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Penitentiary health team: the reality of the work process

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Abstract *This article aims to characterize the work process of the prison health team in the state of Paraíba. This is an exploratory research, with a qualitative approach, carried out with two Prison Primary Care Teams in the state of Paraíba. Individual interviews were carried out with health professionals in order to elucidate the work process developed. The corpus consisted of 10 texts and was analyzed using the software Interface de R pour les Analyzes Multidimensionnelles de Textes et de Questionnaires (Iramuteq) and exposed through the Descending Hierarchical Classification (CHD) and the Similarity Analysis. The analysis of the corpus showed that there were 5,417 occurrences of words, spread in 1,090 forms, whose average occurrence was 5.97 words for each form. The Descending Hierarchical Classification analyzed 152 text segments, with 75% retention of the corpus, which resulted in the construction of four partitions and six classes, namely: attention to perceived needs; counseling activity; reception of PPL and family; difficulties related to the system; difficulties related to resources; and suggestion for professional training for EABP.*

Key words *Prisons, Workflow, Patient assistance team, Prisoners, Qualitative research*

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Introduction

The Prison Primary Care Team (EABP) must perform its duties with People Deprived of Liberty (PDL) in health units located in prison institutions, where they deliver care practices and regulate the continuity of care in the Health Care Networks (RAS). The inclusion of EABPs in Brazilian prisons occurred primarily with the National Penitentiary Health Plan (PNSSP) publication in 2003[1].

Currently, these health teams are regulated by the National Comprehensive Health Care Policy for People Deprived of Liberty in the Prison System (PNAISP). This state policy gathers the Health and Justice ministries. The policy aims to ensure the access of PDLs in the prison system to comprehensive care in the Unified Health System (SUS). To this end, its general guidelines are comprehensiveness, intersectoriality, decentralization, hierarchy, and humanization[2].

The EABP must develop cross-sectional, intersectoral, and universal actions to ensure access and reception among the plural contingent of PDLs and must be considered as a tool for the implementation and universalization of the SUS, which may involve adults, foreigners, seniors, women, and their children, indigenous, lesbians, gays, bisexuals, transvestites, transsexuals, transgenders, queer, intersex, asexual, and others identified (LGBTQIA+), people with mental disorders or disabilities[2].

In this sense, health professionals working in the prison system should receive different health needs and problems affecting PDLs. An epidemiological analysis of the health situation among PDLs in Brazil developed by the Federal University of Espírito Santo (UFES) underscored tuberculosis, dengue, HIV/AIDS, viral hepatitis, acquired syphilis, human anti-rabies care, leprosy, male urethral discharge syndrome, acute Chagas disease, various types of violence, and leptospirosis as the most prevalent diseases or treatments[3-5].

The information mentioned above may interfere with the implementation of actions. The evaluation of the work process among health professionals in the penitentiary system revealed that the quality of the services provided is negatively analyzed by the professionals who work in EABPs. This reality is related to failures regarding structural aspects[6] and the setting and the processes developed in this scope, such as the lack of planning, the turnover of health workers, and the lack of career progression plans[7].

This setting disregards what the SUS advocates and reaffirms the need to develop the PNAISP to its fullest extent and ensure the health of PDLs. Thus, understanding the EABP health professionals' work process recognizes the gaps in the current national legislation. In the face of this concern, the guiding question of this research arises: "How is the EABP work process characterized against what is proposed by the PNAISP?" In this sense, this study aimed to characterize the penitentiary health team's work process in Paraíba.

Methods

This exploratory, qualitative research was conducted with EABP in the state of Paraíba. Information from the last report of the National Penitentiary Department (DEPEN), an agency of the Ministry of Justice, mentions that Paraíba has 9,596 PDLs[8], with 19 penitentiaries, including the Penitentiary of Forensic Psychiatry. Ten EAPBs were implemented in male prisons and one team was included in a female prison.

The sample of this study consisted of one EABP that works in a female prison and another in a male prison, which were randomly selected. The inclusion criterion adopted for randomization was to have a complete primary composition (doctor, nurse, dentist, psychologist, and social worker), as recommended in the PNAISP[2].

After selecting the two EABPs, individual interviews were held with the professionals of the health teams to collect information on the work process developed. In this stage, we adopted a two-part semi-structured interview roadmap. The first part addressed the sociodemographic and professional profile of the subject. In contrast, the second addressed open-ended questions on the understanding of work in the prison environment, legislation, implementation, organization, analysis, the composition of health activities, the attributions of the professionals involved in these actions, and the identification of perceived health impacts.

The responsible researchers in the prison units carried out the interviews on days and times scheduled with the direction of the prisons and health professionals. The corpus was analyzed with the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ), using the Descending Hierarchical Classification (DHC) and Similarity Analysis of words in the text.

The DHC, also called Reinert's method, aims to identify the ideas in the corpus. This type of analysis results in the establishment of classes, which correspond to text segments that, in the

meantime, present words or forms similar to each other and different from the text segments of the other classes[9].

In this way, the grouping of text segments, isolated in classes, corresponds to systems of discourse representation, graphically arranged through the dendrogram. This graph shows the partitions made in the corpus until reaching the final classes. Furthermore, it is noteworthy that the analysis by DHC must show minimum retention of 70% of the text segments to be valid for classifying textual material[10].

The similarity analysis identifies the combined occurrences between the words, and its result is related to the connection between them, informing the level of relationship between the forms in the corpus[11]. The corpus consisted of ten texts, whose segment retention was 75% and characterized by the variables of interest: professional category and EABP from the male and female penitentiary. The criteria adopted for the inclusion of the elements in their respective classes were frequency more significant than the mean occurrences in the corpus and association with the class determined by the chi-square value equal to or greater than 3.84, a setting that provides a margin of error < 0.05.

All research subjects were informed about the study and signed an informed consent form. Their identification consisted of using the letter "P" and a number corresponding to the order of the interview. Data collection began after authorization from the State Penitentiary Administration Secretariat in Paraíba (SEAP-PB) and approval by the Research Ethics Committee of the Federal University of Rio Grande do Norte, under CAAE 62825716.8.0000.5537.

Results

The analysis of the corpus derived from the interviews with the ten professionals who make up the EABP showed 5,417 words spread in 1,090 forms, whose mean occurrence was 5.97 words for each form. The Descending Hierarchical Classification analyzed 152 text segments, with a retention of 75% of the corpus, which resulted in the construction of six classes and four partitions (Figure 1).

Partition 1, formed by classes 4 and 3, reveals aspects related to the work of professionals in the EABP and corresponds to 32.5% of the analyzed content. There is a more significant development of care practices geared to the health needs of inmates and counseling.

Class 4 (19.3%) informs that the activities by the EABPs are visits, services, and follow-ups to solve emerging problems of this population; yet, such actions are often performed at the request of the PDLs. Nursing stands out as the most relevant professional category ($p < 0.001$), per the following excerpts:

The nurse attends to the PDLs, and the health team sees their needs (P5).

The PDLs request service from the specialty heads when there is a need in the pavilion (P8).

The health team work process is primary care, like a PSF. The health team here makes the referral when you need to go to the UPA or hospital (P10).

Class 3 (13.2%) reveals another essential activity in the EABP work process – counseling – mainly related to HIV, in which the psychology service has been present ($p < 0.001$) and is exemplified by the professional's statement.

Many inmates do not want to receive HIV medication directly in the cell, so I call them to talk and deliver the medication, and I provide counseling (P3).

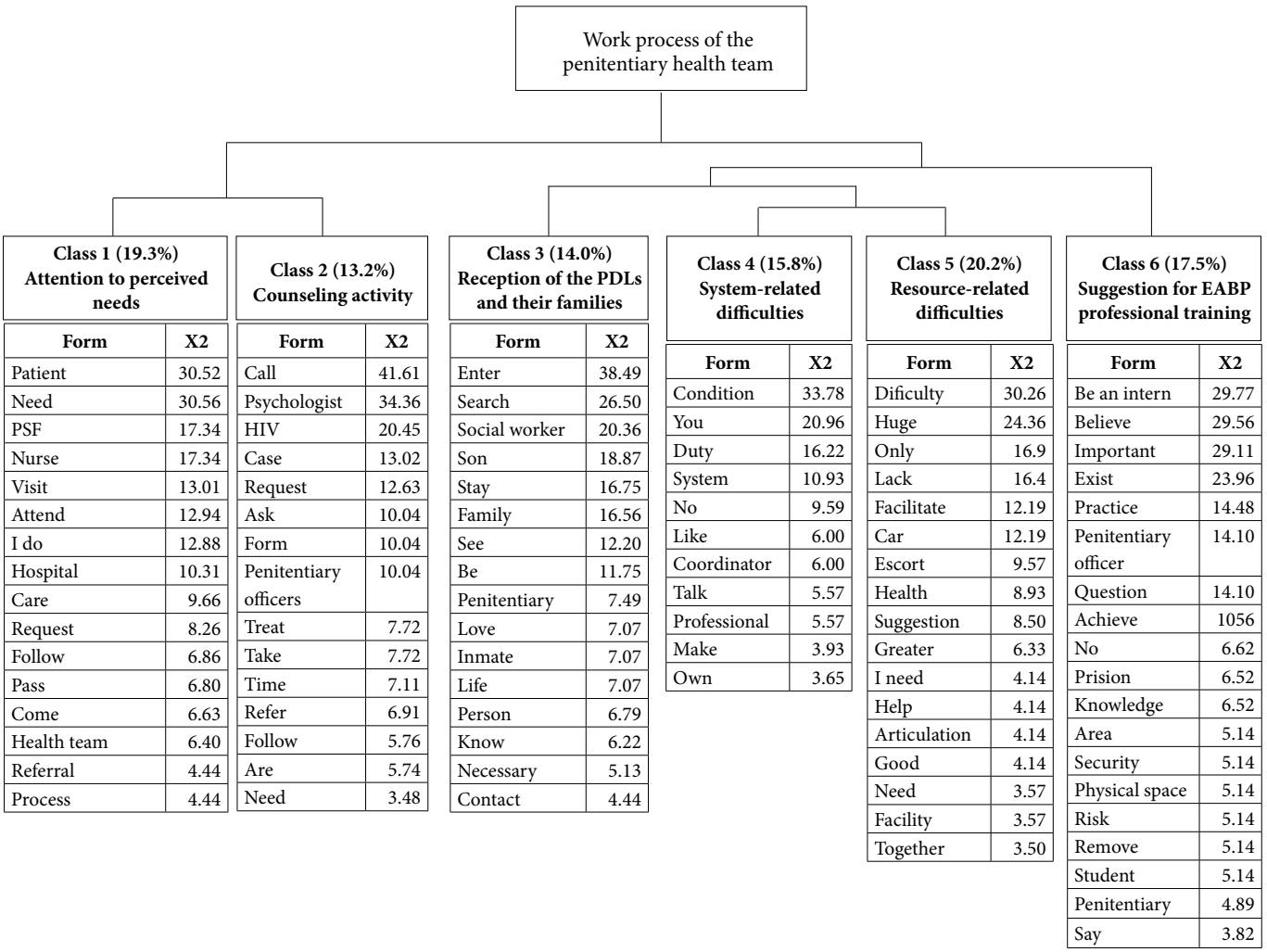
Partition 2 (Figure 1), which is formed by class 6. It captures 14% of the content of the analyzed corpus and addresses aspects related to the activity of receiving the PDLs and their families, in which social workers have essential participation in the connection between these intramural and extramural axes ($p < 0.001$), per the statements below:

From recognition, PDLs are received by the social service, and the social worker contacts the family and seeks information about the PDLs' family, whether it exists, whether they are partners or children and how these children are doing (P2).

PDLs suffer for being here, but their family suffers much more. They pay for an act they did not commit but have to be close to the PDLs. More often than not, the family does not want to enter here. They are afraid to come here, but the social worker works in the family axis because the family is a priority for PDLs (P1).

Partition 3 (Figure 1), formed by classes 2 (15.8%) and 5 (20.2%), corresponds to the highest capture of the analyzed text (36%) and points out the difficulties related to the work process developed by EABP professionals. Class 2 reports obstacles such as overcrowding and the presence of only one health team, as stated by the subjects:

Due to the great demand, the professional must move the patient quickly, there is no way for you to provide complete care, no condition for it to be performed, and you end up doing something purely restricted to the need (P9).



Class 1 (19.3%) Attention to perceived needs

Form	X2
Patient	30.52
Need	30.56
PSF	17.34
Nurse	17.34
Visit	13.01
Attend	12.94
I do	12.88
Hospital	10.31
Care	9.66
Request	8.26
Follow	6.86
Pass	6.80
Come	6.63
Health team	6.40
Referral	4.44
Process	4.44

Class 2 (13.2%) Counseling activity

Form	X2
Call	41.61
Psychologist	34.36
HIV	20.45
Case	13.02
Request	12.63
Ask	10.04
Form	10.04
Penitentiary officers	10.04
Treat	7.72
Take	7.72
Time	7.11
Refer	6.91
Follow	5.76
Are	5.74
Need	3.48

Class 3 (14.0%) Reception of the PDLs and their families

Form	X2
Enter	38.49
Search	26.50
Social worker	20.36
Son	18.87
Stay	16.75
Family	16.56
See	12.20
Be	11.75
Penitentiary	7.49
Love	7.07
Inmate	7.07
Life	7.07
Person	6.79
Know	6.22
Necessary	5.13
Contact	4.44

Class 4 (15.8%) System-related difficulties

Form	X2
Condition	33.78
You	20.96
Duty	16.22
System	10.93
No	9.59
Like	6.00
Coordinator	6.00
Talk	5.57
Professional	5.57
Make	3.93
Own	3.65

Class 5 (20.2%) Resource-related difficulties

Form	X2
Dificulty	30.26
Huge	24.36
Only	16.9
Lack	16.4
Facilitate	12.19
Car	12.19
Escort	9.57
Health	8.93
Suggestion	8.50
Greater	6.33
I need	4.14
Help	4.14
Articulation	4.14
Good	4.14
Need	3.57
Facility	3.57
Together	3.50

Class 6 (17.5%) Suggestion for EABP professional training

Form	X2
Be an intern	29.77
Believe	29.56
Important	29.11
Exist	23.96
Practice	14.48
Penitentiary officer	14.10
Question	14.10
Achieve	1056
No	6.62
Prision	6.52
Knowledge	6.52
Area	5.14
Security	5.14
Physical space	5.14
Risk	5.14
Remove	5.14
Student	5.14
Penitentiary	4.89
Say	3.82

Figure 1. Component classes of the dendrogram of the textual corpus of interviews with EABP professionals, Paraíba, Brazil, 2021.

Source: Authors

The care provided by the health team takes priority PDLs because the team cannot provide care to everyone as it should (P1).

Class 5 addresses other difficulties related to the prison system, which negatively affect the EABP professionals. These hardships refer to structural aspects, such as the lack of a vehicle and escort to carry out the referral and counter-referral in the Health Care Network (RAS), the inadequate physical spaces, and the lack of materials and supplies, mainly dental, as highlighted by the professionals:

Only one vehicle can transport the PDLs to the hearing and other services. So, network appointments are often missed (P6).

The physical space is a difficulty. Sometimes the convicts need to talk confidentially, and unfortunately, the physical space does not give this freedom (P3).

Another difficulty is the lack of supplies and materials to restore and extract. Sometimes the health team spends months without material, carrying out the requisitions (P7).

To broaden the discussion on the subject and, thus, contribute to the involvement of stakeholders with prison health, partition 4 (Figure 1), revealed in class 1 (17.5%), refers to the suggestion of the professionals regarding subjects and other aspects that should be included in health training courses that would contribute to the work

with the PDLs. We underscore the inclusion of curricular internships within the prisons and cross-sectional themes that should be addressed in the courses.

Legislation should be addressed, and the practical internship should be included in the curricula. The student should have direct contact with the PDLs (P9).

Providing an internship in the penitentiary would remove this stigma and even discover that you want to work here (P10).

The similarity analysis (Figure 2) shows the lexical content resulting from the organization of words that reflect the EABP work process, aligned with the classes previously presented. The health team emerges as the central axis of care, in which the strong connection with the word "no", expressed by the extensive connection line, highlights the hardships perceived by professionals, such as the needs regarding structure and processes, the difficulty related to escort, and the lack of inclusion of universities in penitentiary health units. The intense connection of the health team with the convict, represented by the thick line, shows the PDLs as the core of the professionals' attention.

Discussion

The inclusion of EABPs works per the PHC guidelines. It emerges as a device to organize care among those deprived of their liberty within prison institutions and care networks, based on the perception of emerging needs of the population living in prisons in the country, besides performing all the care and practices under the responsibility of the multidisciplinary teams, such as health promotion and disease prevention, disease treatment, and rehabilitation to ensure comprehensive care[2].

Health professionals must have a high degree of knowledge to work in the prison setting to provide comprehensive care to PDLs, given

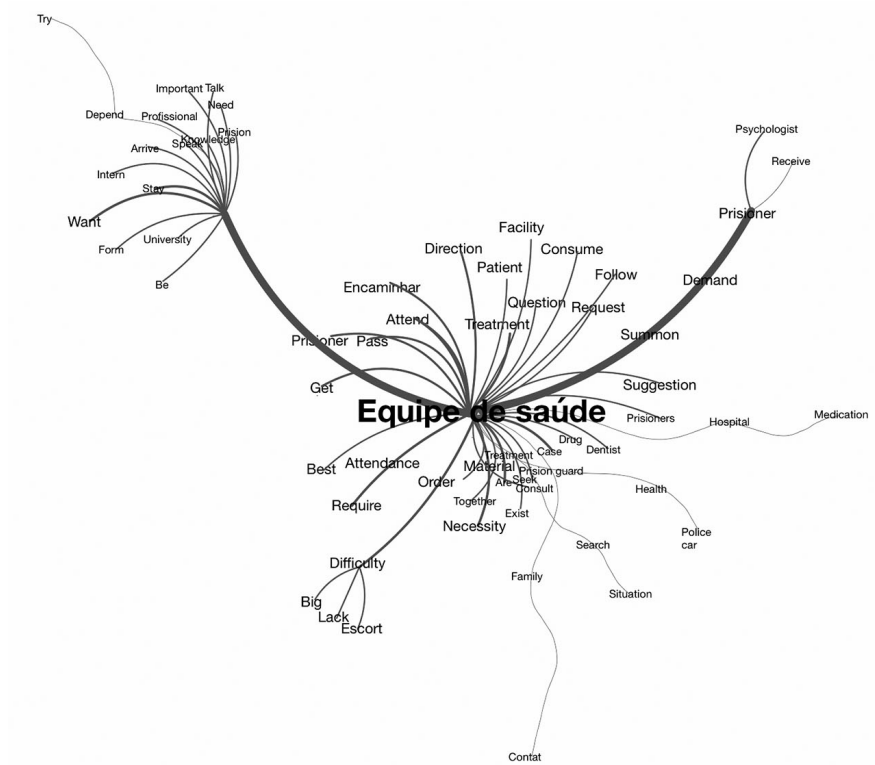


Figure 2. Analysis of corpus similarity, Paraíba, Brazil, 2021.

Source: Authors.

the high complexity of the care provided to this population concerning the diversity of diseases, conditions, and disorders that affect the incarcerated population. Therefore, the development of knowledge and skills is required to address the primary perceived health needs and the peculiarities involving the work in the correctional institution[12].

We should also emphasize that comprehensive care is related to multidisciplinary work, in which each professional in the health team contributes to fulfilling the subjects' several needs. However, the discourses about the health team's work process in the prison context evidence the effective and significant participation of nursing, psychology, social service, and dentistry in activities performed. However, the doctor's figure did not emerge among the analyzed statements. We also identify that the health team professionals' work is flawed.

This setting could be related to the biologicist culture that still permeates Brazilian health care. In this case, visits and prescriptions are part of a list of medical activities already expected by PDLs and professionals. In contrast, other activities, such as counseling and receiving convicts and their families, are less expected actions and, in this sense, cause a stir when they are performed.

Also, the results show a predominance of visits and care directed to the most prevalent diseases and conditions among the activities performed. The emphasis on the biologicist process to the detriment of harm reduction practices observed in this research corroborates what has been verified in other locations, where reality translates into health promotion and incipient disease prevention, even in the face of a significant reduction in illness observed among PDLs who participate in these activities[13].

On the other hand, reception and counseling actions are developed. The results show that they are performed in secrecy, with professionals calling the PDLs for a private conversation, ensuring respect and information confidentiality. The counseling activity on HIV – a prevalent disease in the prison system – reduces stigma, which is strongly felt by people who have HIV, whether internalized, perceived, vicarious, or enacted. As a result, counseling by trained professionals generates positive effects on PDLs infected with the virus as it facilitates the acceptance of the new condition, attenuating the feeling arising from the stigma and reducing discomfort regarding the treatment[14].

Reception activities are aimed at the PDLs, and the families of these people since the deprivation of liberty implies considerable changes in the life of convicts and their families, from the entry into a new environment, which involves changes in self-esteem, the pressure arising from criminal stigmatization, changing habits, and other biological, social and psychological changes that adversely affect the health of individuals and their families[12].

Thus, the reception must be considered an axis in the prison health work process. In this sense, establishing a professional-user bond, shown in the similarity analysis, is an essential condition for the activities of the health worker within the PHC principles and is related to contacting PDLs and their families and active listening, in an expanded care perspective, which aims to empower subjects, equity, and effectiveness of health strategies and actions[15].

Health care for the population deprived of liberty must include comprehensiveness, intersectoriality, decentralization, hierarchy, and humanization as structuring axes to ensure the access of PDLs in the prison system to comprehensive care[2]. Thus, we could infer that appropriately involving inmates in the care network contributes to the health of individuals and the community[16].

The comprehensive health of PDLs is also adversely affected by overcrowding[5], as pointed out in the results of this study. A large population deprived of liberty has to be attended to under an insufficient number of health professionals and inadequate conditions[6]. This setting has negatively impacted the perception of subjects deprived of liberty regarding health care practices within prisons, as it reduces the service capacity[17].

Also, the scarcity of resources reflects on the work process of the health team among the health professionals working in the prison environment[6]. The inadequate physical structure, the lack of a vehicle and escort to carry out the referral and counter-referral in the RAS, and the lack of materials and supplies, mainly dental, are highlighted.

Structural issues are an obstacle in the prison setting, resulting in the spread of diseases and lack of access to health services[17]. When considering the importance of the environment for health, creating healthy places in prisons was listed as a priority topic for research on prison health[18].

Furthermore, deprivation of liberty can and should be considered an opportunity for these subjects – usually in a state of socioeconomic and

educational vulnerability – to access health care and improve their condition[16]. Thus, we should emphasize that they must respect the subjects' autonomy and contribute to their empowerment.

The poor access to the network represents a significant and complex difficulty among the inmates, as it impairs the resolution of health problems of the incarcerated population. It also discredits the value of health actions regarding PDLs[17]. Nonadaptation of convicts' security and transport protocols results in health care restrictions for these subjects. Thus, the existence of health services does not imply their effective care[13].

Furthermore, access can be regulated by the severity of the patients' general condition or the presence of severe diseases. Thus, inmates diagnosed with acquired immunodeficiency syndrome (AIDS) or tuberculosis are assisted more frequently than inmates with more favorable clinical conditions[5].

Thus, the great challenge consists of the efforts of the prison authorities – represented by the unit's general director and coordinators. They have significant participation and influence over providing services for a broad and profound involvement with correctional health care[13].

We should also underscore that health professionals' activity in the prisons is permeated by obstacles of the very SUS, such as shortage of professionals, the deficient number and quality of care services, delayed emergency care, and the substandard or non-existent drug distribution, but also due to peculiarities of the prison environment, such as violence among PDLs and PDLs with prison security agents, which put all people who live or work in these institutions at risk[19].

Furthermore, although official publications report that 100% of Brazilian states are qualified to receive funds related to the implementation and maintenance of EABPs, the health coverage of this population is only 30%, which indicates the low speed of implementation of the state plans referring to the PNSSP and PNAISP. Furthermore, it is essential to increase the budgetary agenda geared to this plan to improve structural aspects and ensure adequate human and material resources for realizing universal, comprehensive, resolute, and continuous care[20].

Finally, broadening the discussion on the subject can reduce the invisibility of PDLs and health professionals who work in the national prison system. One of the main possible paths is incorporating the theme into health training courses and developing curricular internships within the prisons.

According to the PNAISP, through the Ministry of Health, the Federal Government is responsible for encouraging and conducting training and education actions to disseminate the policy in the country[2]. Furthermore, the National Curriculum Guidelines for undergraduate health courses – published in 2001 – mention that training should stimulate skills and competencies for professional team practice aligned with health services and the community[21].

Thus, higher education centers must assume responsibility for training health professionals to act per the Brazilian public health policies to strengthen the SUS and its guidelines.

Final considerations

The work process of the EABPs develops biologicist care practices – visits and referrals – that aim to meet the health needs of inmates as a structuring axis. Counseling activities are also developed, mainly among HIV/AIDS patients, and reception is geared to PDLs and their families, as recommended by the PNAISP. However, the statements of health professionals do not reveal actions aimed at other members of the prison community, such as penitentiary security agents and PDLs' family members, who could also have their health needs met by health teams installed in prisons.

The main difficulties that emerge from the EAPB work process are related to the small contingent of health professionals to meet an overcrowded situation amid the inadequate physical spaces, where the number of vehicles and escorts to perform the referral and counter-referral in the RAS is insufficient, as are the materials and other supplies.

Given the training of health professionals within the national penitentiary context, we observe the need to conduct intramural curricular internships in prisons and an approach of cross-sectional themes – rights of PDLs and work in prisons – in higher education institutions.

The main limitation of this work is the need for an adequate place to hold interviews, which were sometimes performed in a place with some people movements and may have compromised the subjects' discourse. There is also a noticeable need for more material published in the literature that assesses the implementation of the PNAISP in the country.

However, the results contribute to health education, as it elucidates aspects related to the health work process in prisons. The administrations of the state health and prison administration secretariats can employ the data that emerge from this research to solve the perceived obstacles that negatively affect the care provided. Moreover, health professionals can use the discussion undertaken in their planning.

Finally, we underscore the need to review the investments in health care for PDLs to ensure sufficient human resources, adequate structures, and satisfactory materials and supplies, under penalty of failing once again in comprehensive, resolute, and universal care.

Collaborations

Study design and data collections: ML Barbosa and VEP Santos. Data analysis and interpretation; discussion of results; writing or critical review of content; review and approval of the final version: ML Barbosa, PTCO Salvador, ANP Cogo, MA Ferreira Jr, GMC Costa, and VEP Santos.

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