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Pinheiro, Marília Cléssia; Lima de Araújo, Janieiry; Borges de Vasconcelos, Renata;
Gurgel Cosme do Nascimento, Ellany

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Health profile of freedom-deprived men in the prison system

Marília Cléssia Pinheiro¹

Janieiry Lima de Araújo²

Renata Borges de Vasconcelos³

Ellany Gurgel Cosme do Nascimento⁴

Health profile of freedom-deprived men in the prison system

Objective. To understand the needs and health profile of men incarcerated in the Pau dos Ferros Regional Criminal Complex (Rio Grande do Norte, Brazil). **Methodology.** Quanti-qualitative research conducted with 30 men incarcerated in November 2012. Semi-structured interviews were the primary data collection method. Descriptive statistics and thematic analysis of the speeches were used for data analysis. **Results.** The participants' health profile, resulting from deficits in living conditions prior to their imprisonment, is heightened by the degrading conditions of their prison stay, and plays a role in their exclusion and lack of care when admitted as prisoners. The disorders and symptoms most often self-reported by participants were: headache (86.6%), respiratory infections (66.6%), diarrhea (60.0%), stress (60.0%), and depression or deep sadness (56.6%). The responses showed that there is a social gap, especially related to health care, in the prison complex. **Conclusion.** We recognize a need to ensure the physical and moral integrity of inmates, which is compromised by life in prison; the inmates' health problems and needs differ from those of the general population, and require solutions; the inmates' health-disease process deteriorates due to the mere situation of entering the prison system; the inmates' health problems and health needs are treated with palliative and / or no assistance by those legally responsible for their protection; few human and financial resources exist to ensure health actions for the inmates; and there are no interventions or actions of disease prevention and health promotion.

Key words: vulnerable populations; delivery of health care; prisons; morbidity.

Perfil de salud de los hombres privados de libertad en cárceles

Objetivo. Conocer las necesidades y el perfil de salud de los hombres privados de la libertad en el Complejo Penal Regional de Pau dos Ferros (Rio Grande do Norte, Brasil). **Metodología.** Investigación con enfoque cuali-cuantitativo realizado en noviembre de 2012 en el que participaron 30 hombres privados de la libertad en la cárcel en estudio. Para la recolección de la

1 RN. Universidade do Estado do Rio Grande do Norte (UERN), Brazil. email: marilia_ce@hotmail.com

2 RN, Master. Professor, UERN, Brazil. email: janieiry@hotmail.com

3 Nurse. Hospital e Maternidade Venâncio Raimundo de Sousa, Horizonte, Ceará, Brazil. email: renatinha_bv@hotmail.com

4 Nurse, Ph.D student. Professor at UERN, Brazil. email: ellanygurgel@hotmail.com

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información se utilizó una entrevista semiestructurada. El análisis de datos fue mediante estadística descriptiva y análisis temático de los discursos. **Resultados.** El perfil de salud de los participantes fue el resultado de los déficits en las condiciones de vida previas al régimen de prisión, siendo agravado por las condiciones inhumanas de la permanencia en la cárcel, teniendo como consecuencia la exclusión y la falta de asistencia cuando los ingresaron como reclusos. Las enfermedades y los síntomas más frecuentemente reportados por los participantes fueron: dolor de cabeza (86.6%), infecciones respiratorias (66.6%), la diarrea (60.0%), el estrés (60.0%) y la depresión o la tristeza profunda (56.6%). Los discursos mostraron que existe una brecha social relacionada especialmente con la asistencia en salud en el complejo penal. **Conclusión.** Se reconoce la necesidad de garantizar la integridad física y moral de los detenidos; los reclusos tienen problemas de salud y las necesidades de los diferentes grupos de población, se deben resolver; las personas presentan un franco deterioro en el proceso de salud-enfermedad por el simple hecho de entrar en el sistema penitenciario; problemas y necesidades de salud de los presos son tratados con paliativos y / o falta la ayuda por parte del responsable legal para su protección; existen pocos recursos humanos y financieros para garantizar las acciones de salud de los reclusos; no hay intervenciones y acciones para prevenir las enfermedades y para realizar programas de promoción de la salud.

Palabras clave: poblaciones vulnerables; prestación de atención de salud; prisiones; morbilidad.

Perfil de adoecimento dos homens privados de liberdade no sistema prisional

Objetivo. Conhecer as necessidades e o perfil de saúde dos homens privados de liberdade do Complexo Penal Regional de Pau dos Ferros (Rio Grande do Norte, Brasil). **Metodologia.** Pesquisa com abordagem quantitativa, realizada em novembro de 2012, participaram do estudo 30 homens privados de liberdade na prisão. Para coleta de dados utilizou-se entrevista semiestructurada. A análise dos dados ocorreu por meio de estatística descritiva e análise temática dos discursos. **Resultados.** O perfil de saúde dos participantes é resultante de déficits nas condições de vida anteriores ao regime de reclusão, sendo potencializado pelas condições desumanas de estadia na prisão, e resulta na exclusão e falta de cuidado quando admitidos como prisioneiros. As patologias e sintomas mais frequentemente auto-relatados pelos participantes foram: cefaleia (86.6%), infecções respiratórias (66.6%), diarreia (60.0%), estresse (60.0%) e depressão ou tristeza profunda (56.6%). Os discursos mostraram que existe uma lacuna social especialmente relacionados aos cuidados em saúde no complexo penitenciário. **Conclusão.** Reconhece-se a necessidade de garantir a integridade física e moral dos detentos que estão comprometidas pela vida nas prisões; os apenados possuem problemas e necessidades de saúde diferenciadas da população em geral, que precisam de resolubilidade; os apenados diante da vida na prisão têm o seu processo saúde-doença deteriorado pela simples situação de adentrar no sistema prisional; os problemas e as necessidades de saúde dos apenados são tratados com paliativos e/ou com desassistência por parte dos responsáveis legais por sua tutela; poucos recursos humanos e financeiros existem para garantir ações de saúde dos apenados; inexistem intervenções e ações de prevenção aos agravos e promoção à saúde.

Palavras chave: populações vulneráveis; assistência à saúde; prisões; morbidade.

Introduction

Discussing the guarantee of the right to health in Brazil has become synonymous with the struggle for solidifying human rights, insofar as it embodies dignity and civic responsibility. In particular, we highlight the case of individuals deprived of freedom, which a portion of society sees as “non-

citizens”, individuals who have forfeited their rights by entering the world of crime. These men and women are seen as non-bearers of human and social rights, who should not be assisted by the health services.¹ Brazil has the fourth largest prison population in the world, with almost

500,000 prisoners in an overcrowded² prison system. The imprisoned population is composed of approximately 31,000 women and over 442,000 men, distributed in the different facilities making up the prison system.³ However, there are only about 200,000 prison spaces, and the resulting overcrowding is a major focus of criticism by the United Nations (UN) on human rights abuses in Brazil². This reflects the current condition of life and health of incarcerated persons, characterized by unsanitary, overcrowded, and precarious cells, by constant violent actions, and denial of the right to health and / or lack of actions by health services, despite numerous treaties, codes, and laws intended to improve living conditions and health in the prison environment.⁴

A liberty-deprived person not only loses the right of free will, but initiates a process of depersonalization, exclusion of the "I", of not having control over him or herself, but instead being handled by the prison system among bars and high walls.⁵ For a long time, the health care of the prison population was restricted to addressing infectious diseases, which proliferate due to confinement and prison conditions.⁴ The National Health Plan for the Prison System (PNSSP) was instituted in 2003 through Interministerial Ordinance (MS / MJ) No. 1777, which assumes the inclusion of liberty-deprived persons in the Unified Health System (SUS) in order to guarantee their rights as citizens.⁴ Therefore, the health teams would need to understand the social representations of disease (morbidity) and their social determinants, for only then could they be responsible for salutary changes in social spaces (such as Brazilian prisons).⁶

However, these attempts to ensure the right to health have had little impact on the Brazilian prison system scenario. Every day newspapers, magazines, and broadcast media report about prisoners subjected to inhumane conditions, true scenarios of social exclusion and prejudice.⁷ There is now a National Policy for Integral Health Care of Persons Deprived of Liberty in the System Prison (PNAISP), established by Interministerial Ordinance (MS / MJ) N° 1 of 2014. Until then

only a few people in custody under any regime were entitled to healthcare. With the new policy, any prisoners in compliance with security requirements will benefit. To that end, the health services have a direct responsibility to conduct primary health activities, with special attention paid to assisting those with mental disorders. Correctional workers, prisoners' family members, and others that relate to incarcerated persons must all be involved in actions to promote health and prevent disease. Thus, it will be essential to introduce services and multidisciplinary teams across the health system according to the guidelines of the SUS.⁸ Research on how health care is organized for this population allows nurses to understand the work space and enable the development of specific actions. Hence, this study aims to identify the health needs and the health profile of freedom-deprived men incarcerated in the Regional Criminal Complex (CPR) of Pau de Ferros, Rio Grande do Norte.

Methodology

A descriptive and exploratory study, with a quantitative approach, was performed at the Regional Criminal Complex (RCC) in the city of Pau dos Ferros, located in the upper midwestern mesoregion of the state of Rio Grande do Norte, Brazil. The RCC has a capacity of 90 inmates (male only), but currently accommodates 107, of whom 30 participated in the study. Data were collected by applying a semi-structured interview, consisting of objective and subjective questions, between November 1 and 24, 2012. As inclusion criteria we defined liberty-deprived persons imprisoned in the Pau dos Ferros RCC, aged between 18 and 60 years, who have spent a year or more in prison, and who were identified by correctional officers as willing to participate during the data collection period.

We used Microsoft Office Excel® 2007 to perform quantitative data analysis through descriptive statistics. With respect to qualitative data, the interpretation of the interview corpus

progressed through four stages: (1) Pre-Analysis; (2) Material Exploration; (3) Treatment of Results; and (4) Interpretation.⁹ Starting from the subjects' speeches, we identified the ideas and feelings represented through the similarities and contradictions in the testimonies, in order to achieve the nuclei of understanding. We tried to find expressions, words, or significant phrases in order to subsequently organize the contents into analysis or theme categories. The next step was the creation of analysis categories: a) Disease in the prison world: experiences and feelings; b) Access to penitentiary health care; and c) Health education as a care process for prison diseases.

The research project was approved by the Research Ethics Committee of the University of Rio Grande do Norte State (UERN) on May 4, 2012, under the General Certificate of Appreciation for Ethics Nº 0129.0.428.000-11. For acquisition of the Free and Clarified Consent Term (FCCT), days and times for data collection were scheduled; the FCCT was read; objectives, methodology, risks, and benefits of the research were explained; and the FCCT was signed, followed by the application of the questionnaire (form) and interview (recording).

One potential limitation is whether the prison space presents itself as suitable for the development of research. Given the condition of incarceration, it is questionable whether the prisoners are trusted to exercise self-determination, thus the principle of autonomy is a relevant concern. The risks that these inmates have to assume should be comparable to those of a non-prisoner population.¹⁰

Results

General features of the participants

The subjects were predominantly under 30 years of age, and half the group was married. As for the period of freedom deprivation, 50% had three or fewer years in prison. Among the respondents, 96.6% had already fallen ill while in prison, especially with diseases of the respiratory system. (Table 1).

In order to have an overview of the categories, we present the analysis and interpretation of the subjects' speeches, originating ideas and reflections on the health needs and the health profile of the convicts. Sequentially to this description, we organized speeches and perceptions conforming to three analytical categories. First is the perception of disease in the prison world: experiences and feelings, understood as the record of the perception of health and illness of convicts, in addition to their feelings and experience in disease situations. Next comes access to penitentiary health care, where we describe the health care organization in the RCC, which continues with the discussion of health education as a care process for prison diseases, where it is observed how health education activities occur within the RCC and which are the themes involved.

Disease in the prison world: experiences and feelings

This category presents evidence about prisoners' needs and health problems. The speeches refer to the disease process and its relation to living in the prison world. Some respondents refer to the disease as something abrupt, with a sudden onset, and usually only mention the symptoms presented, being unaware in most cases of the existence of an etiology or underlying disease. They cite: *Ear pain, headache, low blood pressure, and diarrhea. Got sick suddenly (Convict 03); [...] I have a problem in the eye, when I was arrested [...] I took a lot of blows to the head, I think this problem has existed since that time, I have to be operated on because it reached a vein, but I've been trying for a long time and I can't, I want to go out to the street for an operation on this eye and return to work (Convict 07).*

Convicts 05 and 07 describe the circumstances of what happened, but do not recognize the determinants of their illness; the fact of being imprisoned and lacking good living and health conditions in prison is already a reason to become ill, besides pointing out neglect and/or lack of assistance for their health problem. There are still those who can connect their health-disease

process to the environment where they live, whether related to hygiene, nutrition, or the environment itself: making the association and understanding the poor condition of their room and board as a risk to their health: *Diarrhea, pressure problems, depression, and allergies are the diseases that I remember. I got sick suddenly,*

I had never had any of these problems. I guess it started with the food here, which is not good (Convict 06); Fatigue, asthma, and stomach pain disturb me constantly. I realize that I will get sick because I feel a cold sweat, shortness of breath, then I notice that I'm not normal, that a crisis is coming. The problem is the hot water, the walls, the muffled cell, anxiety... (Convict 14).

Table 1. General features and morbidity of 30 men who were convicted in the Regional Criminal Complex (RCC) Pau dos Ferros/ RN 2012

Variables	Frequency	%
Age group		
19–30	16	53.3
31–45	10	33.3
46–60	4	13.3
Marital status		
Stable union	15	50.0
Single	15	50.0
Length of freedom deprivation		
1 to 3 years	15	50.0
3 to 6 years	10	33.3
7 years or more	5	16.6
Self-reported morbidity		
Diarrhea	18	60.0
Depression or deep sadness	17	56.6
Skin diseases	7	23.3
Lung diseases	20	66.6
Headache	26	86.6
Abdominal pain	16	53.3
Stress	18	60.0
Hepatitis	1	3.3
HIV/AIDS	1	3.1

Participants describe open sewers, poor hygiene, living with toxic materials without protective equipment, poorly ventilated cells, and poor-quality food, among other factors denying them conditions of a healthy life. It is confirmed that meals are prepared by a group of inmates who lack the skills for this role. They do it because they receive remission of their sentences for each

day worked, so three days labor decreases their sentence by one day. This work also “earns” them the right to move freely at certain times between the yard and the kitchen. At the same time, some said they do not become ill in prison, as can be seen in the set of statements that follow: *I do not get sick, I'm very strong (Convict 17); I have not gotten ill (Convicts 18 and 30).*

Sexually transmitted diseases, in particular HIV / AIDS, need to be the subject of a reflective assessment, even though they appear in small indices, 3.33% of the convicts: *I have positive serum, but I guess I've not caught it here, it must have been when I traveled in Brazil, in the southern regions. I confirmed that I had HIV in 2006 here in prison, when they came to do some tests and I asked to do them and in 2009 I did another test and again the result was the same, positive. Occasionally some very itchy sores appear on my skin, pain throughout the body, headache, fever, abdominal pain and stress* (Convict 12).

Likewise, the symptoms that point to psychological illness onset deserve special care. Three inmates indicate in their speech: *I am depressed, with my nervous system altered. I have had nervous breakdowns since the time I was free, but inside here it got worse* (Convict 09); *I caught depression, I am very afraid and have the impression that I will die here, every time I have a crisis I feel shortness of breath, desire to escape, run, hide* (Convict 20).

The statements clearly show how prison life exacerbates existing psychological symptoms and/or causes them to emerge. Similar conceptions are found about the experiences and feelings of freedom-deprived men in the face of illness and access to care provided by the health services. When inmates get sick they initially communicate this to the prison agents and later to the director of the Complex, seeking to solve their health problems. Some also communicate to their families: *I communicate to my family and the agents. There are a lot of people in the unit, it's easy to get sick, then they do virtually nothing. They have nothing to do, there's no escort and no car to take us to the hospital. The truth is that after we enter here we are the same as nothing, nobody cares. If you get better, good luck, if you don't, only Jesus cares* (Convict 10); *I go to the agents and the director for him to authorize me to leave when things get worse. I like to call my family warning and asking to never let the medicine run out. When they can, they take us to*

the hospital, when they can't, there's nothing to do (Convict 21).

A common problem is the lack of transport (official vehicles) for taking inmates to a health care center for assistance, and lack of palliative measures prevailing or other assistance: *At times I call agents, but they cannot do anything, they say they will take me a certain day and don't, the car is missing. They give the remedies that they have here, generally it is an anti-inflammatory, but never take us to the hospital, it never works* (Convict 05).

Some of the measures taken are a request (loan) of third-party cars, and in more severe cases, officers engaging in unauthorized practices, such as the prescription of medicines and self-medication - some inmates keep medications in their cells and use them as needed, without knowing the risks they are undertaking. According to the statements that follow: *If there's no way to take us, we have to hold out right here. But if it is a disease that does not require the hospital and there are medicines here, then they give them for us to relieve the pain. Sometimes they lack, but when there is, they (correctional officers) give them* (Convict 01); *The agents give me some sleeping pills, I sleep day and night and it doesn't improve or if the medication ends they take me to the hospital because I get mad, stay up walking in the cell, I need medicine, with it I even forget that I'm arrested. They were not taking anyone because the Government had not sent a car, but now they sent one so they will take me to hospital* (Convict 11).

Another key obstacle is the lack of human resources to escort prisoners, since prison guards cannot leave their post and go in search of care for the inmates. In urgent cases, although there is an organization to control who leaves the unit and who stays, the safety of the prison can be compromised.

Access to prison health care

This encompasses the prisoners' perceptions about the care available to meet to their health

needs and health problems, provided by either prison workers or health professionals. A portion of the convicts believe that the health care is provided according to the capabilities of the RCC and the health centers where they are taken, and shows partial conformity with the situations of neglect of these facilities—as if receiving some assistance were a benefit and not a guaranteed right: *The service follows that saying, when you can do, do. We understand, there are many prisoners to oversee, some have some problems, and others have others. [...] The hospital care is good, I have always been well attended because inmates do not have to stay in line, we arrive and they soon solve the case* (Convict 07).

They usually refer to the care provided in health facilities as being effective and quality, but always associate proper care with speed and with receiving medications. The hospital-centered and biologicist concept of welfare prevails in their speech; they see themselves as “sick bodies” in need of medicine, ignoring their joint participation in the health-disease process. *The care in prison is good, they can take us if we don't refuse. The hospital care is good, we do not stay in line because they are afraid of convicts, and see us quickly* (Convict 08). Others go beyond these conceptions and pay attention to the fact that the assistance offered needs improvement, and demonstrate knowledge of their rights as human beings to enjoy health. Regardless of the reason for their crimes they preserve other human rights inherent in their citizenship. *The service here in prison is terrible, it is really bad. In the hospital the care is bad too because the last time I went to the hospital after feeling chest pain and phlegm for many days, the doctor just gave me an injection and sent me back to prison, I tried to talk about the case and he did not even hear, prescribed an injection and sent me back. The assistance could be better* (Convict 06).

The reported scenario is of absence in the guarantee of care for prisoners' needs. In his speech, Convict 13 addresses an important question: oral health. Dental treatment is limited to extractive actions: *When we go to the dentist he soon pulls out the*

tooth, he doesn't treat it. I think he wants to see us “banguelo” [toothless]. He doesn't want to waste time with convicts and pulling out is faster. The service needs to improve a thousand percent. The State of Rio Grande do Norte needs to improve health (Convict 13). However, this does not exist in this reality, and the responsibility lies with the family health team in charge of the coverage area encompassing the complex: *The service here is almost equal to all prisons that I was in, but when I was arrested in another state I thought it was good because there was an infirmary inside the prison, which prevented me having to go to the hospital in the case of a simple disease. Here they give a remedy without even knowing what the disease is, what if it is dengue and the guy is getting worse taking medicine for nothing. What I know is that there isn't even a structure to put an infirmary. The assistance needs to be better, even if it is for prisoners, even considering that judging the condition of this prison there is assistance in excess...* (Convict 15).

Health education as a care process for prison diseases

In the prison system the situation is marked by a scenario of social exclusion. The inmates feel the need for health education practices, attach importance to their existence, understand these as promoters of good health, and suffer from the lack of them. Emphatic, they all respond that did not have access to health education activities during their stay in the CPR: *There aren't. A doctor came twice to visit, early in the year, but did not come again and they were not speaking, just prescribing remedies. The prisoners who were ill went to a room, consulted and that's it. It would be important to have lectures, about health and what to do not to get sick* (Convict 01); *No, there has never been. The health personnel only leave condoms to prevent AIDS ... once they delivered pamphlets, those who cannot read look at the pictures, try to understand and cannot, then throw them away. If they had talks or a project it would be very rewarding for us because we are here, but we have the same rights as citizens of the street. I wanted painting, crafts, or music*

lessons, because these can even re-socialize the prisoner. So it is difficult to go out and be different since there isn't, I have been not resocialized (Convict 06).

Discussion

Almost all prisoners have experienced illness in the prison. The data obtained are similar to the national disease profile in other prisons. This situation demonstrates the negativity in the health-disease process of convicts. The overcrowding of the cells, the poor structuring of the same, the confinement itself, and the inadequate hygiene contribute to or cause this imbalance between health and disease in prisons.¹¹ This situation contributes to the worsening of the health condition of this population and poses a serious risk to the health of freedom-deprived men, their contacts, and the communities in which they will be inserted after their release.¹² After entering the RCC it was observed that they sickened more, but a significant percentage of prisoners did not notice the difference between the illness in and out of the prison world. This finding may be linked to the socioeconomic profile of these men, who are mostly from the poor social strata, often barely literate or not at all, and who usually hail from marginalized communities with poor health services, lack a defined profession, and lived in a situation of social exclusion prior to being admitted to the prison system.⁴

As regards comorbidities, a significant percentage claim to have gotten sick of the same diseases as before imprisonment, and a high percentage realized that their diseases are not the same as those of the world outside prison. The containment conditions promote similarities in the pattern of illness among prisoners, even if they form a diverse / heterogeneous social group. It is noticed that the discourses on sudden onset are in line with the thought of Polak,¹³ according to whom “the disease is an unpredictable event that has an impact on homeostasis and on the sense of personal well-being. [...] Sick people are usually

sensitive and vulnerable; when becoming ill all of one's life changes, at least temporarily.” There are men who did not associate their disease process to any biological or environmental factor. The hospital-centered and biologicist welfare concept prevails in their speech, they see themselves as “sick bodies” in need of medicines, ignoring their joint participation in the health-disease process.⁴

This reality is shared in various prisons, with precarious attention to oral hygiene, virtually no protection, early diagnosis, or even dental rehabilitation. Resolution no. 07 of 2003 of the NSCLC [National Council on Criminal and Penitentiary Policy] provides that oral health actions should be developed taking into account health protection, specific protection, early diagnosis and prompt treatment, damage limitation, and rehabilitation. However, it was found that prisoners do not receive dental care. When provided, it is limited to the extraction of teeth. The number of toothless prisoners or those with bad teeth is enormous.¹⁴

This study deals with men's health, and it should be kept in mind that they have a unique profile, marked by social legacies of gender that creates the “macho” stereotype. The imaginary of being a man can imprison him in cultural moorings, thereby hindering self-care practices, for man is seen as manly, invulnerable, and strong. Men who feel invulnerable are at greater risk, because they get sick in secret and delay seeking appropriate care, becoming more vulnerable. These are two sides of the same coin.¹⁵

The spread of infectious diseases, especially HIV/AIDS, presents a serious health risk to freedom-deprived men, as well as to their contacts and the community itself.¹² Another health profile that deserves highlighting is that linked to mental disorders, insofar as the prison milieu promotes the emergence of prison psychoses and various mental disorders, often caused by an oppressive atmosphere and existing diseases due to poor hygiene, food, and clothing.¹⁴

Although they are aware of the above situations, the attitude taken by the prisoners is appropriate:

because they are deprived of their liberty, the State has an obligation to provide the minimum conditions, since the custody of prisoners is its responsibility. Imprisonment does not deprive individuals of the rights to physical and moral integrity.¹⁶ Some inmates grasp this concept and are aware that the assistance offered needs improvement, and demonstrate knowledge of their right as human beings to enjoy health.

Regardless of the reason for their crimes they preserve the other human rights inherent in their citizenship.¹⁷ However, Diuana¹² clarifies that “often it is the prison guards who judge the need for care based on the prisoner’s request and act to facilitate or hinder this access.” Assuming that the conditions of life and health are important and have an affect on their behavior and their integration into society, it is known that confinement in prisons can by itself affects the stability of an individual; what happens then when the health care is permeated by scenarios of neglect and social exclusion? This is why it is necessary to understand the stories of the men who are incarcerated to then approach their reality, demonstrating partial conformity with the neglect situation.

Health education practices, like care practices, demonstrate their effectiveness in the subject’s autonomy, and are therefore necessary in the prison world to enable the prisoners to be conscious of the determinations of their health-disease process. We consider health education to be a resource capable of having an impact on the lives of individuals, for it encompasses the determinants of the health-disease process and provides input for the adoption of new health habits and behaviors.¹⁸

According to Alves and Aerts,¹⁹ health education has been rethought as a process able to establish reflection and critical awareness about the causes of people’s health problems, thereby enabling the health system to work with people instead of for them. There are numerous means and strategies for minimizing illnesses through health education, it is only necessary to develop them. It is worth

noting that providing health education only to inmates is not enough: all those who make up the criminal justice system must be involved, including managers and prison guards, so that together they understand the relevance of this mechanism in the life and health of the incarcerated population.

The pattern of illness thus results from deficient life conditions prior to the imprisonment regime, exacerbated in prison due to poor, inhumane conditions, making up a panorama of exclusion and lack of assistance to those inserted in the prison system. Enforcement of existing laws on sanitation and rights would lead to significant improvements in meeting health needs as well as a less harmful pattern of illness. Health needs are treated with palliative and/or lacking assistance by those legally responsible for addressing them; not all inmates recognize the reasons for their illness; few human and financial resources exist to promote the health of inmates; and there are no interventions to further actions to promote health and prevent injuries and diseases. This outcome generates reflection and review by health professionals, prison officials, and civil society on the physical and moral integrity of detainees, whose health problems and health needs demand resolution.

Thus it is important to recognize the health needs of this audience so that we can act in a more resolute manner, based on the discussion and proposition of options to meet the health needs of freedom-deprived men and modify their profile of illness. While the Brazilian prison system continues to have a merely punitive character, contradicting the principles of constitutional rights, and respect for life and human dignity, only a few changes can occur in the prison world. We must urgently revive ideas about resocializing the prison community, so that the duration of imprisonment can serve as a time for prisoners to reflect on their crimes and restructure their lives with dignity and health.

We recognize the health needs of freedom-deprived men in the Regional Criminal Complex of Pau dos Ferros, based on the need to ensure the physical and moral integrity of detainees, which is

compromised by life in prison. The inmates' health problems and needs differ from those of the general population, and need solving; life in prison causes inmates' health-disease process to deteriorate as a result of the situation of entering the prison system; their problems and health needs are treated with palliative and/or lacking assistance by those legal responsible for addressing them; few human and financial resources exist to ensure health actions for the inmates; and there are no interventions and actions to prevent diseases and promote health.

The Family Health Team, particularly the nursing subfield, should play a transformative and challenging role in the lives of freedom-deprived individuals. They should visit inmates in their cells to grasp their individual and collective needs and work together with other family health team members in an attempt to meet the social and health needs of inmates. It is worth noting that acting for the health care of convicts involves the other people in their circle of contacts: officials, family, and community. Nursing should promote health protection actions and rehabilitate the sick bodies through educational activities with inmates, addressing several topics including those involving health issues. Inmates need to understand the issues surrounding the process of becoming ill within the prison system.

Family participation is extremely important for the rehabilitation process, and nursing can be a key element of interaction between the family, the convict, and the CPR. It is important that nursing should break with the social stigma surrounding the subjects in private prisons, so that it can provide care free of prejudice, fear, and with the desire for justice. It is important that nurses do not neglect the situation of precariousness and lack of assistance experienced in the reality of RCC Pau de Ferros.

The limitations of this study can be attributed to the challenges of entering the RCC Pau de Ferros, requiring readjustment of the research schedule. Data collection occurred with the monitoring of a prison guard, which may have influenced the

testimony of convicts while speaking about their health needs and problems. The study subjects have some difficulties in expressing themselves. Some demonstrated discomfort from the use of handcuffs, which could not be removed even when signing the informed consent, in accordance with the safety standards of the prison complex.

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