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ORIGINAL ARTICLE

CONTROL ACTIONS OF TUBERCULOSIS IN THE MALE PRISON SYSTEM

AÇÕES PARA CONTROLE DA TUBERCULOSE NO SISTEMA PENITENCIÁRIO MASCULINO

ACCIONES PARA CONTROL DE TUBERCULOSIS EN SISTEMA PENITENCIARIO MASCULINO

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ABSTRACT

Objective*:** to know the opinion of people without freedom about care given for tuberculosis control in the male Prison System. ***Method*:** descriptive-exploratory study with qualitative approach, performed with seven people without freedom through a semi-structure interview script, submitted to content analysis technic. The research project was approved by the Ethic Committee in Research, CAAE nº. 0008.0.000.126-11. ***Results: there were fragility in actions of tuberculosis control due to delay of diagnosis, to the treatment based in the delivery or not of the medicine, the difficulty to health services access out of prison and lack of knowledge about the disease, strengthening the prejudice and stigma about tuberculosis. ***Conclusion:*** it is suggested the implementation of actions with origin compensatory policies for securing benefits for the convict with respect to the principle of universality, health is right, assured the people in the prison system. ***Descriptors*:** Tuberculosis; Prisons; Health Education.

RESUMO

Objetivo*:** conhecer a opinião de pessoas privadas de liberdade sobre a assistência prestada para o controle da tuberculose no Sistema Penitenciário masculino. ***Método*:** estudo descritivo-exploratório, com abordagem qualitativa, realizado com sete pessoas privadas de liberdade por meio de roteiro de entrevista semiestruturado, submetido à técnica análise de conteúdo. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, CAAE nº. 0008.0.000.126-11. ***Resultados: verificou-se fragilidades nas ações de controle da tuberculose devido ao retardo do diagnóstico, ao tratamento baseado na entrega ou não do medicamento, a dificuldades no acesso aos serviços de saúde fora da prisão e à falta de conhecimento sobre a doença, o que potencializa o preconceito e estigma sobre a tuberculose. ***Conclusão:*** propõe-se a implementação de ações com origem em políticas compensatórias na perspectiva de que benefícios sejam assegurados aos presidiários e, no que tange ao princípio da universalidade, a saúde seja de direito, assegurada às pessoas no sistema prisional. ***Descritores*:** Tuberculose; Prisões; Educação em Saúde.

RESUMEN

Objetivo*:** conocer la opinión de personas privadas de libertad sobre la asistencia prestada para el control de la tuberculosis en el Sistema Penitenciario masculino. ***Método*:** estudio descriptivo-exploratorio, con enfoque cualitativo, realizado con siete personas privadas de libertad por medio de guía de entrevista semi-estructurada, sometido a la técnica análisis de contenido. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, CAAE nº. 0008.0.000.126-11. ***Resultados: se verificaron fragilidades en las acciones de control de la tuberculosis debido al retardo del diagnóstico, al tratamiento basado en la entrega o no del medicamento, a dificultades en el acceso a los servicios de salud fuera de la prisión y a la falta de conocimiento sobre la enfermedad, lo que potencializa el prejuicio y estigma sobre la tuberculosis. ***Conclusión:*** se propone la implementación de acciones con origen en políticas compensatorias en la perspectiva de que beneficios sean asegurados a los presidiarios y en lo que se refiere al principio de la universalidad, la salud sea de derecho, asegurada a las personas en el sistema de prisión. ***Descritores*:** Tuberculosis; Prisiones; Educación em Salud.

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INTRODUCTION

Tuberculosis (TB) is still an important health problem around the world. Brazil has the 17th position related to the number of cases, being responsible for 82% of the world cases.[1] TB is extremely endemic in Brazilian prisons and it is necessary the control action, once it has high incidence due to overcrowded, bad ventilated cells, low hygiene, bad nutrition, high incidence of HIV, illegal behavior as use of alcohol and drugs. In addition to this factors, there is also the irregular treatment and the late detection of resistance contributing with a high risk of diseases and death by TB for the population.[2]

People without freedom (PWF) in custody in the Brazilian prison system are, by a majority, men between 20 to 49 years old, with few education and from groups of low buying and social power.[3] Despite the existence of national and international laws about human rights, highlighting the assistance for prison PWF, there is a weak operation, generating concern about the situation the prisoners are, having the existence of violence practice affecting the negligence with physical and psychic health of the population.[4]

TB needs a collective effort to change its endemic standards, reducing infections, deaths and other diseases. Health public policies were adopted for this situation, as the National Program of Tuberculosis Control (NPTC) and the National Plan of Health in Prison System (NPHPS). [5-6]

NPTC is in the health services and it is for the development of strategies related to decentralization and horizontality of prevention, vigilance and control actions.[7] It is developed through a unified program together with the federal, state and municipal sphere. It is subordinated to a programming politics of its actions with well-defined standard assistance and technicians, ensuring the distribution of medicines and other necessary inputs as preventive actions and worsening control. This allows the universal access of the population to their actions.[5]

Since 1996 with the roll of the Emergency Plan For Tuberculosis Control, the Ministry of Health adopted in Brazil the *Directly Observed Treatment-short course* (DOTS) strategy, to reach the cure goal in a minimum of 85% of people by the disease, reducing the abandonment rate to less than 5% providing an effective control of the disease in the country.[6,8]

Among some general national recommendations of TB in prison, there are the early detection of cases, routine and flows establishment for diagnosis examinations and state and municipal program of control and laboratory area, ensuring the sample flow, result return of basilloscopy in 24 hours and immediate starting of treatment.[9]

NPHPS was established through the Inter-ministerial Ordinance number 1.777/2003 and developed for health care according to principles in the Unified Health System (SUS) aiming to promote integral care to the population in male and female prisons, inclusive psychiatric units.[9] This ordinance subside a a commitment by the SUS for Brazilian population, that is, universality of access of any kids for everybody.

Health actions in prison system aim to implement the prevention and promotion of health, to adopt protection measures as vaccination, to attend the prison population in the prison unit, send them to more complex levels when necessary and to stimulate the capacity and awareness of managers and health professionals.[9]

Based on the exposed reflexions and considering purpose of the National Program of Tuberculosis Control for people without freedom in prison system, the following guiding question was created: Which actions are done for tuberculosis control in the prison system in João Pessoa/PB? To seek the answer, the objective was to know the opinion of people without freedom about the care given for the tuberculosis control in the male Prison System.

METHOD

An exploratory descriptive study with a qualitative approach, conducted with people without freedom in the premises of male prisons of the municipality of João Pessoa, Paraíba, in the period December 2011 to February 2012. The city of João Pessoa has eight prisons, seven are male and one for female.

To select the participants, there were a survey and the checking of male population without freedom in seven prisons of this city, reported with TB in 2011, through consultation documents (Data from Information System for Notifiable Diseases - SINAN) as well as records books and charts of consultation with users in a prison situation diagnosed with TB in the reference state service, Clementino Fraga Hospital Complex. From that survey, 25 convicts were identified, of which two had abandoned the treatment, seven were of high dangerousness, excluded for interviews and nine were still under treatment.

Of these 25 convicts, seven were included in this study with the following inclusion criteria: being conscious and oriented in time and space, male, with a history of tuberculosis notified in 2011, entered into the male prison system in the municipality of João Pessoa-PB and had already completed treatment for TB in the period not less than 6 months of the period defined for the interviews.

For this study, researchers were supported by health professionals and prison staff, who made the first contact in order to facilitate the meeting between the researcher and the researched one in a safety way. In the narrative clippings, participants were asked to choose the real name of this research being defaulted the following encodings: Mano, Parceiro, Moral, Brother, Boy, Figura and Maluco.

The empirical material was collected from the interview technique, using a semi-structured script. The interviews were conducted individually with the use of a tape recorder in a reserved place of the prison, guaranteeing the right to anonymity and privacy of the participants.

For the analysis of the empirical material, it was used the technique of Content Analysis proposed by Bardin[10] whose operation was based on three steps: Pre-analysis, material exploration, processing and interpretation of results. For phases of exploration of material and treatment of the results and interpretation all the recordings were listened and transcribed. In this process, the completeness, consistency, representativeness and relevance of content were observed. Finally, it was proceeded to the analysis and discussion of categories, based on the literature relevant to the topic.

This research was the project approved by the Federal University of Paraíba (CEP/HULW/UFPB) by the Ethics Committee in Research of the University Hospital Lauro Wanderley (Protocol 274B/11, CAAE paragraph. 0008.0.000.126-11) Resolution 466/12 of the National Health Council (CNS/MS)[11], dealing with ethics in research involving human beings. All participants were told to read and delivery of the Term of Consent signed in duplicate, after clarification of the research objectives, their voluntary participation, guaranty of their confidentiality and given the right to withdraw their consent at any stage of the research, without suffering losses.

RESULTS AND DISCUSSION

From the analysis of the empirical material, it was possible to apprehend two cores of meanings: *(1) treatment and diagnosis of TB in the prison environment; and (2) educational actions for tuberculosis control in the prison environment*. The first group addresses weaknesses related to access and affordability of TB patient without freedom to health services. There are delayed diagnosis; based treatment delivery or not of the medicine; difficulties in the provision of vehicles to carry them to health institutions of high technological level. The second group addresses questions related to tuberculosis control through information received by health professionals in the prison environment.

♦ Treatment and diagnosis of TB in the prison environment

TB control contemplated by NPHPS is based on the interruption of the transmission chain through case finding, early and proper diagnosis and treatment until healing under the techniques Rules for the Control of TB.[12]

The WHO recommends that actions to TB control in prison are mainly based on the DOTS strategy, which is founded the political commitment; identification of basillypherous cases; short-course chemotherapy with patient follow-up, including supervised medication; regular supply of medicines and registration and evaluation system, including response to treatment,[13] However, it was noted that the recommended by WHO is not running them in prison, since to be encouraged to describe about the treatment received by professionals health in prison, all convicts complained of the delivery of the medication, indicating that the treatment adopted in the prison system is based only on the medical aspect, limited to the delivery of bacteriostatic or not.

> *The received treatment for tuberculosis in prison is not good, only they deliver the medicine. The difficulties I had to deal with, was related medicine delivery (Moral)*
>
> *The received treatment for tuberculosis in prison to tell you the truth, is not that all treatment, I do not even know how to speak. What it had was a medicine for headache and cough, I still take a bit [...] O just know that treatment is not appropriate here. (Maluco)*
>
> *About treatment received in prison, the medicine comes every month, tablet arrives and the nurse give it to me. The difficulty I faced to treat tuberculosis was the worst treatment, because I'm still taking the tablets. (Figura)*
>
> *Health professionals here ran after the medication and I could do the treatment. (Boy)*

Given the reports, it was found that only one of the DOTS strategy resources is being

contemplated, which is the regular supply of medicines. Thus, there is weaknesses in the DOTS strategy and the recommendations of NPHPS. Regarding the treatment way, it was found that 100% of respondents performed the treatment on self-administered form, confirming failures in control measures and non operationalization of DOT (Directly Observed Treatment).

The NPHPS guides that treatment should be supervised daily to all diagnosed cases, but also offering HIV testing to all diagnosed cases, registering cases in the Register of TB cases Book, monitoring monthly the treatment through medical or nursing consultation as well as performing basilloscopy control for the initially positive cases.[9]

It is known that the DOT is a key element in the DOTS strategy aimed at strengthening the patient's adherence to treatment and prevention of emergence of medicine resistant strains, reducing the cases of abandon and increasing the probability of cure. Therefore, it is desirable to the observation be daily from Monday to Friday. However, this strategy can be negotiated with the patients according to their availability.[14]

Supervision in the prison context, must be carried out exclusively by a health professional to ensure access to health services in cases of adverse effects from the treatment, preventing medication used as an element for switching and/or pressure encouraging recognition of the PWF as patient.[6]

People treated with DOT are more likely to cure and not progress to MDR-TB than those who do not have access to this strategy. Moreover, it has the power to bring professionals of patients, strengthening the bond and establishing trust between them, also being an important moment to explain to the patient all the information about the disease.[14]

TB control in this scenario may seem simple: convicts live in restricted environment, had health services, diagnosis and treatment are simple, everything good for success. But actually, the obstacles are many, especially underestimation of symptoms in a violent environment where survival is a priority, not adapting to healthcare services; lack of resources; difficult access due to prioritization by the authorities, the security at the expense of health and fear by health professionals in entering the prison area.[13]

Another situation that demonstrates weakness in actions to TB control in prison is the detection of TB cases by the prison health service. In the convicts´statements, the diagnosis is being made out of the prison environment.

> *I found out I had this disease when I started coughing a lot, spitting, had a fever, not eating, and other factors as well. It was a dry cough that would not stop and spiiting that yellow phlegm. There was no way, I spoke with a prison guard, then they took me to the doctors and then to Clementino Fraga Hospital. At the hospital I had a x-ray and phlegm examination was done. Through this disease has been detected. I thought I should look for medical advice to find out what it was when I took the exam, it was found that I was sick with tuberculosis. (Boy)*
>
> *I discovered that the disease was when they took me once to take the exams in the hospital. (Moral)*
>
> *When the prison's health service was unable to attend, then we all went to the hospital there for U.H. (Maluco)*

These reports show that the TB diagnosis is carried out in areas of high complexity, when in fact, it should be made by the health unit of the prison. Health actions developed in prison system are for prevention, promotion and treatment of diseases for integral health care, prioritizing actions to TB control and laboratory examinations.[6]

Establishing routines and flows for diagnostic studies should be defined with the health of the prison system, with state and local TB control programs and the laboratory in order to ensure the flow of samples, the return of basilloscopy results in 24 hours and the immediate initiation of treatment.[5-6]

According to Resolution No. 11 of the National Council for Criminal and Penitentiary Policy of the Ministry of Justice, the evaluation of health of convicts must be held when entry into the prison system, carrying out systematic examination to detect TB. The examination should be performed no later than the 7th day of admission to the prison unit and should consist of a clinical and radiographic evaluation of the chest. Another important point is the deepen care of the convicts already there, in order to be submitted to TB diagnosis and screening, periodic testing. These procedures should be performed at least once a year.[6]

The basic guidelines relating to the control of tuberculosis in prisons are not being practiced. Some authors show that the test is not routinely performed in most prisons. Patients are not diagnosed at the moment of admission, and those who acquire the infection within the prison are not diagnosed early, which facilitates the transmission and contamination of other convicts.[13.3]

With the reports, operation actions failures are identified by health units in prisons, as they ought to be empowered to promptly diagnose and treat TB cases. According to the Ministry of health, efforts should be made early in order to find the patient and provide appropriate treatment, interrupting the chain of transmission of the disease. Thus, the active search for persons with prolonged cough should be a strategy prioritized in health services for the discovery of such cases and performed at inclusion of the convict in prison.[15]

Convicts have difficulties in being sent to health services, thereby contributing to the failure of control measures of the disease in prison. In this context, failures in the prison system regarding access to health care were found.

> *Forwarding given to other health services was very bad because I had no treatment for where we wanted, which was the Clementino Fraga hospital to are better there, because we knew it is a very serious disease. (Brother)*
>
> *After I did the examinations, after arriving at the hospital, the doctor asked to stay in hospital, but they did not aloow me because there was not a bed for me to stay. Then they said that I had to return with 05 days, but they did not take me back to the hospital, so my treatment was here in the prison. (Mano)*
>
> *There are still a lot of difficulty for you to go to the hospital [...] because it is not all the time that they (prison officials) want to take us. (Boy)*
>
> *When I needed to be sent, it is a very bad sitaution. When there is a sick convict there (in prison), they could not lead him anywhere, they said it was missing escort. (Parceiro)*

Access goes far beyond the use or nonuse of health services, including the adequacy of professional and technological resources used and health needs of patients in order to ensure not only entry and continuity in services and the satisfaction of a health need.[16]

The prison population have the right to access the actions and health services, with legally defined by the Penal Execution Law n. 7210, 1984 by Federal Constitution of 1988, by Law no. 8.080, 1990, regulating the SUS and by Law no. 8,142, 1990, which provides for community participation in the SUS.[9]

In the prison context, there is a number of differences from what is established in legislation and justified by numerous inadequacies related to living conditions, health, diet, lack or shortage of transportation for convicts on an emergency or even unavailability or shortage of health professionals.[17]

In studies about access, there is the idea that one dimension of the performance of health systems associated to the offer.[18] In the definition of access, Sanchez and Ciconelli conclude that when the concept is supported by four main elements: availability, acceptability, ability to pay and information, there is a risk of confusing with health equity. In most research on the concept of access, converge to a common thought: the problem of access to health and therefore health equity that needs to be discussed and developed through cross-sectoral and cross-cutting actions in all areas of government, including social and economic policies, allowing better distribution of income, strengthening citizenship and others.[19]

It is important to note the distinction between the terms access and accessibility, which although used ambiguously, have complementary meanings. The access allows the appropriate use of services to achieve the best possible results. It would, therefore, how the person experiences the health service. The accessibility enables people to get access to services.[20] The access as a possibility of achieving care according to the needs have interrelationship with resoluteness and extrapolates the geographical dimension, covering aspects of economic, cultural and functional order offer services.[21]

When the offering actions in prevention, promotion and recovery is insufficient to meet the health needs of the prison population, as in the case of emergencies or need for examinations, the recluse should be referred for outpatient and hospital care establishments in the city, state or federal health area.[6.12]

These weaknesses in the care of patients with TB, informed by the convicts, contribute to the delay in diagnosis of TB and to the increase in the number of cases in prison. It is worth noting that failures in the early diagnosis of TB can result in increased mortality of the disease and the development of clinical emergencies that increase the rate of hospitalization for TB.[22-3]

The delay in diagnosis and initiation of treatment are clear reflections of the deficiencies in the health system, being prevented with significantly interventions to increase early detection of cases.[24] It is necessary to reinforce the idea that convicts have all fundamental rights and especially the right to enjoy the highest standards of physical and mental health.[9]

It is necessary to emphasize that given the weaknesses highlighted, health is not considered a right of the convict, but a concession of penitentiary administration. According to reports, the difficulty of access is most often associated with the willingness of correctional officers in committing to respond to the complaints of the convicts who had long beg help for their needs.

In this understanding, the NPHPS emphasizes the importance of educational activities regarding the development of skills and awareness, not only to health professionals, but for all workers who work in the prison context, with the aim of expanding the capacity to solve problems and answers the needs of health services and better experienced in dealing with the management of actions to TB control.[24-6]

♦ Educational actions for tuberculosis control in the prison environment.

TB control requires strategies and initiatives promoting early diagnosis and healing the sick. Among these strategies, it is recognized the importance of health education. However, this activity is not routine inside the prisons. When asked about information received by health professionals, essential for action of TB control, the convicts reported:

> *They sent me to do the treatment. (Figura)*
> *The doctor told me to stop smoking, not doing drugs, and takethe right medicine, only that! (Moral)*
> *Health professionals have passed the information for me to make the right treatment for disease because the recurrence is worse than the first time. (Boy)*
> *The information I received from health professionals about TB was to care more, no smoking, no drugs, not being in places with dust, dirty water, they said many things for me to avoid, especially cigarettes. (Maluco)*

The statements show that the information provided by health professionals are limited, which restricts the actions to alert conditions to do the treatment, as well as recommendations on the privations of smoking, drinking and drug use. This lack of interest and not doing what is recommended, for Sanchez and colleagues is due to the health professionals working in prisons are few, poorly paid, with precarious contracts and high turnover.[25]

The implementation of actions for coping TB in their different contexts need to take account of technical and scientific knowledge constructed about TB. However, we cannot ignore the subjective, social, political and cultural dimensions involving it. It requires professionals from different areas, the development of inter-sectorial action, the decision to seek to reduce social inequalities, improving living conditions of these populations, and also consider the priorities that involve subjectivity - individual and collective - of the actors in their daily activities.[26]

To facilitate this information, health professionals should receive, in their admission and periodically, appropriate guidelines on TB control, including measures that they must follow to better care and combating the disease. Before any action, it is critical lifting the profile of the group as to previous experience and qualifications from this survey to define the work process and make prediction strategies for Continuing Education in Health (CEH).[14]

The weaknesses in the actions of health education is reaffirmed in the statements below. Convicts showed to have clarity on how to spread the disease. It is associated with the sharing of personal items and the use of tobacco. Those reporting about the contagion through the air are rare, and when they do, they aggregate information of common sense.

> *I believe I caught tuberculosis smoking too much, because soon I caught it and did not know I had. (Figura)*
> *I found out that I was with tuberculosis due to drugs because I spent eleven days smoking crack without stopping. (Maluco)*
> *I caught this disease from a partner too, eating from the same spoon, sometimes drinking from the same cup, the living also because sometimes it gets in the air. (Mano)*
> *When I was sick with tuberculosis, in this case, cup and spoon that I used, everything was separate, would not let anyone use that no one would catch it. (Boy)*
> *I caught tuberculosis smoking cigarette, smoking too much, drugging me too. (Parceiro)*
> *I caught tuberculosis through drugs, when I smoked, many drugs and too much smoke in the pavilion. (Moral)*

It is known that TB is spread from person to person primarily through the air. The speech, sneezing and especially cough of a patient with active pulmonary TB spread droplets in air of varying sizes, containing bacillus.[5] The transmissibility is present from the first symptoms, falling rapidly after the onset of effective treatment. In practice, when the patient has no history of previous treatment, or resistance may be considered that, after 15 days of treatment, the patient is no longer considered infectious.[17]

The research reveals that most of the students showed no knowledge on how to

contagion. This situation also suggests little involvement of health professionals in the prison system to perform educational activities directed to convicts.

Prison is a community where all interact and are at risk of getting TB. The development of Information, Education and Communication (IEC) programs failure by the large number of detainees as the restriction of carrying out collective activities due to environmental and safety conditions. Furthermore, the ineffectiveness of strategies prescriptive education in a highly hierarchical and rejecting charges (beyond those inherent to incarceration) being necessary to seek other approaches. Awareness strategies elaborated with the participation of convicts that would also multipliers, seem more appropriate, but they will need consciousness degree of autonomy and their right to initiative.[13]

It is fundamental that users are informed of material related to the disease, such as transmission and treatment. However, this information must go beyond, including social, environmental, stigmas and prejudices of the disease. This does not guarantee that the user will have changes in their behavior, but it can contribute to the even understands what he needs to do to have better health and quality of life, not just a knowledge about the disease. This is the true goal of education health.[14.27]

Given the reports, it was observed that the use of tobacco is a routine activity, and many detainees associate the disease with this activity. It is known that the direct form of contagion is not that one. But, indirectly, this practice may contribute to the illness. Thus, tobacco control should be integrated TB control for achieving disease control, as the inhalation of tobacco smoke, passive or active, is a risk factor for TB.[14]

On the habit, the NOHPS recommends actions to be undertaken in reducing damage to PWF who are abusive and/or harmful use of alcohol and other drugs. In case of withdrawal, the health team must perform the appropriate care or send them to a referral hospital.[9]

The lack of knowledge among the population about TB arouses fear in people, which shows the prejudice that accompanies many for years, the disease. The disease, among other social problems, causes negative changes such as remoteness and isolation in the patient's life. The statements below refer this situation:

> *I suffered enough with my fellows in the cell cursing me and saying that I would not be good, always criticizing me. (Parceiro)*
> *It is difficult because almost nobody wants to get near. They get away from you. (Boy)*
> *In the period that I had TB, it was not very good because they do not want to be around you because they can have the disease, the person becomes more isolated, live alone anymore. (Mano)*

Before the speeches, there is a lack of knowledge about the disease among the convicts, which contributes to the isolation of the TB patient before the prejudice from the lack of information about the disease. It is evident that prejudice and discrimination of the patient are unfavorable factors for TB control actions. It is also noteworthy the fact that an infectious disease will certainly affect relations with people, since the prejudice and fear contribute to reduce or prevent relations of solidarity. Moreover, the fact that the disease is contagious and recurrences are very constant lead to disbelief in curing TB.[28]

The experience of having TB modifies people's daily lives and how relates to others, leading to suffering marked by isolation and lack of help. All these factors contribute to the non-acceptance of the disease, with the fear of revealing the diagnosis, preferring to keep the illness a secret.[28]

The fear of having TB has implicit stigmatization inherent in the disease itself, as well as those who have it, discouraging people from seeking health services, including diagnosis and treatment. The best way to combat the stigma associated with TB is sensitize communities through health education.

Generally, it is perceived by the statements of the convicts, the need to work on education based on dialogue, exchange of health knowledge in order to foster mutual understanding between technical and popular knowledge, leading to possible changes in the understanding disease and its prevention.[29]

The strategy of health education provides a positive health behavior for enabling the development of greater control over the factors that determine it, promoting a healthier life and improving self-esteem. It is essential that patients are participating, with freedom and right to make good decisions about their health.[30]

FINAL REMARKS

The health care for PWF, concerning the TB control, is not in agreement with NPHPS and the NPTC guidance, contributing to the control of the disease in prison is a big challenge. Investment will be required in

human and financial resources to ensure the thousands Brazilian without freedom to care access, not as a privilege or charity, but as a constitutional right.

The unit of reference for the diagnosis and treatment of tuberculosis is the hospital, contrary to what is recommended by the programs of the disease be treated in the health system. The care for low and medium complexity are poor referenced to these aspects. This demonstrates failures in public policy surrounding the health of PWF, taking into account that changes need to be made in this context, both structurally and in a matter of health work.

In operational terms, it is necessary to identify early cases of the disease, enabling access to health services according to the complaints of convicts and develop health education strategy that favors greater case detection and combating prejudice. It is suggested that discussion, deployment and implementation of actions originating from compensatory policies from the perspective that, in addition to free medication, benefits are provided to the convicts, giving them a greater chance of healing and health, and with regard to the principle universality, health is a right guaranteed to the sick people in the prison system.

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