

Attention to the health of people deprived of their liberty

Edna Maria Alves Valim¹, Ana Maria Lombardi Daibem², William Saad Hossne³

Abstract

The right to health, guaranteed by the current Constitution, has not yet been implemented for persons deprived of their liberty. Only in the last years did government actions aim at the social reintegration of these people, through education, work and health. This is a qualitative study to verify the accomplishment of consultation and guidance on health service at the time of admission to a penitentiary in the State of Minas Gerais, Brazil. Twenty-one people in this situation were interviewed. The majority reported an absence of consultation at admission, and the lack of guidance on the functioning of the prison health unit as well as on the situations in which they would be referred for extramural care. There were also reports of difficulties in being attended to, dissatisfaction with therapeutic conduct, and concern with intra-institutional transmission of diseases. Considering that the lack of consultation and guidance at the time of admission can cause irreparable damage, this study, based on Bioethics, sought to reflect on State negligence regarding inmates in a vulnerable situation.

Keywords: Bioethics. Health services accessibility. Health care (public health). Prisoners. Prisons.

Resumo

Atenção à saúde de pessoas privadas de liberdade

O direito à saúde, assegurado pela atual Constituição, ainda não foi efetivado para as pessoas privadas de liberdade. Somente nos últimos anos ocorreram ações governamentais visando reintegrar socialmente essas pessoas pela educação, trabalho e saúde. Trata-se de estudo qualitativo para verificar a realização de consulta e orientação sobre serviço de saúde no momento do ingresso em uma penitenciária de Minas Gerais, Brasil. Foram entrevistadas 21 pessoas nessa situação, e a maioria referiu ausência de consulta no ingresso e inexistência de orientação sobre funcionamento da unidade de saúde prisional e sobre as situações nas quais são encaminhadas para atendimento extramuros. Ainda foram relatadas dificuldade para atendimento, insatisfação com conduta terapêutica e preocupação com transmissão intrainstitucional de doenças. Considerando que a falta de consulta e orientação nesse momento podem gerar danos irreparáveis, buscou-se, com base na bioética, refletir sobre a negligência do Estado para com o custodiado em situação de vulnerabilidade.

Palavras-chave: Bioética. Acesso aos serviços de saúde. Atenção à saúde. Prisioneiros. Prisões.

Resumen

Atención de la salud de personas privadas de libertad

El derecho a la salud, garantizado por la actual Constitución, aún no se ha efectivizado para las personas privadas de libertad. Solo en los últimos años tuvieron lugar acciones gubernamentales destinadas a la reinserción social de estas personas, a través de la educación, el trabajo y la salud. Se trata de un estudio cualitativo para verificar la realización de consultas y orientaciones sobre el servicio de salud en el momento del ingreso a una penitenciaría de Minas Gerais, Brasil. Se entrevistaron 21 personas en esta situación, y la mayoría hizo referencia a la falta de atención en el ingreso y a la inexistencia de orientación sobre el funcionamiento de la unidad de salud de la prisión, y a las situaciones en las que se deriva a la atención extramuros. Además, reportaron dificultades en la asistencia, insatisfacción con el enfoque terapéutico y preocupación por la transmisión intrainstitucional de enfermedades. Considerando que la falta de atención y orientación en este momento puede causar daños irreparables, se buscó, sobre la base de la bioética, reflexionar sobre la negligencia del Estado hacia el custodiado en situación de vulnerabilidad.

Palabras clave: Bioética. Accesibilidad a los servicios de salud. Atención a la salud. Prisioneros. Prisiones.

Aprovação CEP-UFTM CAAE 49917315.0.0000.5154 e CEP-Unisc CAAE 49917315.0.3001.0062

1. **Doutora** edna.valim@uftm.edu.br – Universidade Federal do Triângulo Mineiro, Uberaba/MG 2. **Doutora** amldaibem@gmail.com – Centro Universitário São Camilo, São Paulo/SP, Brasil 3. **Doutor** andreaHossne@gmail.com – *In memoriam*.

Correspondência

Edna Maria Alves Valim – Praça Manoel Terra, 330, Centro CEP 38015-050. Uberaba/MG, Brasil.

Declaram não haver conflito de interesse.

The social rights provided by the Federal Constitution¹ were not put into practice for the Brazilian population at the same time. The right to health is a right of all Brazilians and a duty of the State, guaranteed by Article 196 of the Constitution¹ and by the Law 8080², which established the Sistema Único de Saúde - SUS (Unified Health System), and the Law 8142³, which provides for community participation in the management of the SUS. But that right was not guaranteed to persons deprived of their liberty. It was just in recent years that Government measures were taken to fulfil the State's duty to assist detainees through education, work and health, as provided by the Law 7.210⁴, the *Lei de Execução Penal* - LEP (Criminal Execution Law). The objective of the measures is to guide detainees's social reintegration.

Regarding health, the Portaria Interministerial do Ministério da Saúde/Ministério da Justiça (MS/MJ) 1.777/2003⁵ (Inter Ministerial Decree of the Ministry of Health / Ministry of Justice) which instituted the Plano Nacional de Saúde no Sistema Penitenciário - PNSSP (National Health Plan in the Penitentiary System) was published after years of discussions. It emphasised the need for a specialised public health policy. Assuring transfer of resources, this policy should have justice, ethics, citizenship, human rights, equality and participation in the democratic process of rights and social control as its main basis. There are great distortions in the implementation of the right to health for a significant part of the Brazilian population, which includes persons deprived of their liberty (PDTL).

The PDTLs in the country have greater social vulnerability due to their position in society, with restricted access to goods and services and few opportunities. They are prisoners in prisons, living under unfavourable housing conditions, health and access to health actions. As a result, these people may have a more compromised physical and mental health when compared to the general population⁶.

The PNSSP has been considered a landmark in health care in the Brazilian's prison context by establishing the logic of basic care for health care teams in the system. However, even though the PNSSP was not implemented in a homogeneous and simultaneous way in all units of the country's penitentiary system, the Política Nacional de Atenção Integral à Saúde das Pessoas Privadas de Liberdade no Sistema Prisional (National Policy for Comprehensive Health Care of Persons Deprived of their liberty in the prison system) was established under the SUS in 2014. The Interministerial

Decree MS / MJ 1/2014⁷ outlines the conditions for adherence to this policy and the agreement to provide basic health care in the prison system.

Citizens are considered as inserted in social relations in Brazil; however, this does not guarantee that vulnerable people have their needs and rights fulfilled. According to Sarmento, *it is in the process of universalisation that we can glimpse at the most pathological aspect of the process of affirmation of human dignity in Brazil*⁸. The economic factor is related to the creation of inequality, but other factors interfere in the definition of those that will be affected. The poor are stigmatised and, in specific circumstances, *other vulnerable groups such as blacks, indigenous people, women, homosexuals, prisoners and people with disabilities, each group being stigmatised in their own way*⁸.

It is responsibility of the State to protect the rights of the individual, especially those who are unable to fully exercise them. While there are international or regional legal frameworks, it is observed that the difficulties that prevent vulnerable people from fully exercising their rights are still present, on its own particular way in each state. These difficulties assume a greater proportion in regard to prisoners in several aspects such as access to education, to work and also to health care.

There are currently eight international treaties that seek to guarantee human rights in patient care. These treaties are binding on States that have ratified them, but have moral and political force even in countries that have not ratified them⁹. The United Nations (UN) oversees treaties compliance by States and may receive and examine denunciations of violation of human rights⁹. One of these treaties is the International Covenant on Civil and Political Rights¹⁰, ratified by Brazil in 1992¹¹.

There are also international instruments that do not have the binding force of a treaty but help to interpret the rights of the patient. Among them and closely related to the topic under study, is the *set of principles for the protection of all persons subjected to any form of detention or imprisonment*¹². These guidelines provide, in the 24th principle, that *a proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary*¹².

Considering that it is responsibility of the State to protect the rights of citizens and that people

in vulnerable situations have more difficulties in guaranteeing their rights, it is attempted, through bioethics and human rights, to find conducts based on the essential values of society that meet the needs of these individuals for harmonious coexistence and adequate conditions of life. The references of bioethics proposed by Hossne¹³ can be a means for discussion and reflection, so that the *voice of the other is always present*¹⁴ when defining priorities and adopting measures to achieve equality, through the identification, recognition and analysis of inequalities, their causes and possible consequences¹⁵.

There are few studies on health conditions of persons deprived of their liberty. The general objective of the research carried out by Valim¹⁶ was to know their problems and their health care needs, in the light of bioethics, in order to ensure human dignity. This study is based on that research and had the objective to verify if prisoners are attended by prison health teams when they enter a penitentiary located in the state of Minas Gerais, Brazil, and if they receive guidance on the operation of the health facility on the location.

Method

This is a qualitative, descriptive and exploratory study conducted in January 2016 in a penitentiary located in the state of Minas Gerais, designed to house prisoners of both sexes who were not sentenced and who were sentenced to prison in closed or semi-open regimes. 24 prisoners of both sexes participated in the study. These individuals had been trained as health agents between 2012 and 2014 and were incarcerated at the time of the study. The choice of working with prisoners who had been trained as health agents is justified by their participation in activities in which the SUS organisation was presented, mainly regarding health promotion actions and prevention measures that should be provided by the prison health team.

After its acceptance by the direction of the penitentiary, the research was registered in the *Plataforma Brasil* and approved. The administration of the penitentiary carried out the survey of which persons deprived of their liberty who had been trained as health agents were still prisoners. Once the survey was completed, the order of the invitations, the schedule of the interviews and the place for their execution were defined together with the direction of the penitentiary because of logistics

and security. Conditions that ensured privacy were considered in order to choose the location of the interviews.

Participation in the survey was not compulsory, and the confidentiality of the information provided was guaranteed. Only those prisoners who, after clarification, freely agreed to participate and signed the free and informed consent form were interviewed. The interviews were individual, semistructured and recorded in audio.

All speeches were transcribed and typed, and each was checked and compared with their audios to verify and correct any errors in the understanding of the speeches. In order to ensure confidentiality, in some sections the lines were suppressed, replaced by reticences between parentheses. Pauses in the interviewee's speech were marked with continuous reticence in the text¹⁷. A continuous line "____" ¹⁷ was used in the parts where it wasn't possible to understand what had been said. People who were interviewed will be identified only as "participants" and their profiles will not be displayed in order to protect their identity. Thus, in the transcribed excerpts from interviews, "P" was used for participant and "I" for interviewer.

Results

All prisoners contacted to participate in the study were receptive. No emotional discomfort was detected during the interviews, which took place in pleasant atmosphere. Twenty-one people freely agreed to participate. Just one participant informed, after clarification, that he or she did not want to be included. Two people were not consulted because they were in a semi open regime and worked in a service external to the institution. In order to be able to approach these prisoners for invitation, clarification and possible participation in the study, it would be necessary for them to be absent from their work, due to the time of return to the institution, which is around 4pm. It would also be impracticable to schedule the interviews shortly after the return of the prisoner, due to the administrative routines of closing regular daily activities and the proximity of the times of team changing at the security sectors of the penitentiary. As a result, we opted to exclude those two prisoners from the study.

The reports obtained in the interviews were not edited. Data analysis was performed according to Bardin content analysis approach¹⁸, culminating

in the definition of the following categories and sub-categories: 1) entry into the prison system; 2) access to the health service; 2.1) existence of a previous health problem; 2.2) development of health problems after imprisonment; and 3) access to health care in the light of bioethics.

This work is a part of the research with emphasis on the entrance in the prison system, in which the initial consultation and orientation about the functioning of the health service will be approached. Participants' reports suggest that there is no standardised procedure for initial consultation and guidance on the functioning of the health service in the last ten years, since the time of detention of eighteen prisoners interviewed ranged from two to ten years and nine months and only three persons deprived of their liberty were detained less than a year ago. The apparent contradiction between a detention time of less than one year and the health agent training period from 2012 to 2014 is due to the fact that the prisoners were detained during the training period as health agents, then they left the prison and returned to it as a result of sentence or new unlawful act. Of the 21 persons deprived of their liberty who participated in the study, five mentioned health care during the admission, as reported:

"When we arrive, about three or four days later, they come to the infirmary and they ask if you have any health problem, if you used to take some medicine ... controlled ... these things, but tests are not done, no" (P);

"That did not ask for exams, no. Just asked if there was any problem, these things" (P).

It was not possible to identify, from the survey on the time of detention, in which years there were regular health consultations at the time of admission. Likewise, it was not possible to associate the number of prisoners and the capacity of the penitentiary to verify if overcrowding led to an increase in demand for the prison's health unit and, as a consequence, the failure to carry out consultations upon entry into the institution. One can, however, consider the hypothesis.

Two participants mentioned the accomplishment of the health service, one of them due to the occasional need: *"No, sometimes, so sometimes, when we don't feel well, sometimes they take you, right? (...) No. No. Only. I went only when I was sick" (P).* One participant reported that he / she was only attended near the release of the

prison, upon being received by the Comissão Técnica de Classificação - CTC (Technical Classification Commission): *"No. No, I did not. Never asked. Only when you go through the CTC in order to leave" (P).* Attention is also drawn to the speech of a prisoner which allows us to infer that exams are not routine - rather, they are only done in specific situations: *"No, no. I went straight to the cell. The right would be to do exams, right? To do some exams, right? To see if we have HIV, see if there are other types of disease. That would be the right thing. But it was not what happened" (P).*

Regarding the second question, all 21 participants reported that they did not receive guidance from the prison's administration on the functioning of the existing health service or on the types of care that may be provided by the local health unit team or in which situations the team would refer to care in other units of the public municipal health network.

Three detainees reported having received health information, but only during participation in training activities to form health agents. One participant reported that he or she frequently passes the orientation to other prisoners in the prison block where he or she is. When a person deprived of their liberty requires care, the information on health care in the institution is obtained from the inmates of the blocks where the new prisoners are housed, with the "cell-free" or with prison security agents. This informal communication is carried out by "ticket", internally called "talk to me", which is given to a certain inmate, the "free cell" who performs internal activities in the gallery, that is, not restricted to the prisoner's own cell, as can be seen in the following speech:

"No, usually when we arrive, we ask for assistance, just the same, the agents tell us ... we have to wait! Because everything is through appointment! That is a thousand and so much prisoner, for two doctors, so we have to wait for our turn." (P)

"So, but someone told you so ... if you need to see someone, what do you have to do, who do you look for?" (I)

"No, we do a talk with me, hand it over to the agent, they bring it down here ... Then when there's a vacancy for us, the doctor books and calls."

"So it's the 'talk to me' that you ..." (I)

"Yeah, 'talk to me.'" (P)

"... You deliver to the agent?" (I)

"We deliver to [the] free cell, [the] free cell delivers to the agent and they bring them down here and call us to the care. Or if you get sick too, scream, make a noise and you get to see the doctor too! And then they take them too. If it's a more serious case, right?" (P)

"But who told you? This is what I wanted to understand, who explained ..." (I)

"Who told me?" (P)

"Yeah, who told you that you had to do the 'talk to me'?" (I)

"No, that's when you get here in jail. When you have just been arrested." (P)

"Right." (I)

"You're here, you're not feeling well. A cellmate in the cell is already aware of your problem, he or she is going to tell you, what is so bad? He or she will call the agents. If it's one minor thing, let's do 'talk to me', pass to them so they'll give you assistance." (P)

"So it is your colleagues who ...?" (I)

"You always get there, someone gives you an orientation." (P)

"But here, of the health service, no one told you, thus, on one who works in the penitentiary; the person who gives information is usually another inmate?" (I)

"Yes, but a partner there." (P).

In the following report, there is a difficulty that may arise from the absence of guidance on the type of care provided by the health team of the institution and the services that are performed outside the walls:

"It was only like that, on the day I went felt unwell, that I wanted them to call, to talk to Dr. (...). I spoke with (...), with (...). Book a doctor for me if Dr. (...) can not answer. Then he or she said: 'You are going to pay?' I said, 'I can not pay!' Then he or she [turned] like this: 'then there is no way, there is no way to book it. Because to be able to book an appointment it has to be paid'. Because it did not work in the State, and only they could book" (P).

In addition, it is possible to observe in the following report, besides the absence of orientation, the non-attendance and the dissatisfaction due to

the therapeutic conduct and the internal transfer of a prisoner with suspected tuberculosis:

"Do not pay any attention, just keep us there. (...) It's always the same. The service there is really difficult. They take their time to go there. (...) They do not bring anything. They never bring medicine (...) But sometimes it's there, just like tuberculosis, there are people coming from other blocks that never _____ there, they put them together with you ... Tuberculosis, that never happened here so you could see what it is. (...) They come from the street, then the prison guards put them with you and you end up catching tuberculosis. Then you ask to go to the health unit, there's no way, you have to book first _____. (...) We are going to ask to bring the attendance here, the agents say that it has to book. (...) Then, if you go and forward your name, it is never scheduled, that is when you have to make agitation in the block" (P).

Discussion

The reports obtained from the interviews suggest an irregularity in the accomplishment of the minimum protocol for the health diagnosis established in the PNSSP, which aims to develop health promotion actions and the prevention of aggravations upon the entry of the prisoner in the System⁵.

Observance of the UN body of principles to protect persons subject to detention ensures that they are subjected to medical examination to detect any need for care and treatment, thus avoiding the occurrence of health problems¹². Similarly, the American Convention on Human Rights from November 22, 1969, known as the Pact of San Jose, Costa Rica¹⁹ and promulgated only in 1992 by the Brazilian government²⁰, assures to everyone respect for life and their physical, mental and moral integrity. It further guarantees to all persons deprived of their liberty respect for their dignity as a human being¹⁹.

In a recent publication, the Inter-American Court of Human Rights ruled on the situation of persons deprived of their liberty in the countries under their jurisdiction. It highlighted contentious cases, decisions and measures proposed to fulfil the obligations of the State regarding the conditions of detention, including sanitary conditions and medical care²¹. In cases submitted to the Court²¹, there were facts that constituted a disrespect for the rights of the persons deprived of their liberty, in

particular the lack of health care, and the Court²¹ in its pronouncements has considered in its decisions that the right to life and personal integrity are directly linked to the attention to human health. The absence of such a protocol, plus the lack of guidance from the prison administration on the procedures concerning prevention, promotion and assistance to health in the system may be causing harm to persons deprived of their liberty. These damages reveal that the State has not assumed its responsibility towards the persons in its custody.

Investigations into the conditions of prisoners, as well as the types of health care provided by the prison system, are relatively rare. The World Health Organisation (WHO) 2007 publication, the "Health in Prisons" guide, stands out²². This guide, in addition to addressing infectious diseases, sexually transmitted diseases, mental diseases, drug abstinence and others, also reaffirms the principle that prisoners should not be released from prison worse off than when they entered. This concern about prisoners' health is so far incipient. Much remains to be done to change the situation in almost all of Brazil's prisons.

The Universal Declaration of Human Rights states that *Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world*,²³. Consequently, dignity is the essence of human rights that have been reaffirmed by UN countries through the *Universal Declaration on Bioethics and Human Rights (DUBDH)*. In its article 2^o, DUBDH has as one of its objectives *to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms...*²⁴

Therefore, it is fundamental to the discussion on human rights to consider, among other issues, how it is possible to ensure respect for people's rights and how to prevent the development of actions that restrict them. With the support of international and, to a lesser extent, regional instruments, a certain consensus has been possible in the interpretation of rights, including patients' rights⁹. Two central points closely related to the subject under discussion are contained in legal instruments: the right to life and respect for the inherent dignity of the human being, that is, equality and protection against discrimination.

All human beings are owed the same respect and consideration on the part of the State and the community, that is, persons deprived of their

liberty must also be treated with humanity and dignity. And, omitting to offer health care to persons deprived of their liberty, the Brazilian State violates articles 6^o and 10 of the International Covenant on Civil and Political Rights promulgated in 1992¹¹ and article 4^o and section 2 of article 5^o of the American Convention on Human Rights¹⁹.

The analysis of the population of inmates of the penitentiary where the survey was carried out revealed that in the year following its inauguration, the prison population was 1.59 times greater than the occupancy capacity. Four years after the inauguration, the capacity was increased by 75%. The following year, the prison occupation reached 1.38 times the capacity and, in 2016, reached double the capacity²⁵, that is, it is in disagreement with the provisions of the state legislation in force²⁶.

A similar trend is observed in the state of Minas Gerais in general, seeing that in 2007, 37,354 people were detained in institutions with a capacity for 24,876 people. In 2010, the situation continued to worsen: 46,296 prisoners for 30,905 vacancies, reaching, in 2014, 61,392 people for 36,685 vacancies²⁷. Overcrowding is a reality in Minas Gerais as well as in the whole country, although, comparatively, there are states where the units are in worse conditions either because of deterioration of physical infrastructure or overcrowding itself.

The detention in overcrowded cells, in degrading conditions, disrespects human dignity. Overcrowding and lack of evaluation for the adoption of uninterrupted health care, prevention and promotion measures directed at persons deprived of their liberty may aggravate past illnesses and develop diseases, as well as to facilitate the intra institutional transmission of infectious diseases. Tuberculosis represents an important health problem in the country. The risk of tuberculosis in more vulnerable populations is high compared to the Brazilian population in general. The risk observed in the homeless population in the city of São Paulo was 56 times higher. The risk for the indigenous people was three times higher and the risk for people with HIV / AIDS and in persons deprived of their liberty was 28 times higher than in the general population²⁸. The problem is recognised in prisons, but its scale has not yet been determined due to the lack of regular case detection and treatment of patients^{29,30}.

In discussing the endemicity of tuberculosis in prisons, Larouze et al³¹ draw attention to the misconception that the justification for this situation is attributed to the characteristics of

persons deprived of their liberty- that is, people from disadvantaged classes, HIV carriers and drug users. The transmission of tuberculosis within these institutions is a reality, so it is not appropriate to attribute the high numbers to the predominant characteristics of the incarcerated population^{31,32}.

The irregularity in the accomplishment of the minimum protocol⁵ at the moment of entry can generate risks of intra institutional transmission of several diseases, among them tuberculosis. In addition, seclusion in overcrowded, poorly ventilated cells can lead to the spread of this disease, creating risk for both persons deprived of their liberty and their families, prison staff, and even communities to where prisoners will return after their release from prisons³⁰.

Both in UN³³ regulations and in the Lei de Execução Penal - LEP (Criminal Execution Law)⁴, preventive and curative health care is assured to prisoners. It is observed in published works about health care in the prison system of the country, which, in most cases, actions are emergency care, which repercutes in the efficiency of the health care, that is, the emergency care doesn't deal with prevention of injuries and integral care, and therefore is not complying with the provisions of the LEP³⁴⁻³⁶.

It is important to emphasise that the Plano Nacional de Saúde no Sistema Penitenciário - PNSSP (National Health Plan in the Penitentiary System)⁵ institution sought to harmonize the provisions of the LEP⁴ and the SUS², so that the persons deprived of their liberty were less invisible in the public health policy in force in Brazil. In turn, the PNAISP⁷ is focused on the expansion of health actions in the system, besides the concern with its financing. Although one of the objectives of PNSSP was the access of prisoners to health care, via SUS, it is observed in the penitentiary where this study was carried out that the accomplishment of this objective is still distant. PNAISP sought to ensure progress, if compared to PNSSP conditions, but several institutions in the country's prison system have not yet fully adhered to this policy. Thus, it can be concluded that much remains to be done to reverse the current situation.

The care that the prisoner needs and to what he or she is entitled can be guaranteed only if he or she is evaluated at the time of his or her entry in

the prison system or, if it is not possible, during the first days of imprisonment. If this evaluation does not occur, the continuation of the treatment of a prisoner who already enters the prison with health problems is not possible. This condition was also observed by Minayo and Ribeiro³⁶, in a study carried out in the prison system of Rio de Janeiro.

The lack of evaluation of health conditions in this initial situation, coupled with the lack of guidance on access to the health service located in the prison, certainly causes harm to these people. The damages compromise human dignity and can have irreparable consequences. Therefore, it is necessary to strive to comply with the provisions of specific legislation and related policies, seeking to modify the current framework. Therefore, it is imperative that those involved are truly committed, willing, without prejudices and guided by bioethics references¹³ in order to address the situation and adopt the necessary conduct, considering that not only duties and rights should be promoted, but also values, concepts and commitments.

Currently, in Brazil, social relations are still permeated by the difference between people, which affects access to rights. It is essential to universalise human dignity⁸: in addition to recognising the inequalities that stigmatise vulnerable groups, our society must be willing to reverse this situation. It is then necessary to reflect and act in order to identify directions to overcome the existing challenges.

Final considerations

It is essential to observe the international standards of UN and WHO's initiatives, as well as legislation relating to the prison system, in order to ensure the health care of persons deprived of their liberty. Likewise, it is fundamental to regularly follow the minimum protocol for the health diagnosis of persons deprived of their liberty at the moment when they are admitted into the prison system and to effectuate the orientation regarding the access to health actions inside the prison and the kinds of health care available outside the prison through the SUS. It is necessary to change the current perspective, which has led to disrespect and discrimination, and to consider human dignity through the critical reflexion made possible by bioethics.

Work produced within the scope of the Programa de Pós-Graduação em Bioética do Centro Universitário São Camilo, São Paulo/SP, Brasil.

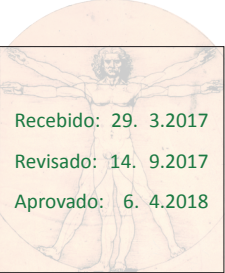
Referências

1. Brasil. Presidência da República. Constituição da República Federativa do Brasil [Internet]. Diário Oficial da União. Brasília; 5 out 1988 [acesso 9 set 2016]. Disponível: <https://bit.ly/1bIJ9XW>
2. Brasil. Presidência da República. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências [Internet]. Diário Oficial da União. Brasília; 20 set 1990 [acesso 13 set 2016]. Disponível: <https://bit.ly/1UVpr2U>
3. Brasil. Presidência da República. Lei nº 8.142, de 28 de dezembro de 1990. Dispõe sobre participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros de áreas da saúde e dá outras providências [Internet]. Diário Oficial da União. Brasília; 31 dez 1990 [acesso 30 maio 2015]. Disponível: <https://bit.ly/2Evzrei>
4. Brasil. Presidência da República. Lei nº 7.210, de 11 de julho de 1984. Institui a Lei de Execução Penal [Internet]. Diário Oficial da União. Brasília; 13 jul 1984 [acesso 21 abr 2015]. Disponível: <https://bit.ly/1JeIrcR>
5. Brasil. Ministério da Saúde. Portaria Interministerial MS/MJ nº 1.777, de 9 de setembro de 2003. Aprova o Plano Nacional de Saúde no Sistema Penitenciário [Internet]. Diário Oficial da União. Brasília; nº 176, p. 39-43, 11 set 2003 [acesso 21 abr 2015]. Seção 1. Disponível: <https://bit.ly/2GMbxBm>
6. Diuana V, Lhuillier D, Sánchez AR, Amado G, Araújo L, Duarte AM *et al.* Saúde em prisões: representações e práticas dos agentes de segurança penitenciária no Rio de Janeiro, Brasil. *Cad Saúde Pública* [Internet]. 2008 [acesso 11 maio 2018];24(8):1887-96. Disponível: <http://ref.scielo.org/965w5x>
7. Brasil. Ministério da Saúde. Portaria Interministerial MS/MJ nº 1, de 2 de janeiro de 2014. Institui a Política Nacional de Atenção Integral à Saúde das Pessoas Privadas de Liberdade no Sistema Prisional (PNAISP) no âmbito do Sistema Único de Saúde (SUS) [Internet]. Diário Oficial da União. Brasília; nº 2, p. 18-23, 3 jan 2014 [acesso 21 abr 2015]. Seção 1. Disponível: <https://bit.ly/2G1YmN>
8. Sarmento D. Dignidade da pessoa humana: conteúdo, trajetórias e metodologia. 2ª ed. Belo Horizonte: Fórum; 2016. p. 376.
9. Escuela Andaluza de Salud Pública. Guía práctica sobre derechos humanos en la atención al paciente: capítulos internacionales y regionales actualizados [Internet]. 2015 [acesso 8 mar 2018]. Disponível: <https://bit.ly/2qfpHAA>
10. United Nations. International covenant on civil and political rights [Internet]. 1966 [acesso 8 mar 2018]. Disponível: <https://bit.ly/2qhEdaf>
11. Brasil. Presidência da República. Decreto nº 592, de 6 de julho de 1992. Atos internacionais: pacto internacional sobre direitos civis e políticos: promulgação [Internet]. Diário Oficial da União. Brasília; 7 jul 1992 [acesso 31 ago 2016]. Disponível: <https://bit.ly/1UeolAo>
12. United Nations. Body of principles for the protection of all persons under any form of detention or imprisonment [Internet]. 9 dez 1988 [acesso 6 out 2016]. Disponível: <https://bit.ly/1M9rtL4>
13. Hossne WS. Bioética: princípios ou referenciais? *O Mundo da Saúde* [Internet]. 2006 [acesso 11 maio 2018];30(4):673-6. Disponível: <https://bit.ly/2G9abeE>
14. Hossne WS, Pessini L. Bioética: ouvir é preciso. *Bioethikos* [Internet]. 2011 [acesso 11 maio 2018];5(4):359-61. p. 359. Disponível: <https://bit.ly/2G68PKY>
15. Hossne WS. Dos referenciais da bioética: a equidade. *Bioethikos* [Internet]. 2009 [acesso 11 maio 2018];3(2):211-6. Disponível: <https://bit.ly/2Ker8qw>
16. Valim EMA. Atenção à saúde das pessoas privadas de liberdade à luz da bioética [tese]. São Paulo: Centro Universitário São Camilo; 2017.
17. Navarrete MLV, Silva MRF, Pérez ASM, Sanmamed MJF, Gallego MED, Lorenzo IV. Introdução às técnicas qualitativas de pesquisa aplicadas em saúde. Recife: Imip; 2009. p.130.
18. Bardin L. Análise de conteúdo. São Paulo: Almedina; 2011. p. 279.
19. Organização dos Estados Americanos. Comissão Interamericana de Direitos Humanos. Convenção americana sobre direitos humanos [Internet]. 22 nov 1969 [acesso 20 set 2016]. Disponível: <https://bit.ly/29HCHYS>
20. Brasil. Presidência da República. Decreto nº 678, de 6 de novembro de 1992. Promulga a Convenção Americana sobre Direitos Humanos (Pacto de São José da Costa Rica), de 22 de novembro de 1969 [Internet]. Diário Oficial da União. Brasília; 9 nov 1992 [acesso 9 jun 2016]. Disponível: <https://bit.ly/2bGzS93>
21. Corte Interamericana de Derechos Humanos. Cuadernillo de jurisprudencia de la Corte Interamericana de Derechos Humanos nº 9: personas privadas de libertad [Internet]. 2017 [acesso 20 set 2016]. Disponível: <https://bit.ly/2HlpuTZ>
22. World Health Organization. Health in prisons: a WHO guide to the essentials in prison health [Internet]. Copenhagen: WHO; 2007 [acesso 15 fev 2017]. Disponível: <https://bit.ly/2H6PpkA>
23. Organização das Nações Unidas. Declaração universal dos direitos humanos [Internet]. 1948 [acesso 19 set 2016]. Disponível: <https://bit.ly/1yAeHbb>
24. Organização das Nações Unidas para a Educação, a Ciência e a Cultura. Declaração universal sobre bioética e direitos humanos [Internet]. 2005 [acesso 6 fev 2017]. Disponível: <https://bit.ly/1TRJFa9>

25. Costa BEC. Secretaria de Estado de Defesa Social. Parecer de aprovação de projeto e emenda CEP-UFTM [Mensagem pessoal recebida 29 nov 2016].
26. Minas Gerais. Decreto nº 46.647, de 11 de novembro de 2014. Dispõe sobre a organização da Secretaria de Estado de Defesa Social [Internet]. Diário Oficial de Minas Gerais. Belo Horizonte; 12 nov 2014 [acesso 13 set 2016]. Disponível: <https://bit.ly/2IEVMZr>
27. Brasil. Ministério da Justiça. Relatórios estatísticos: analíticos do sistema prisional do estado de Minas Gerais [Internet]. 2015 [acesso 15 fev 2017]. Disponível: <https://bit.ly/2GHhwY9>
28. Brasil. Ministério da Saúde. Tuberculose: populações vulneráveis [Internet]. 2016 [acesso 6 fev 2017]. Disponível: <https://bit.ly/2IDM9du>
29. Sánchez AR, Massari V, Gerhardt G, Barreto AW, Cesconi V, Pires J *et al*. A tuberculose nas prisões do Rio de Janeiro, Brasil: uma urgência de saúde pública. *Cad Saúde Pública* [Internet]. 2007 [acesso 11 maio 2018];23(3):545-52. Disponível: <http://ref.scielo.org/bt62pm>
30. Sánchez A, Larouzé B. Controle da tuberculose nas prisões, da pesquisa à ação: a experiência do Rio de Janeiro, Brasil. *Ciênc Saúde Coletiva* [Internet]. 2016 [acesso 11 maio 2018];21(7):2071-9. Disponível: <http://ref.scielo.org/bs28x7>
31. Larouzé B, Ventura M, Sánchez AR, Diuana V. Tuberculose nos presídios brasileiros: entre a responsabilização estatal e a dupla penalização dos detentos. *Cad Saúde Pública* [Internet]. 2015 [acesso 11 maio 2018];31(6):1127-30. Disponível: <https://bit.ly/2KbM6X5>
32. Le Marcis F. A impossível governança da saúde em prisão? Reflexões a partir da MACA (Costa do Marfim). *Ciênc Saúde Coletiva* [Internet]. 2016 [acesso 11 maio 2018];21(7):2011-9. Disponível: <http://ref.scielo.org/kkz8vb>
33. Office of the United Nations High Commissioner for Human Rights. Resolution ONU 45/111, de 14 dez 1990. Basic principles for the treatment of prisoners [Internet]. 14 dez 1990 [acesso 6 fev 2017]. Disponível: <https://bit.ly/2IEXOJ3>
34. Fernandes LH, Alvarenga CW, Santos LL, Pazin-Filho A. Necessidade de aprimoramento do atendimento à saúde no sistema carcerário. *Rev Saúde Pública* [Internet]. 2014 [acesso 11 maio 2018];48(2):275-83. Disponível: <https://bit.ly/2Gaq2tk>
35. Soares Filho MM, Bueno PMMG. Demografia, vulnerabilidades e direito à saúde da população prisional brasileira. *Ciênc Saúde Coletiva* [Internet]. 2016 [acesso 11 maio 2018];21(7):1999-2010. Disponível: <https://bit.ly/2wB8mYo>
36. Minayo MCS, Ribeiro AP. Condições de saúde dos presos do estado do Rio de Janeiro, Brasil. *Ciênc Saúde Coletiva* [Internet]. 2016 [acesso 11 maio 2018];21(7):2031-40. Disponível: <https://bit.ly/2KgR6Ka>

Participação dos autores

Edna Maria Alves Valim concebeu e desenhou o estudo, e colaborou na coleta, análise e interpretação dos dados e redação do artigo. Ana Maria Lombardi Daibem contribuiu com a análise e interpretação dos dados do estudo e redação do artigo. William Saad Hossne participou da concepção e desenho do estudo e contribuiu com a análise dos dados.



Recebido: 29. 3.2017
Revisado: 14. 9.2017
Aprovado: 6. 4.2018