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RESEARCH PAPER

'Behind closed doors, no one sees, no one knows': hepatitis C, stigma and treatment-as-prevention in prison

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ABSTRACT

The recent advent of new, highly effective, direct-acting antivirals (DAAs) is dramatically reshaping the hepatitis C virus (HCV) treatment landscape and prisons are set to play an important role. While there is a substantial literature addressing the centrality of stigma to experiences of living with HCV in the community, including as a barrier to treatment, scant attention has been paid to documenting how HCV-stigma figures within the distinct sociality of prison life. This article focuses on initial, pretreatment interviews with prisoner participants (n = 32) from the first, real-world trial of HCV 'treatment-as-prevention' in prison: Australia's Surveillance and Treatment of Prisoners with Hepatitis C (SToP-C) study. Drawing on recent developments in stigma theory alongside Goffman's original insights, we posit HCV-stigma as a relational, contingent and political process, materialised across the network of power relations in prison. Participant accounts describe a complex picture, with reports ranging from those suggesting the 'normalisation' of HCV to those detailing the potential effects of HCV-stigma, including additional disciplinary attention from officers and/or the rejection from peer networks by fellow prisoners. While acknowledging the limiting effects HCV-stigma may yet have on treatment-as-prevention efforts, we speculate that with committed political leadership, operational investment, sufficient prisoner engagement, interventions such as SToP-C may also afford opportunities for such effects to be challenged, disrupted, and even left behind.

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Introduction

Globally, the burden of the hepatitis C virus (HCV) is disproportionately borne by those in prison (Dolan, Wirtz, & Moazen et al., 2016). Within the general Australian prison population, HCV antibody prevalence is estimated to be 22%, with that figure well-over doubling among those who report injecting drug use (Butler & Simpson, 2017). Of the 50,000 detained in Australian prisons each year (ABS, 2017), an estimated 70% are indicted for drug-related crimes (Yap, Carruthers, & Thompson et al., 2014) and almost half report injecting drug use (Butler & Simpson, 2017). While the higher prevalence of HCV in prison populations compared with the general population is primarily due to the criminalisation of drug use and the imprisonment of people who use drugs (Dolan et al., 2016), injecting drug use itself is now described as a 'normative characteristic' of Western prisons (Bonnycastle & Villebrun, 2011). And although rates of injecting are reported to decrease following imprisonment (Wright, Tompkins, & Farragher, 2015), the frequency of sharing injecting equipment increases – particularly in the widespread absence of prison needle syringe programs (PNSP) – thus significantly raising the per

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episode risk of transmission (Cunningham, Hajarizadeh, & Bretana et al., 2017). Yet, despite this unique risk profile and their designation as a priority population for treatment under the national HCV strategy (Australian Government Department of Health, 2014), estimates among eligible prisoners who have received treatment *while incarcerated* remain as low as 1% (Lloyd, Clegg, & Lange et al., 2013).

Nonetheless, in this new era of highly effective, direct-acting antivirals (DAAs) and the potential of treatment-as-prevention, prisons are anticipated to serve as critical access points (Hajarizadeh, Grebely, & Martinello et al., 2016). While the feasibility of treatment-as-prevention for HCV has been demonstrated in modelling work (e.g., Martin, Vickerman, & Grebely et al., 2013; Vickerman, Martin, & Hickman, 2011), its translation into real-world settings has yet to be tested. In many respects the controlled environment of the prison provides an opportune and advantageous setting for such a trial. This article analyses initial, pretreatment interviews with participating prisoners from the Australian 'Surveillance and Treatment of Prisoners with Hepatitis C' (SToP-C) study: the first, real-world trial of HCV 'treatment as prevention' in prison.

One of the primary roles of the SToP-C qualitative component is to explore ongoing social barriers to treatment-as-prevention efforts. While the introduction of DAAs has undoubtedly removed many of the clinical barriers associated with interferon-based treatment, contending with the effects of stigma may yet prove crucial to treatment-as-prevention efforts (Brener, Horwitz, & von Hippel et al., 2015; Harris, Albers, & Swan, 2015; Northrop, 2017). Social research has consistently underscored the need to recognise the 'intensely social nature' (Harris et al., 2015) of living with HCV, positing that the meanings of events such as disclosure and treatment are necessarily embedded within the social and cultural dimensions of everyday life and relationships (Fraser & Seear, 2011; Hepworth & Krug, 1999; Rance, Treloar, & Fraser et al., 2017). While there is substantial documentation regarding the centrality of stigma to the experience of living with HCV in the community (Northrop, 2017; Treloar, Rance, & Backmund, 2013; Treloar & Rhodes, 2009), scant attention has been paid to documenting these experiences in prison.

Approach

Hepatitis C is a 'symbolically and materially potent epidemic' (Fraser & Seear, 2011, p. 2) widely stigmatised as a 'junkies disease' (Krug, 1995). It is well recognised in the scholarly literature that stigma constitutes a 'core feature' (Treloar et al., 2016) of living with the virus and that central to this stigma is its enduring association with the illicit practice of injecting drug use (e.g., Fraser & Seear, 2011; Harris, 2009). As Treloar and Rhodes (2009) argue, the '[s]ocial stigma associated with hepatitis C is often indistinguishable from stigma related to injecting drug use' (p. 1325). Within Western contexts, including prison, the presence of HCV routinely functions as a sign of, or *proxy* for, the presence of injecting drug use and the despised figure of the injecting subject (e.g. Harris, 2005).

Arguably, the most important development in the now considerable literature since Goffman's (1973/1963) classic work on the notion of a 'spoiled' identity has been the insistence social psychology and sociology has come to place on recognising the ineluctable relationship between stigma and power (e.g. Fraser & Dilkes-Frayne et al., 2017; Hatzenbuehler, Phelan, & Link, 2013; Link & Phelan, 2014; Parker & Aggleton, 2003). In this article, we are particularly interested in the influence of post-structural theory in reconceptualising this relationship. Parker and Aggleton (2003, p. 17), for instance, propose that reading Foucault's work on power alongside Goffman's (1973/1963) classic work on stigma offers a 'compelling case for the role of culturally constituted stigmatisation … as central to the establishment and maintenance of the social order'. Here stigmatisation is understood as a fluid, ongoing *social process* not simply linked to the production of negatively valued social difference (as stigma), but part of the 'political economy of social exclusion' (Parker & Aggleton, 2003, p. 19). In their investigation of 'addiction stigma', Fraser et al. (2017) similarly emphasise the political and processual nature of stigma. Drawing on Butler's (1993) insights into the political processes of normalisation, subjectification and the

production of abjection, they propose a re-conceptualisation of stigma as a 'performative biopolitical technology of power' (Fraser & Dilkes-Frayne et al., 2017, p. 4). Stigma is understood as a systemic and normalising process which simultaneously constitutes legitimacy and abjection, belonging and exclusion.

This emphasis on stigma as a *contingent* and *performative* process, rather than as a 'stable marker' (Fraser & Dilkes-Frayne et al., 2017, p. 2) of some form of anterior difference, is critical to our purposes. Defining what HCV-stigma *is* becomes less important than determining what it *does*: its *effects*. Within a post-structural framework, power is similarly reconceptualised: no longer repressive, nor the property of an individual or social class, but instead a relational and productive network that shapes subjectivities, produces truth and is generally constitutive of reality (e.g., Bacchi & Goodwin, 2016; Foucault, 1982). Here, the emphasis becomes one of power *relations* rather than power *tout court* (Bacchi & Goodwin, 2016, p. 28). Notwithstanding that the field of possibilities for exercising power in prison is inevitably circumscribed and underpinned by permanent disciplinary and governmental structures (e.g., de Viggiani, 2007; Foucault, 1979), foregrounding the relational nature of power is elucidating for our purposes. In this article, we conceive of prison as an integrated network comprising two relatively discrete sets of power relations: between prisoners and prison officers, and between prisoners themselves. We focus on the different materialisations and effects of HCV-stigma within these two local sets of power relations. In conclusion, we reflect on the role of HCV-stigma within the (re)production of prison sociality more broadly and the potential for its disruption in the face of the recent scale-up of public health, treatment-as-prevention interventions.

Methods

The SToP-C study is being run across four prisons in New South Wales, Australia, including one minimum/medium security women's facility, and three men's facilities (one minimum and two maximum). Recruitment for the first round of pretreatment interviews for the qualitative sub-study was conducted across all four prisons, with an equal number of participants (n = 8) selected from each site (total = 32 participants).

All participants had a history of injecting drug use (i.e. risk of HCV) and had been tested for HCV in the previous six months. Participants were recruited by study nurses working on site. Purposive sampling was used to ensure near equal representation of those living with HCV (RNA+) and without (RNA-). Prospective participants provided verbal consent to the study nurse before being called up to a designated interview area. Written consent forms were reviewed with each participant before signed consent was obtained. Participants were under no obligation to participate and were assured that non-participation in the qualitative component would have no bearing on their eligibility for the clinical arm of the study (i.e. treatment).

Interviews were in-depth and semi-structured, focussing on participants' experience or knowledge of, living with HCV in prison. Participants were asked about current and suggested strategies for HCV prevention; barriers and facilitators to HCV treatment; risks of re-infection; injecting cultures and networks within prison; age of initiation to injecting drug use and history of HCV. This article draws on interviews that were conducted prior to treatment roll-out in order to explore initial acceptability and perceptions of treatment-as-prevention among participants.

Interviews were audio-recorded, transcribed verbatim and de-identified. A coding frame was developed collaboratively by the authors, drawing on the data itself, the interview schedule, and on our knowledge of the relevant literature. A thematic heading entitled 'stigma' was included in the coding frame. Transcripts were coded using NVivo 11 qualitative software (QSR International, Melbourne). Coded data was then re-analysed for the purposes of this article. Our analysis was informed by data drawn principally from the 'stigma' node, plus relevant prison and stigma-theory literature. This process of informed coding and re-analysis has previously been described as 'adaptive coding' (Layder, 1988).

Ethics approvals were obtained from all relevant research ethics committees: Justice Health & Forensic Mental Health Network (G621/13); Corrective Services NSW (qualitative sub-study approval on 5 April 2016); and Aboriginal Health and Medical Research Council of NSW (1253/17). All extracts cited here are identified by the participant's pseudonym, most recent HCV test result, and the security classification of the recruitment prison.

Results

The 32 participants ranged in age from 24 to 59 years; 25% (n = 8) of whom were women. Recent tests indicated 16 participants were HCV RNA positive (i.e. chronically infected), 14 were RNA negative, and two were still awaiting results. One-third of male participants (n = 8) and over one third of female participants (n = 3) had previously completed interferon-based treatment. All participants reported a lifetime history of injecting drug use, with time since most recent injection varying markedly: from nearly three decades to the day prior to interview. The mean age of initiation to injecting was 22 (men: 19 years old; women: 24 years old). Slightly more than one-third of participants reported currently injecting drugs in prison (men: 33%; women: 38%); however, given the sensitivities around this issue this could well be under-reported. Fourteen participants were currently receiving either methadone (n = 12) or buprenorphine (n = 2).

This section begins with an overview of participants' accounts of HCV-stigma in prison and of the thematic similarities they share with reports from the general community. The following two sub-sections go on to explore the ways in which, commonalities notwithstanding, HCV-stigma is materialised with particular effects within penal power relations: firstly, between prisoners and officers, and secondly, between prisoners themselves.

Accounts of hepatitis C-related stigma in prison

Reports of HCV-stigma differed across the four prison sites. For some participants, concern regarding stigma dominated talk about the virus, including fears associated with both contagion – 'they think you can catch it from coughing' (Gus) – and social exclusion – 'he's got hep C, he's dirty, he's a junkie' (Gary, RNA^{-}, maximum). Marco, along with a number of other inmates, explained the importance of keeping one's infection secret, 'hidden', as a strategy to avoid the potentially stigmatising effects of being identified as someone living with HCV: 'A lot of people hide it. It's the same as in society, it's the same in here' (RNA unknown, minimum). Here Gus elaborates about 'the spectre of stigma hanging over your head':

> Having hep C is a bad stigma … straight away people link it to intravenous drug use … The stigma of hepatitis, I just want to get rid of it and be done with it … When [other inmates] find out you've got hepatitis … they don't want to be out with you [share a cell] … [You're] like a pariah. (Gus, RNA^{+}, maximum)

In keeping with our argument emphasising the contingent and provisional nature of HCV-stigma, while such reports were commonplace they were by no means uniform. Not all participants agreed that HCV-stigma was a matter of current concern within prison. Both Dennis and Tanya (below) maintained they had witnessed a diminution in HCV-stigma during their respective sentences, while Liam (RNA^{+}, maximum) minimised the fears associated with HCV via the commonplace trope that 'HIV is the bad one … the only thing everybody is worried about'.

> Hep C is more accepted now … it's not shunned like it would've been back in the day. (Dennis, RNA^{+}, maximum)

> There is no stigma around it at all. Maybe you may have found it when I first come to jail about 10 years ago, people will hide that they had Hep C. It was a very hush, hush: "oh she's got hep C". Now it's a very open thing. (Tanya, RNA^{-}, minimum/medium)

Interestingly, despite Tanya's insistence on the absence of HCV-stigma among fellow prisoners, her interview nonetheless suggested an HCV-positive status continues to attract stigmatisation from prison officers in the form of a moral taxonomy: 'Oh, we didn't think that *you'd* have it [HCV]'!

These accounts of HCV-stigma in prison share considerable thematic ground with those reported in the general community. Given that a core feature of living with HCV in the community is the stigma associated with the infection (Northrop, 2017; Treloar et al., 2013; Treloar & Rhodes, 2009), it is not surprising that HCV-stigma in prison is freighted with many of the same social and cultural meanings. Reports of prisoners' distress following HCV diagnoses cited elsewhere (Treloar, 2015), or of their desire to rid themselves of the associated stigma (such as Gus, above), have been well documented in community-based studies (Clark & Gifford, 2015; Fraser & Treloar, 2006; Northrop, 2017). Similarly, debates regarding the putative 'normalisation' of HCV within certain communities; its minimisation relative to the 'more serious' threat of HIV; and the fears surrounding disclosure: all have been identified across community settings (Harris, 2005; Northrop, 2017; Rhodes & Treloar, 2008).

The cost of identification

While participants reported a number of HCV-stigma experiences and themes common to both prison and community-based accounts, including its apparent 'normalisation', the unique physical environment and sociality of the prison setting introduced its own particular set of contingencies. With regards to the relationship between prisoners and prison officers, participants described how various prisoner actions or behaviours are marked out – *tainted* – by their symbolic association with the stigmatising nexus of HCV and injecting drug use. A request for Fincol (a bleach alternative available within NSW prisons), a presentation at the prison clinic with an abscess, an inquiry about HCV testing or treatment: all function as potential signs of the despised and discredited injector. Here Marco recalls his requests for Fincol:

> You put your head on show and the screws [prison officers] know straight away. If anyone wants bleach, they even ask you, 'what do you want bleach for?' … You get put on as a junkie like straight away. (RNA unknown, minimum)

As Marco goes on to explain: 'the screws do have an image of you: "oh you're just a junkie". You hear it every day.' Importantly, being labelled as such – as *lesser* than or *not quite* human (Goffman, 1973/1963) – is not 'merely' an act of symbolic devaluation. Prisoners become part of a disciplinary regime that carries with it a set of material consequences: of scrutinising practices and punishments; of body searches, cell raids and urine tests. Or, as Jim (RNA^{-}, maximum) put it: getting 'ramped and raided'. Here, the potential cost of identification influences the nature of prisoners' engagement with prison health services (notwithstanding their operational and administrative independence from correctional services) for fear of 'word' reaching officers.

Interviewer: Do people get loads of [injecting-related] abscesses and sores … Do they come to the clinic?

Jim: Sometimes. A lot of people are scared to bring it to attention, because they're going to get urines and lose their visits and buy-ups and everything else, which then limits them getting their drugs. (Jim, RNA^{-}, maximum) Another participant, Lenny, reported a further consequence of prisoner officers gaining knowledge of prisoners' HCV status

Lenny: Officers talk about families coming through on visits and stuff like that, you know what I mean?

Interviewer: Right, so the officers may tell your family something you don't want them to know?

Lenny: Of course and they're good at doing that. Trust me when I say that. They're good at fucking us, especially when the spiteful ones come out … (RNA^{-}, maximum)

Importantly, not all reports regarding prison officers and HCV-stigma were uniformly condemnatory. Tanya noted that in her experience officers who were known to have families affected by drug use were less likely to be judgemental. Participants also acknowledged the high levels of fear associated with HCV among prison officers, particularly among the older officers. As Gus and Steve explained

> A lot of the old officers that are my age … they're petrified of it [HCV]. (Gus, RNA^+, maximum)
> One of the officers' biggest problems, or biggest worries, is getting pricked by needles in cells … none of them want to catch something. (Steve, RNA^+, maximum)

The threat of exclusion

The inadvertent disclosure or 'outing' of a HCV-positive status and/or injecting drug use carries potentially serious consequences not only for relations between prisoners and officers, but for relations between prisoners themselves. Once again, as with prisoner-officer relations, participant accounts suggested that HCV-stigma was bound up with the complexities and maintenance of prison politics and relations. Here too, the emphasis was on managing the critical relationship between *information* (knowledge) and *image* (identity) in order to 'pass' (Goffman, 1973/1963). Marco's explanation was reiterated by a number of other participants:

Interviewer: They won't come up to get treated if they've got [HCV], because it will out them?
Marco: Yeah of course … A lot of people hide it … There's a lot of people who don't use [inject drugs] and boys are trying to put on façade sort of thing … Say if they're in the bikie crew, a lot of bikies don't use … no way they'll come in [for testing] … because if it gets around that he's got [HCV] it will be an embarrassment and he'll think well he's not going to get on [buy drugs] and shit like that … They care about what people think, they care about their persona or whatever you want to call it … (RNA unknown, minimum)

Entering prison is a particularly vulnerable period for all prisoners, but especially for those who are drug dependent and facing withdrawals (Hughes & Huby, 2000). While it is important for all prisoners to secure some degree of social acceptance and inclusion, for those who inject drugs, the necessity of quickly establishing and maintaining social relationships and injecting networks is particularly so (Treloar et al., 2015). In the Australian context, the absence of prison needle syringe programs means that inclusion within injecting networks ensures access to both drugs *and* (invariably unsterile) injecting equipment. Yet, as OJ (below) explains, the threat of social exclusion is precisely what underpins HCV-related (dis)information or deception within prison injecting networks. Here, as in the account of Marco cited above, OJ describes the social cost of deception. Interestingly, however, while Marco cites injecting drug use as the 'object' of deception – betrayed by the presence of its viral proxy, HCV – OJ cites the virus itself as the object of deception.

OJ: They could be feeling like they are in trouble if they were to come up and try and do something about it [HCV] because they'll be thinking everyone else will find out they've got hep C if they are doing the hep C program … They might not be part of that crowd anymore … So they'd stay quiet and they wouldn't say nothing about it, so that's probably why they wouldn't participate in something like that [SToP-C], because they'll feel scared that they'll be out of it … Once they get caught and everything like that, life becomes difficult for them in here and they know that.
Interviewer: They'd have no friends?
OJ: Yeah, because I see them go down from there and they're like suicidal kind of thing.
Interviewer: Have you seen that happen here? For guys that got found out for having hep C?
OJ: Yeah in other jails too. (RNA unknown, minimum)

Discussion

Drawing on qualitative interviews with prisoners this article examines the issue of HCV-stigma within four Australian prisons. Participant accounts revealed the extent to which many of the themes of HCV-stigma are common to both prison and community settings. Permeable boundaries and transient populations ensure that contemporary prisons are no longer closed nor 'total institutions' but in some respects operate as microcosms of the broader social world, with incarcerated populations affected by many of the same determinants of health (de Viggiani, 2007). The shared themes of HCV-stigma are indicative of the degree to which prisons 'import' the normative values of the broader community.

Nonetheless, the experience of imprisonment inevitably exerts its own significant impact on the lives and health of prisoners, often overwhelming pre-existing social and demographic differences (Yap et al., 2014). The overcrowded, highly governed and resource-limited nature of the prison environment produces distinct forms of power relations, both between prisoners and officers, and between prisoners themselves. Via a process originally coined *'prisonisation'* (Clemmer, 1940), prisoners undergo a form of secondary socialisation, adapting to the strictures of prison life by becoming habituated to, and subscribing to, a fixed system of values reinforced by an inflexible regime: a social hierarchy characterised by 'exploitation and victimisation' (de Viggiani, 2007). Here, alongside some of the thematic commonalities it shares with the broader community, HCV-stigma is materialised in ways that reflect the unique contingencies of the prison setting. The intense scrutiny (from officers *and* fellow prisoners) that typically surround visits to prison clinics both produced and compounded our participants' fears regarding confidentiality and inadvertent disclosure of HCV-status. Such fears and sense of surveillance have been identified elsewhere as barriers to prison-based testing and treatment (Khaw, Stobbart, Murtagh, 2007; Lafferty, Rance, & Grebely et al., 2018b; Lafferty, Rance, & Treloar, 2018a; Yap et al., 2014).

Parker and Aggleton (2003, pp. 16–17) maintain that the process of stigmatisation always takes place in a 'specific context of culture and power', functioning 'quite literally, at the point of intersection between culture, power and difference'. Within an already-stigmatised and disciplined prison population, HCV-stigma affords prison officers another means by which differences between prisoners can be further classified and stigmatised in the service of power. While prisoners may be always-already diminished and discredited by officers – generically referred to as 'its', as one participant put it – evidence of prisoner conduct commensurate with a *'junkie'* identity (requests for Fincol, for example) establishes a pretext for additional levels of surveillance and disciplinary attention. Here, knowledge, power and identity come together under the rubric of HCV-stigma to facilitate the identification and classification of prisoners and the authorisation of strip-searches, cell raids, threatened disclosures to family members and so forth.

Broadening our argument to include relations between prisoners, we note that Goffman (1973/1963) himself underscored the need to understand stigma through the *language of relationships* rather than attributes. Within this lexicon, Goffman emphasised the association between identity and information (or knowledge). In his terms, a *discredited* versus a *discreditable* identity referred to the difference between the *known-about-ness* or secret nature of an individual's stigma. While Goffman's work made no mention of 'power', his focus on relationships, information control and identity management resonates strongly with many of our participants' accounts. A resonance reinforced by Foucault's (1982, p. 338) contention that: 'Power relations are exercised, to an exceedingly important extent, through the production and exchange of signs'. For as we have seen, the production and exchange of signs – the identification and dissemination of information (regarding HCV, injecting drug use and so forth) – is integral to the exercise of power relations in prison. This basic mechanism is true for relations between prisoners *and* between prisoners and officers. Nonetheless, as participants recounted, the effects or consequences of HCV-stigma differ markedly depending on the type of relationship involved. Above we noted the possible consequences for relations involving officers: of increased surveillance and disciplinary attention; for

relations between prisoners, however, the potential costs include rejection from one's peer network (including injecting-based) and social isolation.

Link and Phelan (2014) suggest 'stigma power' functions as a 'resource' with which to manage, control or exclude others. Within both prisoner and prisoner-officers relations it does so through the production and exchange of information which works to *identify* and *classify* prison subjects on the basis of their putative status as 'HCV-positive', 'injecting drug user', 'junkie'. Whether that information is empirically accurate arguably matters less than what *counts as* – or is *seen to be* – the truth; for it is upon the latter that power will be exercised. In an important sense then, as Goffman observed, stigmatisation connotes 'the arts of impression management' and the practice of 'passing' (1973/1963, p. 130). Indeed, as a number of participants noted, it is often the management of image or persona which matters most. For many prisoners, managing HCV-stigma is a necessary part of negotiating the broader politics of prison identity-making. This is not intended to minimise or disregard the genuine sense of internalised HCV-stigma and shame that some participants spoke of, but rather to emphasis the *contingent* and *performative* nature of prison-based HCV-stigma: its 'political productivity' (Fraser & Dilkes-Frayne et al., 2017).

This paper is based on a dataset where HCV-stigma was one of a number of topic areas explored with participants. We acknowledge that structural differences (insofar as they pertain to HCV-stigma) may exist *between* different prisons; however, given the relatively small participant numbers ($n = 8$) from each prison, our focus has been on attempting to draw together and make sense of accounts of HCV-stigma from *across* the four sites. We were interested in participants' shared experiences and observations of HCV-stigma: in what common forms and effects it appears to play in prison life. It is also important to note that within the Australian prison system a high number of prisoners are routinely moved between prisons: either transferred (due to change in security classification, for example) or moved temporarily (to obtain medical treatment, for example) (Bretaña et al., 2015). Consequently, prisoner accounts of HCV-stigma are likely to be informed by experiences from more than one prison. Indeed, the participants cited in support of our argument represent a broad cross section of prison security classifications (including gender), HCV RNA status and drug-use history.

Conclusion

We know from extant prison and community-based research that HCV-stigma can be a significant barrier to seeking treatment. Nonetheless, understanding stigmatisation as a *process* that is relational, contingent, and political, rather than as a fixed or stable *attribute*, suggests the possibility that things could be otherwise. Here the ambiguous role of the State warrants brief mention. On one hand, as Parker and Aggleton (2003) argue, stigmatisation is best understood as part of a broader political economy of social exclusion, central to the establishment and maintenance of social order. So, in this sense, the State benefits from stigmatisation's 'political productivity' (Fraser & Dilkes-Frayne et al., 2017), both from its role in prison governance and its function in the broader systemic process of 'normalisation' (e.g., Butler, 1993; Foucault, 1979). Yet, under the special provisions negotiated for prisoners as part of universal access, HCV treatment in prisons is now fully funded by the Australian State, leaving absolutely no costs to be borne by prisoners themselves.

In a forthcoming publication drawing on the same pretreatment dataset, prisoners identify a number of potential advantages of prison-based over community-based treatment (Lafferty et al., 2018b). While noting HCV-stigma and possible reinfection as their primary concerns, prisoners reported a general level of support for SToP-C. We suggest that the more prisoners themselves are consulted regarding such interventions, the better equipped public health education and promotion will be to address (if not necessarily resolve) prisoner fears surrounding disclosure and the uptake of treatment. Public health needs to build on the insights regarding injecting drug use in prison gleaned through qualitative research to innovate new initiatives. This could include targeting injecting networks (see Hellard, Rolls, & Sacks-Davis et al., 2014) for testing and treatment as an alternative to the individualised model of care

that currently exists. Similarly, providing education to prison officers about the potential positive impacts of HCV treatment on prisoners, the community and themselves (such as reduced viral prevalence and subsequent safer work environment) may assist to remake the relational aspects of HCV-stigma between officers and prisoners.

The effects of HCV-stigma may yet prove to be a limiting factor in treatment scale-up efforts within prison. Nonetheless, with committed political leadership, operational investment, and sufficient prisoner engagement, interventions such as SToP-C may also afford opportunities for such effects to be challenged, disrupted, even left behind.

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