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Public Interest Ethnography: Women's Prisons and Health Care in California[1]

Rachael Stryker

Public interest ethnography is a branch of applied anthropology that has at least four goals: the study of people affected by public policy, an emphasis on the human consequences of public policy, the production of advice for policy makers, and the empowerment of those affected by policy. In this article, Rachael Stryker describes a public interest study she and six of her undergraduate students conducted in two California women's prisons. Made possible by a U.S. government suit designed to remedy poor health conditions in the California prison system, they conducted ethnographic interviews of numerous female inmates about their health care experiences. They discovered that prison rules and personnel delayed the provision of care, driving many inmates to treat themselves. Women convicts related stories about their health care experiences that revealed a mistrust of prison medical staff, a lack of

[1]Undergraduates Angele Alexander, Natalie Chriss, Kristen Darling, Erin Lucas, Johanna Paillet, and Ali Uscilka authored "Over the Wall: Women Insides' Perspectives on Health Care in California Women's Prisons," the ethnography on which this article is based. They did so in collaboration with Jane Dorotik, Sara Olson, Cynthia Purcell, Angelina Rodriguez, Mary Shields, Sherrie Smith, Silvia Vigil, Annabelle Chapa, and other women inside who have chosen to remain anonymous. Where requested, the names of women inside have been changed.

*prison sanitation and food nutrition, the consequences of severe overcrowding, the effects of poverty (co-pays were required) on gaining access to care, and the language barrier faced by the non-English speakers. The research team presented a list of recommendations based on their findings, several of which were incorporated in new prison regulations regarding prison health care.**

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"It only takes one bad incident," shared Nicole, a prisoner at Valley State Prison for Women in Chowchilla, California. She was explaining to interviewers why she abstains from contact with prison doctors. "When I feel sick, I go to my cell, kneel in front of the toilet, and pray to God to make me better." Nicole's fear of prison doctors began almost immediately after she was admitted to the prison in 2001. When she first arrived, doctors discovered during a mandatory physical exam that Nicole had high blood pressure. They then prescribed her medication. Unable to speak English in a prison with no translation services, she did not understand what the medicine was for or how it would affect her. After taking the pill, she said, she felt her "heart racing" and sought medical attention. Because of the language barrier, however, no one understood her concerns, and she began to scream in hopes of getting the medical staff's attention. Prison guards, believing she wished to harm herself, stripped and sequestered her for five days. While in isolation, she said, guards walked past her and taunted her. Fearing they might hurt her, she did not want to eat or drink what they gave her. Following her release from isolation, she says, medical staff and guards continuously mocked her. Nicole vowed never to see the prison doctors again.

Nicole's story is not an isolated incident: inadequate health care practices in her prison have been pervasive since it opened in 1995. And although the prison has been recognized as having some of the most advanced medical equipment and capacity in the United States, it, and others like it in California, have been consistently cited for substandard medical delivery, medical neglect, and unnecessary prisoner deaths, especially among those with serious or chronic conditions.

In the light of these problems, it was a common interest in using ethnography to positively impact health care delivery in California women's prisons that provided the seed for the Women's Prison Health Care Project at Mills College in 2006–2007. In collaboration with the San Francisco grassroots organization, California Coalition for Women Prisoners (CCWP), six undergraduates set out to write cultural descriptions of two California women's prisons to answer the questions: (1) What types of experiences do women have in the prisons when they become sick? (2) How do women access health care in the prisons? and (3) What, if anything, do women believe should be changed with regard to the prison health care system? In the process, students learned to use ethnography to render more than just a clearer view of the norms and mores of prison life; they illuminated ethnography as a tool for understanding power, for the humanization of the people involved, and for developing theoretical frameworks and practical protocols for improving people's access to basic needs. In short, they learned to write public interest ethnography (PIE).

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Ethnography and Public Interest Anthropology

What do we mean when we use the term *public interest ethnography*? The answer lies not just in the ethnographic content, but also in the ethnography's intent, context, and possibilities. There are many interpretations of the term, but public interest ethnography is commonly understood as a methodology and product shaped by the principles of the larger subfield of public interest anthropology (PIA). PIA is anthropology that has a problem orientation, that advances knowledge through attention to topics that large groups of people would likely to identify as important to their well-being (although not always, and that is some of its value), that makes clear the relationship between individuals and the broader society, and that expands democracy in the way the research is carried out, is made available, and inspires others.[2]

Put more simply, public interest ethnography is ethnography that might:

1. involve the ethnography of people who are affected by policy.
2. humanize those impacted by policy (and hopefully, policy makers).
3. inform policy.
4. inform the redistribution of power to those affected by policy.

A good example of PIA is also one of the first, carried out during World War II, one of the most prolific periods of applied anthropology in the United States. In 1942, President Franklin Roosevelt appointed several social scientists or "community analysts" to conduct ethnographies of Japanese internment camps that would help shape public policy around the issues of Japanese containment and eventual reintegration into post-war America. Earlier that year, under pressure from Western agriculture lobbies and some high-level members of the U.S. military, Roosevelt had ordered the removal and containment of some 110,000 Japanese-Americans within military camps throughout the western United States. Understanding the controversial nature of his decision, immediately after the order Roosevelt created a civilian agency—the War Relocation Authority (WRA)—to oversee the welfare of the evacuees. In an era that would come to be marked by intense public demand for repressive measures against Japanese-Americans in the name of military defense and national security, the WRA analysts wrote over eighty ethnographic reports or monographs, several illuminating internment as a human rights violation. The ethnographies, which ranged from such topics as Japanese cultural traditions to the results of segregation systems within the camps to perceptions of loyalty among Japanese-Americans, would eventually contribute to policy allowing the mass release in 1945 of those interned as well as the funding for government programs to ease interns' transition into civilian life.[3]

Today, anthropologists write public interest ethnographies to inform policy in a range of areas. Anthropologists document low-income residents' perceptions of production and consumption to reduce environmental pollution in their communities, write collaborative ethnographies with LGBTQ teens to better understand and reduce

[2]Peggy Reeves Sanday, "Opening Statement: Defining Public Interest Anthropology" (paper presented at the 97th annual meeting of the American Anthropological Association, December 3, 1998). Available: http://www.sas.upenn.edu/~psanday/pia.99.html

[3]Edward Spicer, "Anthropologists and the War Relocation Authority," in *The Uses of Anthropology*, ed. Walter Goldschmidt (Washington, DC: American Anthropological Association, 1979).

their suicide rates, and work with seniors to write oral histories to improve care for the elderly.[4] Wherever there is policy, there is an opportunity for an anthropologist to creatively use ethnography to influence it.

The Women's Prison Health Care Project

In the 1990s, growing numbers of unnecessary prisoner deaths led several families to bring lawsuits against the state of California to try to improve health care in a variety of areas, including dental care, women's care, HIV/AIDS treatment, custom care for disabled prisoners, and compassionate release. One of the most important of these was a 2001 federal class-action suit (*Plata* v. *Schwarzenegger*), which challenged the general quality of medical care in the state's thirty-three prisons as unconstitutional. The state settled the suit in 2002, agreeing to a range of remedies that would bring prison medical care in line with constitutional standards. However, the state ultimately failed to comply with the court's direction.

In June 2005, upon the discovery that despite the 2002 settlement, California's $1.1 billion-a-year, state-run prison health system was now producing a staggering average of one unnecessary prisoner death per week, Judge Thelton Henderson of the federal court of the Northern California District ruled that the California Department of Corrections and Rehabilitation's (CDCR's) prison health care practices violated the Eighth Amendment constitutional ban on cruel and unusual punishment. In April 2006, in an unprecedented decision, Henderson transferred control of the entire prison medical system from the state of California to his own federal court and named long-time Santa Clara County public hospital administrator Robert Sillen to manage the system as a federal receiver. Sillen's main task was to make appropriate changes to state prison health care infrastructure to accommodate immediate quality of care issues. His tenure as receiver would last until 2008 when he was replaced by lawyer, academic, and former California insurance commissioner J. Clark Kelso.

When Thelton ruled in 2005 that the CDCR would be stripped of its authority to determine issues related to medical care in California prisons, many prisoner advocacy groups saw it as a window of opportunity for prison reform. One of these groups was the California Coalition for Women Prisoners (CCWP), a self-defined grassroots racial justice organization that understands issues such as poor prison health care and unnecessary prisoner deaths as issues of institutional violence.

In January 2006, CCWP director and former prisoner Yvonne Hamdiya Cooks and I met at a Prison Issues roundtable in San Francisco, where she gave a talk that asked, "Given the new receivership, is it possible for female prisoners' voices and experiences to now influence large-scale prison health care reform in California?" I then gave a talk on the value of anthropology and ethnographic method for better understanding prisoners' perspectives on prison life. It was a pretty serendipitous meeting. Within a few weeks, six students in my public interest ethnography class began collaborating with the organization to clarify research questions. Students then worked with CCWP to develop open-ended, yet streamlined and culturally sensitive interview questions that would yield information about how women inside actually responded to illness and the prisons' protocols as well as their women's perspectives, if any, on how to improve health care delivery. In March 2006, CCWP familiarized students with

[4] Rachael Stryker, *Public Interest Ethnography: A Primer* (Walnut Creek, CA: Left Coast Press, in press).

the appropriate procedures, conduct, and dress necessary to enter two women's prisons in central California: Central California Women's Prison and Valley State Prison for Women (VSPW). Students each performed five to seven ethnographic interviews with women incarcerated at either prison. The team then collaboratively authored an ethnography based on the findings and presented their results to CCWP and the women inside. In late 2006, CCWP would also present the ethnography to receiver Sillen for his consideration.

Accessing Health Care in Women's Prisons

Interviews with the thirty-seven women highlighted a vast difference between the intent of California prison health care policy and the actual situation. Particularly, women access their health care in ways that are very different from how prison health care delivery is mandated. Amid what women often described as an elusive and unreliable health care system, they had to think and act creatively to access help and treatment. There are at least two different ways that prisoners access medical care at VSPW and Central California Women's Prison. The first is "formal care," which is nonemergency health care received by following the prison's official protocol. The second is "informal care," or care received without the aid of official prison medical staff.

Formal Care

When prisoners are admitted to either VSPW or Central California Women's Prison, they meet with counselors during a fifteen-minute orientation program and are given a Title 15, which is a document that outlines the rules and regulations for everything that happens in the prison, including health care. The orientation and Title 15 are only available in English, although some women mentioned that they had heard of, but never seen, a Spanish version. A new version of Title 15 is supposed to be published whenever prison protocol changes, but women are not given updated copies. In fact, some women didn't recall ever receiving a Title 15, and others said they had access to outdated copies that might be used for reference, but they might be useless, because the information had definitely changed. Since the brief orientation and Title 15 are not reliable sources of information for how to receive health care, many women inside often turned to one another. For example, when asked where she received information about health care, Annabelle, 36, said she asked her cellmates: "You go with the flow and learn by watching or asking." Especially for women who don't speak English, fellow prisoners serve as important sources of information and translation services. Said Sera, who spoke only Spanish, "for women like me, there are things that we just don't know."

Although there are protocols outlined in Title 15, what happens in the prisons often depends on which staff members are working and how they individually respond to a given health situation. As a result, women had different and conflicting ideas about how to navigate the health care system. Despite this fact, there were certain steps they needed to take to obtain the prison's formal care. The first was to fill out a "co-pay," which is a form with boxes to check for symptoms and a pain scale from one to ten. When a co-pay is filed, the prison automatically deducts five dollars from the prisoner's account. Prisoners who require health care, but who have no money in their accounts are not refused care, but these prisoners do accrue debt, which they slowly pay off with a prison job (paid anywhere from eighteen to sixty cents an hour) or if possible, with monetary gifts from family and/or friends outside the prison. After

filling out a co-pay, the prisoner waits to receive a "ducat," which is a form of permission to leave a room or normal activity for any reason, including a medical visit. This could take from three days to three weeks to receive one. The women prisoners' responses about the next phase of the procedure varied greatly. Some said they first saw a correctional officer (guard) and then a "Medical Technical Assistant" (MTA, a correctional guard with medical training) who took them to a nurse or doctor, while others said they went to an MTA or a nurse directly. Some women said they had to see a nurse before a doctor, and others said they never saw a nurse.

Informal Care

Since women perceive formal health care protocols as complicated, time consuming, and not always reliable, many women said that they preferred to practice informal forms of care. These included ignoring illness symptoms altogether, self-medicating, sharing medications with each other, or receiving medical care from fellow prisoners. For example, said Hilly, 28, "I'm lucky because [one of my cellmates] was a nurse before she was here. Well, not a nurse. But an EMT? Or trained like an EMT? She knows CPR and what to do if you break something. I dislocate my shoulder sometimes and she pops it in for me." If women are feeling desperate or a sense of urgency, however, they might decide to "fall out," or fake an emergency to get immediate medical attention. Mary, 55, explained the context in which women might resort to falling out: "It doesn't matter how sick you are [prison staff will not offer to bring you to the doctor without going through formal channels]. So, it's a matter of banging on the window of the medical department or passing out where the ambulance has to come and get you." Another reason for falling out had to do with the MTAs. According to many women, the MTA position was problematic: since MTAs' primary duties are correctional and not medical, unlike medical personnel, MTAs are not mandated to "do no harm" and to heal sick prisoners under oath. The custodial aspect of the position thus often trumped the medical aspect, leaving women in correctional units with illnesses and pain longer than they needed to be. Women thus fell out to increase their chances of being tended to more immediately by medical personnel rather than take their chance waiting on an MTA.

Experiences of Formal Health Care in Women's Prisons

What are some themes that characterize the quality of the formal care that women do receive in the two prisons? The most common word women used to categorize their health care experiences was *inefficiency*. All mentioned problems that had to do with the timing and organization of their health care.

Inefficiency

Perhaps the most frustrating experience in this regard, was the delay between the amount of time it took to get ducated after filling out a co-pay and the amount of time it actually took to see a doctor. Women stated that this was the primary reason that they used informal care. And as several women shared, this was usually the reason why anyone would decide to fall out. "It can take from three days to three months to see the doctor," said Sara, 60: "what would you do if you were in pain and you didn't know when you'd get relief?"

Women were also frustrated by inefficient treatment. For example, women sometimes waited years for treatments for simple infections that could be fixed with a prescription for antibiotics, or for necessary surgeries without which women were left for long periods of time in excruciating pain. Inefficiency was also a characteristic of treatment for other chronic, but less serious medical problems. Said Mary, a 58-year-old asthmatic, of her experiences with "the med line"(where women go several times daily to take medication in a supervised fashion): "At night, sometimes the line is so long, that ladies have to miss dinner. So you have to decide, are you going to have dinner or take your meds? Sometimes you have to choose dinner."

According to some women, the problems with inefficiency were not necessarily systemic. Rather, it was individual unresponsive medical staff that caused delays and problems. All women worried that prison medical staff were unqualified and lacking credentials to care for them (a fear flamed by the fact that medical personnel are not required to, and do not, post their credentials in the medical center). There was a general sense that prison doctors only worked at the prisons because they were denied work at other facilities. Many women also stated that medical staff often lost, forgot, or ignored women's health histories prior to incarceration when examining, prescribing, or treating them.

Mistrust of Prison Medical Staff

A second theme among the interviews was fear and mistrust of prison medical procedures and staff. As one woman stated, "Don't assume that everyone even goes to see the doctor. Because then you're not in touch with how bad it might be once you manage to get there." Aside from a basic fear of medical procedures themselves, as we saw at the beginning of this chapter, fear and mistrust of medical procedures can be exacerbated by such things as language barriers and insensitive medical staff members. Nicole's lack of comprehension about her prescription and its effects as well as the derogatory behavior of the doctors and guards created a snowball effect of fear and mistrust of medical personnel that was long lasting. Indeed, most women noted that they had experienced some form of verbal abuse or unwanted sexual advances at their medical centers. For example, Vicky, 45, shared a story about a doctor menacingly and inappropriately flicking her nipples while performing a routine breast exam. She also shared that women in her prison knew which doctors to try to stay away from because they commonly used sexually inappropriate language with, or inappropriately touched, their patients. And as some women noted, disrespect from medical staff might continue even after a prisoner dies. For example, Nicole shared the story of fellow prisoner Martha Fernandez, who had recently died in prison and whose burial was postponed because the prison took weeks to sign her death certificate and release her body to family members. In a similar vein, because little was done to update prisoners' families' contact information, women were also concerned about who the prison would contact if they died. Women thus regularly organized, exchanged, and updated family contact lists with one another to help create a system of family notification should any of them pass away.

Poor Prison Sanitation

In addition, women were very aware of the larger roles that poor sanitation, lack of ability to maintain their hygiene, and poor nutrition and exercise options in the prison likely played in their health trajectory while incarcerated. Women reported

that although the prison common rooms and family visiting rooms were kept fairly clean, most found their own living conditions substandard. Much of this was attributed to the fact that it was typical in both prisons for eight women to room together in one cell, which was a problem for several reasons. First, although women said that they were happy to clean up after themselves in their cells (and often wanted to), the prison did not provide an appropriate or adequate amount of cleaning supplies for them to do so. Said Josie, 32, "They should at least give us [dispensable] soap for our hands." In addition, with overcrowded cell conditions at the two prisons, it was of special concern to the women to keep their areas clean to thwart potentially dangerous effects of overcrowding on their health. As Sherrie, 50, stated, "HIV-positive prisoners and other prisoners with infectious diseases are not always housed separately. Because it is unclean inside, you never know what you are sharing with other prisoners and you need to just take their word that they're healthy." She also shared that overcrowding lent its self to hot tempers and physical fights, which resulted in exposure to blood and other bodily fluids. Finally, women shared that such close proximity sometimes lent itself to sexual relations as well. Since there are no sexual education programs at either prison, women inside are not taught about safe sex practices. They also do not receive supplies to help prevent the spread of sexually transmitted diseases.

In addition, women do not receive adequate or enough personal hygiene products. Although the prison supplies them with toilet paper, women said they usually run out quickly. Women who have money in their prison accounts can purchase toiletries, and women who have fewer than five dollars in their account receive a monthly "indigent package" or "fish kit," which includes three small bars of soap, two tubes of toothpaste, a razor, a small bottle of shampoo, laundry soap, deodorant, and 20 envelopes for personal correspondence. The quality of the products is poor, however, and usually not enough to last the entire month. The package also does not include sanitary napkins or tampons.

Poor Prison Nutrition

Several women inside were concerned about the quality of prison food. It was well-known among the women that lifers get stomach problems from eating bad food for so many years. Said one woman, "I try not to eat the food . . . I feel bad for prisoners that come back from eating regular food because they often have to run to the bathroom for diarrhea and stomach aches." Food is pre-frozen and then reheated, and there are few, if any, healthy options. Women with conditions such as diabetes who have special dietary restrictions are also not provided with the specific options they need. And although women with money in their accounts can purchase food at the prison canteen (store), there are no healthy options there either.

Women also fear about the prison's drinking water. Josie, 23, for example, expressed her and other prisoners' suspicions that some of the women's dental problems come from drinking unclean water, and said that some women refrain from drinking water altogether because they are worried about the health effects. This can result in serious stomach problems, because the only other beverages available are coffee with high caffeine content and juices with high sugar content. Another prisoner, Susan, recently had a serious kidney problem because she had been afraid to drink the water and only drank coffee. Linda said that although she knows that drinking water is an important part of staying healthy, she is afraid the water at VSPW will make her even sicker.

Women were also concerned about insufficient access to exercise facilities. Women prisoners have recreation time in the exercise yard, but yard privileges can be revoked as a form of punishment. There is an exercise gym available at VSPW, but it is often closed and has been used for storage, and is therefore inaccessible to the women inside. This restricted access to exercise, combined with poor nutritional quality of food, severely limits the extent to which the women prisoners can manage their own personal health.

Incurring Debt

Finally, women discussed the worry and anxiety they felt about the debt they often incurred as a result of medical treatment. Women prisoners have limited access to money and many of them are indigent. Many also enter the prison with a large amount of restitution debt that results from unpaid court fees and other legal expenses. As mentioned earlier, during their tenure in California prisons, prisoners are assigned "bank accounts," into which family members can deposit funds for prisoners to use for prison expenses or debt. When prisoners perform their paid prison work, however, the prison administration automatically garnishes any wages earned in the amount of 44 percent to pay restitution debt. This severely depletes their resources for health care provision and hygiene products, just to name a few prison expenses. Prisoners often feel that paying $5 to fill out a co-pay is a sacrifice. This sacrifice is compounded by the fact that women work in the prison facility for extremely low wages. As Linda explained, "We get paid eight cents in the kitchen and sixty cents in the laundry room." Thus a $5 co-pay represents almost a week's wages, so some women decide to avoid medical care as a result.

Using Ethnography to Inform Prison Health Care Policy

The Women's Health Care Project elicited several insider suggestions for improving prison health care:

1. ***Make Prison Health Care More Efficient***
   a. Provide regular checkups for prisoners
   b. Provide and educate about preventive care for prisoners
   c. Provide opportunities for posttreatment appointments with doctors
   d. Create better access to specialists in a timely manner, especially gynecologists, surgeons, and neurologists
   e. Consider and respond to women's specific health issues (i.e., gynecological, obstetric, and cardiac)
   f. Provide reliable transportation from prisoners' cells to the medical building, especially for disabled prisoners
2. ***Make Medical Staff More Reliable and Trustworthy***
   a. Hire more medical staff members, and those with a larger variety of specialties, especially dentistry
   b. Hire medical staff that is compassionate and competent, younger and motivated to heal
   c. Hire medical staff members that are respectful of women's bodies
   d. Mandate that medical staff members post their credentials at the medical center

   e. Eliminate the MTA position in favor of hiring prison guards who can also act as medical staff, to decrease response time to illnesses and emergencies
   f. Hire health educators
3. ***Increase Language Accessibility***
   a. Provide prison translation services
   b. Increase knowledge about, and respond to, differences in health care experiences between native English-speaking prisoners and prisoners who can speak little or no English
4. ***Improve Nutrition Options***
   a. Provide more balanced and healthier foods in the prison commissary
   b. Offer specific food options for people with diabetes and other health issues
5. ***Reduce Debt Accrual***
   a. Eliminate the co-pay necessary to access prison health care
6. ***Improve Sanitation and Hygiene***
   a. Decrease number of prisoners assigned to each cell
   b. Allow more access to basic supplies such as soaps and feminine products
   c. Provide sex education and safe sex supplies
7. ***Additional Recommendations for Improvements***
   a. Provide grief counseling
   b. Provide a broader array of health issue support groups

Outcome

In late 2006, receiver Sillen read the ethnography in full. He noted that some of the women's suggestions mirrored his own understanding of what would make prison health care more efficient. In particular, he was encouraged by women's understanding and concerns about prison overcrowding. He was also struck by the disparity of health care experiences between English-speaking and non-English-speaking prisoners and by the needless costs of language miscommunication. And like the women inside, he thought that the MTA position was not the most efficient way to manage women's medical emergencies. The women's concerns spoke to Sillen as an administrator: he understood their logic in terms of efficient labor practices and cost-effectiveness.

In 2008, Judge Thelton Henderson replaced Sillen with J. Clark Kelso. Before the end of Sillen's tenure, however, he increased the number and types of non-English translation services associated with medical care in all California prisons. Although a small step toward constitutionally adequate prison health care, it means that stories like Nicole's might be less likely to happen. Sillen also eliminated the MTA position; guards would now be responsible only for correctional duties, while nursing assistants would conduct triage in custodial units.

During J. Clark Kelso's tenure as receiver, via the work of CCWP and other prisoner advocacy organizations, the ethnography continues to help identify overcrowding as a serious, "bottom-line" issue for prison health care. In January 2010, a panel of three federal judges determined that overcrowding was the "primary cause" of inmates being denied their constitutional rights to adequate medical and mental health

care. They also ruled that the state must reduce prison overcrowding in California, and mandated the state to develop a comprehensive plan to reduce the prison population by approximately 40,000 prisoners. The state reluctantly developed a population reduction plan while Governor Arnold Schwarzenegger appealed the prison population reduction order to the United States Supreme Court, who agreed in June 2010 to reconsider the lower court's decision. The ruling, which will take place during the Supreme Court's October 2010 term, could mean between 38,000 and 46,000 inmates will be released from prisons around the state. From a prison health perspective, a favorable ruling will significantly respond to the concerns about overcrowding expressed by the women inside.

Conclusion

The Women's Prison Health Care Project illuminates the discrepancy between state mandates for prison health care and lived health care experiences of women incarcerated in California prisons. The project also provides a unique and up-to-date description of what constitutionally inadequate medical care to patient-inmates looks like, as well as its effects on prisoners and how prisoners cope. Particularly, it demonstrates that women prisoners must think creatively to access health care in the face of inefficiency, certain forms of discrimination, and insufficient access to resources. Women inside also have many ideas for how to improve their situations.

But like all good public interest ethnography, the project is doing much more than this. It is informing steps toward making constitutionally equitable health care in California prisoners a reality. It has helped inspire state administrators to link the personal experiences and stories of women inside to more efficient prison health care policy, encouraging more translation services for non-English-speaking prisoners seeking medical care, and eliminating what many understand to be one of the causes of delayed medical care and even unnecessary prisoner deaths: MTA positions.

Finally, the ethnography contributes to prisoner advocates' broader efforts to raise ever more public questions and concerns about prisoners' (lack of) access to resources basic human rights. As one woman incarcerated at VSPW put it, the ethnography ". . . shows not only what's happening, but . . . ask[s] people [in charge] to think about *why* it's happening. And make some change." Concerns about overcrowding in California prisons have now been elevated to the federal level. The ethnography thus contributed to larger grassroots and legal movements to make the poor quality of prison health care in California a public interest issue. In the process, it helped connect the micro to the macro, and the personal to the political, planting seeds for possibility and alternate futures.

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Review Questions

1. What is the definition of public interest anthropology and public interest ethnography, according to Stryker?
2. What evidence, based on this article, supports the utility of ethnographic interviewing for the construction or revision of public policy?

3. How did inmates' poverty affect their access to effective health care, according to Stryker?
4. What were the major impediments to effective health care revealed by the stories told by inmates?
5. What recommendations did the ethnographers make to California authorities concerning the provision of effective prison health care?
6. What strategies did inmates employ to treat problems with their health?