

“Inside” Healthcare and Recidivism: A Case Study of Gulu Prison

Introduction:

The International Committee of the Red Cross (ICRC), in partnership with the Uganda Prison Service, initiated pilot programs at three Ugandan federal prisons in 2008. This initiative aims to improve current programs for in-prison prevention and treatment of malaria, tuberculosis and HIV/AIDS. In addition, health workers at the district level are researching effective ways to track the progress of released inmates. Currently, the lack of communication between the prison and referral health centers creates challenges with respect to follow-up. Consistent with the Ugandan constitution and echoed in the National Health Policy, these ongoing initiatives understand access to basic health services as a fundamental right of all Ugandan citizens.¹

Providing released inmates with continuous access to care eases the process of reintegration and lessens the “anomie” or normlessness felt by individuals during the transition.² Although recidivism is a complex process involving various structural causes, scholars suggest that discontinued access to healthcare contributes to reincarceration.³ Understanding this relationship, the ICRC has recently implemented a program that encourages released offenders to return to the prison health center for treatment and general care. Given that 21.9% of the male inmates at Gulu Prison are infected with HIV⁴ and prison conditions of overcrowding and improper ventilation make these individuals more susceptible to opportunistic infections like

¹ The Republic of Uganda Ministry of Health, *The Second National Health Policy: Promoting People’s Health to Enhance Socio-economic Development*, 2010.

² Émile Durkheim, “Suicide: A Study in Sociology,” Glencoe, Ill: Free Press, 1951.

³ Vigilante, K.C. et al., *Reduction in Recidivism of Incarcerated Women through Primary Care, Peer Counseling, and Discharge Planning*, 1999.

⁴ International Committee of the Red Cross, *Health Pilot Project in Uganda Prisons: Quarterly Report III* (Gulu, 2010).

tuberculosis, continuous access to healthcare is even more pressing—both for the individual and society at large.

This project seeks to assess this recent initiative at Gulu Prison from the perspectives of both the inmates and health professionals. Medical workers from the ICRC and Uganda Prison Service are the primary respondents in this study. Clinical observations and information discussions add a framework in which to assess the qualitative data gathered.

Methodological Accomplishments and Challenges:

One major limitation of the original methodology was its use of a convenience sample. The health team at Gulu Prison, a federal prison in northern Uganda, was pinpointed because of their ongoing partnership with the Red Cross. While this decision allowed for clinical, hands-on experience, it simultaneously limited the study and the researcher's potential conclusions. One particular accomplishment involved increasing this sample size to six federal prisons in the northern region. I spent a week visiting these sites as part of a medical outreach with the regional director of health services. Understanding the differential services available has allowed for greater and more in-depth sociological analysis. For example, the process of transferring inmates on medical grounds to ICRC-supported prisons was particularly salient. The implications of these transfers add an additional dimension to the study.

The combination of qualitative data gathered in formal interviews and on-site, clinical observations has allowed for data triangulation. This was positive in the sense of adding a measurable “realness” to the data. On the other hand, it also led to various challenges. In June, two weeks were spent organizing and running a mass TB screening at the prison. This involves interviewing suspects, collecting sputum samples, testing the samples for the bacilli and examining X-rays. During those two weeks, research became secondary to the mass screening of

the roughly 800 male inmates at Gulu Prison. Even after the screening, striking the balance between formal research and clinical work was challenging. My role and the health team's understanding of that role were dubious at times. This was particularly evident during the medical outreach and visitations to other prisons in northern Uganda. At Pece Prison, I interviewed the nursing assistant who, as the sole health worker, is in charge of all health services. During the middle of the interview, she was reminded of a patient complaining of a sexually transmitted infection. Not able to diagnose the infection, the nurse called the patient into the room and asked me to investigate. This highlights two particular challenges: the difficulty of separating work and research, along with the challenge of asserting my role. Needless to say, no diagnoses were made and the health team (at least at Gulu Prison) agreed to cease using the name Doctor Greg.

As mentioned previously, observations in the clinic triangulated the qualitative data collected during interviews. Interviews were conducted with health professionals, while observations generally revolved around the inmates. Informal discussions with the inmates at times contradicted the information gathered from the health workers. For example, I visited the police holding center where alleged offenders are held before being sent to prison. During the interview, the clinical officer conceded that these individuals were kept in the cells for a maximum of 48 hours.⁵ While visiting the cramped, congested and excruciatingly hot cells, I asked the men how long they had been held at the holding center; I heard three weeks, four weeks, two months. This dilemma boils down to the difference between theory and practice. Theoretically, the accused offenders should be kept in the holding cells for no longer than 48 hours. What actually occurs in those cells, however, is quite different. Capturing the experiences of both professionals (through interviews) and inmates (through observations and informal

⁵ Clinical Officer, Interview by Researcher, Police Headquarters, Gulu town, Gulu district. 01 July 2011.

discussions) was challenging in that they oftentimes contradicted one-another. These discrepancies will be assessed in a sociological framework, which could shed light on the relationships between inmates and health workers.

Finally, where do you stop? The social issues encountered in a prison setting lead into one another in an almost “perfect” sense. Gulu Prison, with better resources in terms of healthcare, attracts transfers from other prisons on medical grounds. This leads to overcrowding and congestion, which, compounded by improper ventilation, lead to public health problems. This is one example of how inseparable these issues become. During interviews, problems of education policy in Uganda, the war in the north and the current economic crisis were mentioned. When these issues were introduced, it would feel as though the interview was getting too far from the medical and public health angles that were to be the focus. But these issues cannot be separated and when separated, are in some ways less meaningful.

Findings:

While general follow-up is explored in this study, particular focus is placed on the ICRC pilot initiative to invite TB patients back to the prison for care. One objective at the onset was to uncover the incentives that inmates have for participating in the program and that health professionals have for providing post-release care. Stigmatization as a prisoner is seen as one incentive to returning to the prison for care. Referral forms indicate that the individual spent time in prison. This, compounded by their current or recent infection with TB, leaves them vulnerable to rejection by community members and in particular, community health workers. Multiple respondents voiced the incentive of familiarity and comfort enmeshed in the ICRC program. Challenges to participation include transportation fees (a problem that has been ameliorated by financial incentives provided by the Red Cross), distance from the patient’s village to Gulu

Prison and asymptomatic cases in which the bacilli are still active, but symptoms are nonexistent. This leads many to default treatment.

Observations and the information gathered on site visits suggest that there are stark differences in the services available at each prison. At Gulu, the team is comprised of five nurses, one doctor, two clinical officers, one laboratory technician and one laboratory assistant. This serves a population of nearly 800 inmates. Conversely, there were 126 inmates at Pece Prison on June 24, 2011. This inmate population receives care from a single nursing assistant, who simultaneously works as a uniformed guard. Other prisons, like that of Maruzi, have no health workers and rely on the Officer in Charge to organize care at local health centers. In some cases, budgets and drug supplies are inadequate, forcing employees to purchase medicine for the inmates with their own resources.

Another fascinating finding surrounds the incentives that healthcare providers have for treating ex-prisoners. There is no monetary incentive to providing these services, but rather, it is seen as part of the job description. Many respondents mentioned the need to preserve the human rights of each inmate, which include access to adequate healthcare. But, in addition, the interviewees voiced a lack of faith in the legal side of things. Seeing corruption in the legal system and the unjust imprisonment of innocent individuals prompts many to provide quality care. One health worker noted that, based on his experiences, much less than half of all inmates actually committed the crime for which they have been incarcerated.

The prominent concern was not about the right to healthcare while in prison. It was more a dissatisfaction with the entire legal system and the question of *why* and *how* innocent people can be imprisoned. Forms of structural violence and their connection to criminal behavior were also mentioned during interviews. These connections and insights should redefine our

understanding of healthcare and human rights. It is not merely the right to health services and treatment of diseases. But true concern for human rights also involves looking at the structures that put people in situations that have the potential to harm their health.

Moving Forward:

This semester, I will be sifting through the data in a Directed Research course with my advisor, Mim Thomas. All recorded interviews will be transcribed and coded. The data gathered will possibly be used in a sociology honors thesis. I also hope to present my research at undergraduate research conferences throughout the year.

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