staffing levels. Officers felt ill equipped to deal with what they saw as increasing prevalence of mental health and drug-related problems in the prison population. Some of this may have manifested in a tendency to stereotype prisoners negatively. Nurses too demonstrated considerable frustration about the increasing
prevalence of drug-related harm in the prison setting. There was a lack of integration between nursing and correctional staff with little awareness of the others’ roles, duties, and concerns.

Nurses and prison officers perceived hepatitis C as an important issue in their workplace. Prison officers did express greater concern about the potential for HCV transmission; however, both groups were confident in the effectiveness of ‘universal precautions.’ While hepatitis C was the main focus of this inquiry, it was clear that prison officers were as, if not more, concerned about a range of microbial agents—with fear of transmission of disease to family and friends commonly expressed. Improving access to appropriate hand washing facilities, including the provision of alcohol-based hand washing gels, were among strategies proposed and commonly supported by officers.

The ‘blood protocol’ was a common experience among officers and most reported a lack of departmental support during the relatively lengthy waiting periods between follow-up tests. At the time of the interviews, requirements for officer co-payments for influenza vaccinations and self-directed GP attendance for the hepatitis B vaccination program had been imposed. Prison officers expressed resentment about these perceived barriers to complete immunization—particularly given prisoner vaccinations programs remained intact.

Nurses expressed confidence in their knowledge about HCV and other communicable diseases. Conversely, officers frequently expressed the need for ongoing training and education and were concerned about their current level of understanding. The conviction that nurses were providing opiate replacement therapy to prisoners who had entered ‘clean’ was widely voiced by prison officers. Nurses described the ongoing assessment processes followed to ensure only opioid-dependent prisoners entered the opiate replacement program, yet these processes were not generally known by prison officers. Prison nurses were unaware of restrictions to the officer vaccination program, another major issue for prison officers. It seems a more integrated approach to prisoner management will be required if the well-being of prisoners is to be improved in future.

An increase in HCV education programs was the only proposed strategy accepted by the prison officers and nursing staff. Overwhelmingly, officers perceived the introduction of bleach, subsidized commercial tattoo application or inmate training in tattoo application, and safe injecting environments as a threat to officer–prisoner power relations and a means of providing privileged conditions to inmates. Such views were reinforced by a hierarchical system apparent in the prison environment. The proposed strategies were perceived to represent an undermining of their role and status. In particular, they were threatened by a loss of respect from the community for working in an environment that benefited prisoner privilege. Officers voiced concerns about perceived entitlements they felt had been eroded in recent years, such as staff hepatitis B and influenza vaccinations. The notion of shifting power relations compounded by strategies that were perceived to favor prisoners served to confirm to officers that they worked in a system that had little regard or value for their responsibilities and the high risk environment they existed within.

The context of power struggle and ongoing resentment colored the officers’ assessments of the harm reduction strategies proposed. Hesitation to engage and discuss strategies regarding health and prisoner welfare appears to have been driven by widespread perceptions that such topics sat outside of their working role. Thus, there was a tendency to refer back to their position rather than engage in the discussion with confidence to declare authoritative comment.

The remaining strategies, rejected for their perceived threat to staff, also drew on the power relations and employee hierarchy of the prison setting. Prisoner privilege was perceived as an indictment on prison officers as they regarded their role as important in the upholding of community values and, thus, resented any intervention that appeared to reward prisoners. Changes to the officer vaccination program and limited education opportunities were perceived as a lack of support for improving officer working conditions and safety. It is possible that this might further exacerbate resentment of prisoner ‘privilege’ by lowering officer self-esteem and respect for the correctional system and governance.

Given this context, it is not surprising that officers were strongly opposed to HCV interventions that have the potential to improve prisoner welfare. Although nurses did voice concerns about the threat of skin infection and scarring in relation to tattooing, they also tended to demonstrate reduced interest in the welfare of inmates overall, inferring that prisoners were disinterested in the health and safety of fellow prisoners. There was little evidence that nurses perceived a duty of care toward their clients as might be ordinarily expected of nurses in other clinical settings. It could be concluded that such attitudes are representative of the context in which prison officers and nursing staff work. The tensions and high risk environment in which staff need to respond and make immediate decisions have the potential to drain compassion and observance of a duty of care (Tewksbury & Higgins, 2006). Similar experiences of frustration and of being undervalued may have driven some degree of acculturation, particularly in what seems to have been the nurses’ selective adaptation and adoption of the value systems of the correctional workforce (Padilla & Perez, 2003).

The very high risk for hepatitis C in the correctional environment, for prisoners and prison staff, presents an urgent case for the introduction of further harm reduction strategies in this setting. Strategies such as the provision of bleach to prisoners and even a clean needle program (given successful international pilots) are worthy of serious consideration. It seems highly unlikely, however, that either of these strategies would be accepted within the context described here.
There has been widespread acknowledgment of the principle of providing prisoners with the same standard of health care available to the communities in which the prison is situated (WHO Global Programme on AIDS, 1993). As Jürgens, Nowak, and Day (2011) discussed, prisoners may lose their right to liberty but no other international human right and privilege. They stated, “The state’s duty with respect to health does not end at the gates of prisons” (p. 17). Yet, Australia, as with elsewhere in the world, has been very slow to adopt these guidelines (Bollini et al., 2002). Nonetheless, against profound political and community opposition, a prison-based pilot needle-exchange program has been approved in one Australian jurisdiction (Sweet, 2012). In introducing this pilot, the Chief Minister of the Australian Capital Territory (Ms. Katy Gallagher) has taken a very brave political step given almost unswerving adherence to the ‘tough on drugs’ mantra across the broader community. As Wodak (2012) stated, “More draconian approaches to prison are always expensive, rarely effective and often have severe unintended negative consequences. But draconian approaches are political viagra while pragmatic and effective approaches are often considered politically suicidal.”

It seems reasonable to assume that community values are shared by prison officers and nursing staff and would, therefore, color their own perceptions of preventive strategies within the specific context described.

We used a qualitative approach to explore the perspectives of prison staff in this study. Unlike quantitative approaches, the purpose of sampling is not to achieve representativeness but to explore a range of opinions. Thus, the sample size will differ depending on the issue and the various perspectives associated with it. Achieving ‘saturation’ is often put forward as the main criterion assessing the adequacy of sampling for qualitative interview—defined as the point at which no new themes or concepts are provided on an issue (Mason, 2010). This is a hotly debated criterion for quality, however, as the actual method of sampling and the intensiveness of the interviewing are also put forward as important modifiers in identifying the saturation point (O’Reilly & Parker, 2012). The 15 interviewees were self-selected and this may have limited the range of views expressed. Nonetheless, the participants were site-specific staff members who were not homogeneous with respect to age, sex, duration of employment, or role within the prison. This, in combination with the near consensus on a range of views expressed, provides some support for the adequacy of the sampling procedure used.

That the fieldwork for this study was conducted some time ago may be considered a limitation of this analysis. Participation in the interviews was facilitated by conducting interviews during work hours and on paid time. Yet, the need for arranging cover for their work roles increased the possibility that participants might be identifiable, and this formed a key reason for the delay in the secondary analysis. Yet, the context described remains relevant to the seemingly intractable position of SA Department for Correctional Services in relation to harm reduction approaches. For instance, a suggestion for the national implementation of the prison-based pilot needle-exchange program (discussed above) was strongly opposed by prison officers across Australia for the same reasons discussed in our article. Ruling out a similar pilot for SA, Department of Correctional Services of SA claimed it “would put staff and prisoners at risk because needles could be used as weapons” (ABC News Online, 2012).

**Conclusion**

As discussed by Mogg and Levy (2009), an impasse has now been reached between proponents of the provision of preventive resources (such as needle and syringe programs) and their opponents—where no amount of evidence supporting these resources in prisons can overcome the widespread conviction that needles and bleach could be used as weapons, and that their provision is tantamount to condoning drug use. As our analysis has demonstrated, the power and privilege paradigm fed by wells of resentment and frustration can only more firmly entrench this deadlock. Successfully commencing pragmatic dialogue about the need for further harm reduction approaches may ultimately depend on directly addressing these contextual factors. Improving officer education around communicable diseases, providing assistance to achieve appropriate levels of vaccination coverage, and generally promoting a more integrated approach to the management of communicable diseases and infection control by correctional and health staff may help to foster a more collaborative approach to future harm reduction strategies.

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