

Access to health's right in prison: between the prescription and the real

RESUMO | Objetivo: Conhecer como ocorre o acesso à saúde das pessoas privadas de liberdade. Métodos: Pesquisa qualitativa, realizada em um presídio no interior de Minas Gerais, com 19 pessoas privadas de liberdade. Os dados foram coletados mediante entrevista aberta orientada por roteiro semiestruturado no período de agosto a dezembro de 2017. Realizou-se Análise de Conteúdo de Bardin. Projeto aprovado no Comitê de Ética e Pesquisa com Seres Humanos. Resultados: Apesar do direito à saúde ser uma prerrogativa constitucional a ser garantida a todo cidadão, inclusive aos privados de liberdade, existem barreiras no cárcere que impedem esse acesso, como: dependência do agente penitenciário por meio de comunicação mediante bilhete, ausência de profissionais de saúde em tempo integral e falta de medicações, necessitando que a família atue como rede de cuidado. Conclusão: Evidencia-se a necessidade de melhor estruturar o acesso à saúde das pessoas privadas de liberdade, a fim de assegurar esse direito.

Palavras-chave: Direito à Saúde; Acesso aos Serviços de Saúde; Prisioneiros.

ABSTRACT | Objective: To establish how it occurs the access to health care for people deprived of liberty. Methods: Qualitative research, carried out in a prison Minas Gerais's inland, with 19 people deprived of liberty. Data were collected through open interviews guided by semi-structured rotation from August to December 2017. Bardin's Content Analysis was performed. Project approved by the Ethics and Research with Human Beings Committee. Results: Despite being a constitutional prerogative to be guaranteed to all citizens, including people deprived of liberty, there are prison obstacles that prevent this access, such as: dependence on the prison guard through communication by ticket, absence of a health professional full-time and lack of medication, making it necessary for the family to see itself as a care network. Conclusion: The need to structure the access to health care for people deprived of their liberty, in order to ensure their rights.

Keywords: Right to Health; Health Services Accessibility; Prisoners

RESUMEN | Objetivo: Conocer cómo se dá el acceso a la salud de las personas privó de su libertad. Métodos: Investigación cualitativa, realizada en una prisión del interior de Minas Gerais, con 19 personas privadas de libertad. Los datos fueron coleccionados através de una entrevista abierta orientado por un itinerario semi-estructurado. Se realizó el Análisis de Contenido de Bardin. Proyecto aprobado por el Comité de Ética e Investigación con Seres Humanos. Resultados: A pesar de que el derecho a la salud es una prerrogativa constitucional que debe garantizarse a todos los ciudadanos, incluidos los privados de libertad, existen barreras en la prisión que impiden este acceso, tales como: dependencia del guardia penitenciario mediante comunicación vía boleta, ausencia de salud profesionales de salud a tiempo completo y falta de medicación, lo que obliga a la familia a actuar como red asistencial. Conclusión: Se evidencia la necesidad de estructurar mejor el acceso a la salud de las personas privó de su libertad, a fin de garantizar este derecho.

Palabras clave: Derecho a la Salud; Accesibilidad a los Servicios de Salud; Prisioneros

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INTRODUCTION

The Brazilian population is marked by inequities and social vulnerabilities, which become very clear when it comes to health, especially in the prison system. In this context, those deprived of liberty are exposed to a series of human rights negligence and lack of fundamental guarantees of the right to health.¹

The right to health is provided for in the Federal Constitution of 1988 - article 196, as a right of all and a duty of the State, and when entering the deprived of liberty, it is guaranteed by the Penal Execution Law of 1984 and by the National Policy for Comprehensive Care to the Health of Persons Deprived

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of Liberty in the Prison System (PNAISP - Pessoas Privadas de Liberdade no Sistema Prisional) 2014.²

The operationalization of the PNAISP is regulated by Consolidation Ordinance No. 2/2017, which has as reference the prison population of a given prison unit to classify the health services as well as their hours of operation. Furthermore, it determines the need for integration between the prison health unit and a basic health unit in the city so that professionals from the local SUS health network can work in the prison system.³

PNAISP aims to guarantee the right to health and access to the Unified Health System (SUS) for all individuals in the prison system, through health promotion and disease prevention actions, including care, medication and vaccination, through the Health Care Network (RAS - Rede de Atenção à Saúde) in the territory.^{2,4}

The right to health must be ensured in a universal, integral and equitable way, through the understanding that each individual has its uniqueness, constituting a unique identity, which lives under social determinants and needs different forms of care.²

Paradoxically, the right to health must be offered by the State to the entire population, regardless of whether they are deprived of liberty or not, however, since they are "outside" the prison walls, due to marginalization, poverty and vulnerability, most of these people do not have access to health, and when entering prison, this access becomes even more difficult.⁵

Through the above, concerns arise in relation to access to health care for a population deprived of freedom that experiences daily life in a prison in the interior of Minas Gerais. Therefore, the question is: How is the access of the population deprived of liberty to the right to health? In this sense, the objective of the study was to understand the access of people deprived of liberty to

the right to health.

METHODS

Qualitative study carried out in a prison in the interior of Minas Gerais. Qualitative research focuses on the world of meanings, desires, aspirations, and values, which corresponds to a deeper space in the relationships of processes and phenomena.⁶

Nineteen people deprived of liberty participated in the research. Inclusion criteria were: over 18 years of age in State custody on a provisional basis or sentenced to serve a custodial sentence or a security measure. The exclusion criteria were: being in a semi-open regime, in temporary detention, due to food debt and minors. One participant from each cell was invited, usually the one with the longest experience in prison.

Data collection took place between August and December 2017. An open interview script guided by semi-structured questions was used. The statements were recorded and transcribed in full, ensuring the reliability of the data. The interviews lasted an average of 40 minutes to 1 hour and a half. Prison officers awaited the end of the interviews outside the room, ensuring greater privacy for the participants. In order to ensure confidentiality, the interviews were identified from E1 to E19.

Data were treated using Bardin's content analysis technique.⁷ A pre-analysis was carried out, with a transcript of the interviews in full, a skimming and exhaustive reading of the material. Next, the material was explored, with descriptive treatment of the information contained in the statements, transforming them into meaningful data. Finally, there was the treatment of results, inference and interpretation, with data confrontation in the light of the literature.

The ethical precepts of Resolution 466/2012 of the National Health Cou-

ncil and Resolution 510/2016, which provides for the standards applicable to research in Human and Social Sciences, were respected. The research was approved by the Ethics Committee for Research with Human Beings at the Federal University of Viçosa (CEPH-UFV Opinion 2.164.274) and by the Public Security Department of the State of Minas Gerais. Participants signed the Informed Consent Term after being informed about the guarantee of anonymity, privacy and use of results only for scientific purposes.

RESULTS

Through the analysis of the testimonies of the deprived of liberty who participated in this study, it is evident that access to health care in prison is very far from the perspective of universality, equity and integrality registered in the SUS.

The way detainees use to express their health needs and request care is through tickets delivered to prison officers. They are responsible for forwarding the tickets to the health sector so that professionals in the area can handle the demand, as evidenced by the statements below.

Send a note to the doctor if he's not too busy he comes the same day... if not you have to wait. (E12)

Write a note to the doctor, then this note... give it to the doctor... and the doctor orders us to be taken away. (E19)

I send a note! (E5)

Thus, there is a centrality in the figure of the prison agent as a mediator between the health needs expressed by the inmate and the care provided by health professionals. It means that the relationship established with the prison guard influences the referral - or not -

to the manifest demand for the person deprived of liberty.

Thus, some participants report access to the health service through a link with the prison agent. But, also, there are reports of inmates who report kicking the cell bars so that their health needs are perceived, as shown below.

Look, I call the agent right? Every time I needed it, when I had a problem, they took me to the doctor, they took care of me in the proper way. (E8)

Particularly every time I need him, I send a note, he answers me. (E11)

If the person has it that bad, right? We have to kick the grid... First we call, right? When it takes time, then that mess becomes, right? (E9)

I've seen feeling sick inside a cell asking for care and there wasn't. (E10)

I've already asked for care, it took a while to take it out, we even got better before taking it out, it even got better. (E17)

With the agents, it's more of a favor, asking for things, getting medicine, sending a note. (E7)

The perspective that access to health is a favor offered shows that those deprived of liberty do not recognize health as a right. From the testimonies, it is clear that the delay in accessing health care occurs as a result of the absence of full-time health professionals, as well as the overcrowding of the prison. Therefore, there is a need to prioritize serious care, not always being possible to meet everyone who needs it.

Whoever gets sick at dawn, the-

re's no way, there's no doctor attending at the time. A lot of people for a single doctor to see, got it? For a single nurse to attend. (E2)

It takes a while to get him out of the cell, he gets sick for a long time. (E6)

Sometimes the service takes time. It happened to have people sending notes for several days and it hasn't been solved. (E12)

Getting sick in jail is the worst thing there is. (E14)

In addition to the delay in receiving care, most respondents report difficulty in accessing medication, which can be considered another barrier to accessing health care.

Often there is a lack of medicine, there is no medicine for the prisoner. (E4)

And they tell us that they don't have medication, so what?! You see?! He wants the family to bring it and such... but there's no way to call our family to ask to bring it. But most medications here don't have it. (E19)

It is noticed that the family acts as an important care network, as it makes up for the absence of the State, especially with regard to guaranteeing access to medications. However, not all family members have the material conditions to purchase medication, so that access to medication occurs according to financial conditions, which undermines the perspective of health as a right for everyone.

I always asked for syrup, there wasn't any anti-inflammatory, omeprazole doesn't have either,

then you have to bring it from home. I ask my mother to bring it, she brings it there. (E6)

It takes a long time, it usually doesn't even make it here, sometimes they have to send it from home to us, sometimes the family doesn't have the conditions, then it's difficult. (E11)

When there isn't, they call the family and the family brings it. Sometimes the family brings it and then it ends, until they call the family, until they bring it again, I think if there was one here, it would be better. (E8)

There is no health business here, understand?! If the guy wants to, he has to send a family to bring the medicine, if he doesn't have a family, he stays there. (E19)

DISCUSSION

The Brazilian Federal Constitution of 1988 represents an important milestone in the country's redemocratization process and provides for health as a condition of citizenship for every citizen. Promoting health goes beyond the offer of practices to prevent injuries and diseases, as it also includes the offer of healthy environments, the search for quality of life and protection from the risk of illness.⁸

Being deprived of liberty does not mean depriving the subject of their dignity and access to constitutional rights and guarantees, such as access to health. Thus, it is not an option for the State to naturalize the neglect of the rights of this population.⁸

It is known that, even outside prison, there are many challenges to achieve the guarantee of access to the right to health in the scope of the SUS. Although in its legal and legal bases, the SUS is universal, in practice it lives

on quotas.⁹ Thus, there are barriers to accessing health not only in the prison system, but in the Brazilian health system as a whole. It should be noted, however, that the prison environment enhances existing barriers, in addition to providing other conditions that aggravate existing gaps.

In this regard, it is important to bring to the reflection Caputo's perspective¹⁰ who affirms that the deprivation of liberty generates, by nature, a deterioration of the state of health, configuring itself as a factory of diseases. Deprivation of freedom has deleterious effects on bodies such as digestive and sleep disorders, skin and teeth diseases, depression, hearing and vision loss, among others. In addition, poor sanitary conditions and overcrowding promote the spread of infectious diseases.

Also, daily life in prison is characterized by psychological and moral violence, which has devastating effects on the health of this population. The psychological submission imposed in this environment acts as a form of punishment, replacing physical punishment. Thus, the former figure of the executioner, today, is personified by the penitentiary agent, whose role of agent of social re-education establishes important power relations.¹¹

It is worth situating the family context of those deprived of liberty, often marked by belonging to the less favored social class, which experiences vulnerabilities in daily life and restricted access to care policies. Thus, the life context is characterized by poverty and low access to health and education.¹²

In contrast, even with a life context characterized by poverty and low access to health and education, the family reveals itself as support, capable of offering emotional, economic and social support to those deprived of liberty. In addition, it acts as a source of support needed to find possible alternatives and overcome important obstacles, such as lack of medication, personal hygiene

items, food and external social contact.¹³

Difficulty in accessing medications hurts one of the components of the PNAISP, in which pharmaceutical assistance must be present in all prisons, linked to the network of health services for the supply and dispensing of medications, upon pharmaceutical authorization.²

Also, in order to facilitate the access of people deprived of liberty to the right to health, the PNAISP determines that each prison unit has the work of a multidisciplinary team composed of a doctor, nurse, dentist, nursing technician and oral hygiene technician, to act as a point of attention for the health services network.²

Also, in order to facilitate the access of people deprived of liberty to the right to health, the PNAISP determines that each prison unit has the work of a multidisciplinary team composed of a doctor, nurse, dentist, nursing technician and oral hygiene technician, to act as a point of attention for the health services network.¹⁴

Thus, in the prescribed dimension, there are public policies that aim to ensure access to health care for those protected by the State, through medication, health care with qualified professionals and in an ideal quantity, vaccination, exams, among others. However, it is clear that in the real dimension of this daily life, such policies are minimally implemented and produce results that are incapable of guaranteeing this fundamental right.

CONCLUSION

It is essential to understand how the access to health of people deprived of liberty occurs so that it is possible to identify the gaps, barriers and weaknesses that prevent them from being guaranteed the right to health.

The research showed that access to the right to health in prison, when it oc-

curs, is crossed by many barriers such as the absence of full-time health professionals, the overcrowding of cells, the dependence of the prison guard to conduct the demands, as well as the lack of medications help to make this access merely an expectation of a right and not a de facto right. The family is an important care network, however, not all of them have the financial conditions to fill the gaps neglected by the State.

Thus, it is noted that it is necessary to broaden the horizon of understanding about the health reality in the context of prison, especially from the perspective of people deprived of liberty, so that it is possible to intervene in this reality in a coherent way and capable of transforming it. 🍵

References

1. Kölling GJ; Silva MBB; Sá MCDNP. O Direito à Saúde no Sistema Prisional. *Revista Tempus - Actas de Saúde Coletiva*, Brasília, p. 281-297, 2013. <https://doi.org/10.18569/tempus.v7i1.1304>
2. Barbosa ML, Medeiros SG, Chiavone FBT, Atanásio LLM, Costa GMC, Santos VEP. Ações de enfermagem no sistema penitenciário. *Escola Anna Nery* 23(3) 2019. Doi: 10.1590/2177-9465-EAN-2019-0098
3. Simas L; Sánchez A; Ventura M; Diuana V; Larouza B. Análise crítica do modelo de atenção à saúde das pessoas privadas de liberdade no Brasil. *Cad. Ibero-amer. Dir. Sanit.*, Brasília, 10(1): jan./mar., 2021
4. Brasil. Ministério da Saúde (MS). Política Nacional de Atenção Integral à Saúde das Pessoas Privadas de Liberdade no Sistema Prisional. Brasília: MS, Ministério da Justiça; 2014. Disponível em: https://bvsm.sau.gov.br/bvs/sau/legis/gm/2014/pri0001_02_01_2014.html
5. Graça BC, Mariano MM, Gusmão MAJX, Cabral JF, Nascimento VF, Gleriano JS et al. Dificuldades das mulheres privadas de liberdade no acesso aos serviços de saúde. *Rev Bras Promoç Saúde*, Fortaleza, 31(2): 1-9, abr./jun., 2018. doi: <https://doi.org/10.5020/18061230.2018.7374>
6. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 8ª ed. São Paulo: Hucitec; 2004.
7. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2009.
8. Tavares NLF, Garrido RG, Santoro AER. Política de saúde no cárcere fluminense: impactos da pandemia de COVID-19. *Revista Estudos Institucionais*, v. 6, n. 1, p. 277-300, jan./abr. 2020. doi: 10.21783/rei.v6i1.480
9. Viegas SMF, Penna CMM. O SUS é universal, mas vivemos de cotas. *Ciênc. saúde coletiva* 18 (1). Jan 2013. <https://doi.org/10.1590/S1413-81232013000100019>
10. Caputo G. A pena corporal do cárcere e o direito à saúde: entre a normativa penitenciária europeia e italiana. *Revista de Estudos Constitucionais, Hermenêutica e Teoria do Direito (RECHTD)*11(2):184-210, maio-agosto, 2019. Unisinos -doi: 10.4013/rechtd.2019.112.04
11. Lourenço LC. Na frente das grades: uma pesquisa com agentes penitenciários da região metropolitana de Belo Horizonte. EDUFBA, 2012, pp. 97-119. ISBN 978- 85-232-1735-8.
12. Lermen HS, Gil BL, Cúnico SD, Jesus LO. Saúde no cárcere: análise das políticas sociais de saúde voltadas à população prisional brasileira. *Physis Revista de Saúde Coletiva*, Rio de Janeiro, 25 [3]: 905-924, 2015. <https://doi.org/10.1590/S0103-73312015000300012>
13. Lourenço LC. Na frente das grades: uma pesquisa com agentes penitenciários da região metropolitana de Belo Horizonte. EDUFBA, 2012, pp. 97-119. ISBN 978- 85-232-1735-8.
14. Carvalho LES, Sousa PCP, Veloso MV, Luz VLES, Feitosa VC. Percepção de detentos sobre a assistência à saúde em um presídio Estadual. *R. Interd.* v. 9, n. 4, p. 79-88, out. nov. dez. 2016. Disponível em: <https://revistainterdisciplinar.uninovafapi.edu.br/index.php/revinter/article/view/660>