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HEALTH AND DISEASE: OPINIONS AND NEEDS PERCEIVED IN THE PRISON SYSTEM

SAÚDE E DOENÇA: CONCEPÇÕES E NECESSIDADES PERCEBIDAS NO SISTEMA PENITENCIÁRIO

SALUD Y ENFERMEDAD: CONCEPTOS Y NECESIDADES PERCIBIDAS EN EL SISTEMA PENITENCIARIO

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ABSTRACT

Objective: understanding the opinions and the needs perceived of the inmates of the penitentiary system in the State of Paraiba. ***Method:*** a descriptive study with a qualitative approach conducted between February and December 2012. The sample was finished on 53 inmates with the aid of information saturation technique. The production of data was done from a semi-structured interview and analyzed with the analysis of technical content. The research had the project approved by the Research Ethics Committee, CAAE: 0400.0.133.000-09. ***Results:*** there was a predominance of inmates aged 20 to 29 years old, single, natural from Paraiba, with some kind of religion and with incomplete primary education. Through speeches emerged the categories << **Opinions about health and disease** >> and << **Perceived needs** >>. ***Conclusion:*** when discoursing about these aspects, the inmates reported from religious opinion until the current concept of social determinants of health-disease process, and the existence of a need for health care. ***Descriptors:*** Health-Disease Process; Prisons; Determination of Health Care Needs.

RESUMO

Objetivo: compreender as concepções e as necessidades percebidas dos detentos do sistema penitenciário do Estado da Paraíba. ***Método:*** estudo descritivo, com abordagem qualitativa, realizado entre os meses de fevereiro e dezembro de 2012. A amostra foi encerrada em 53 apenados com auxílio da técnica de saturação das informações. A produção de dados foi realizada a partir de uma entrevista semiestruturada e analisados sob a técnica de Análise de conteúdo. A pesquisa teve o projeto aprovado pelo Comitê de Ética em Pesquisa, CAAE: 0400.0.133.000-09. ***Resultados***: verificou-se a predominância de detentos com idades entre os 20 aos 29 anos, solteiros, com naturalidade paraibana, com algum tipo de religião e com ensino fundamental incompleto. Por meio dos discursos emergiram as categorias **<< Concepções sobre saúde-doença >>** e **<< Necessidades percebidas >>. *Conclusão***: ao discorrerem sobre estes aspectos, os apenados reportaram desde concepção religiosa, até o conceito atual de determinantes sociais do processo saúde-doença, bem como a existência de uma necessidade de assistência em saúde. ***Descritores*:** Processo Saúde-Doença; Prisões; Determinação de Necessidades de Cuidados de Saúde.

RESUMEN

Objetivo: comprender los conceptos y las necesidades percibidas de los internos del sistema penitenciario del Estado de Paraíba. ***Método:*** es un estudio descriptivo con abordaje cualitativo, realizado entre febrero y diciembre de 2012. La muestra se cerró en 53 reclusos con la ayuda de la técnica de saturación de información. Los datos se produjeron a partir de una entrevista semi-estructurada y fueron analizados en el análisis de contenido técnico. La investigación tuvo el proyecto aprobado por el Comité de Ética en la Investigación, CAAE: 0400.0.133.000-09. ***Resultados:*** se observó un predominio de los reclusos entre 20 a 29 años, solteros, naturales de Paraíba, con algún tipo de religión, y con educación primaria incompleta. A través de discursos surgieron las categorías << **Conceptos de salud y enfermedad** >> y << **Necesidades percibidas** >>. ***Conclusión:*** cuando discursando acerca de estos aspectos, los internos informaron desde la concepción religiosa hasta el concepto actual de los determinantes sociales del proceso salud-enfermedad, y la existencia de una necesidad de atención de la salud. ***Descriptores:*** Proceso Salud-Enfermedad; Prisiones; Determinación de Necesidades de Atención Médica.

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INTRODUCTION

The opinions of health and disease have been addressed in different ways throughout history, reflecting the economic, political and cultural life of a society. One can also say that these concepts are related to individual values and scientific, religious, philosophical opinions of each epoch and context.[1]

Thus, despite the preponderant focus on the biological medical model initial projection of public health, throughout the twentieth century, various approaches were interspersed on the design of the health-disease. In 1948, the World Health Organization (WHO) defined health in a very broad concept, as a state of complete physical welfare, mental and social, not merely the absence of disease. However, already in the 1950s, there was a greater focus on fighting specific diseases actions, triggered by the successful eradication of smallpox to the implementation of prevention and cure technologies.[2]

This way of understanding the disease reflects the theory of unicausality, whose postulates were aware that diseases were caused only by microbes, which was surpassed years later by the theory of multiple causes, due mainly to advances in studies of diseases, passing into believing that the imbalance in several, and not just in one aspect, competed for the illness of the human being.[3]

However, only in 1986, during the International Conference on Health Promotion (PS), in Ottawa, the idea of health emerges as conditioned quality of life by many factors, such as peace, shelter, food, income, education, economic resources, stable ecosystem, sustainable resources, equity and social justice[4]. In Brazil, specifically, this way of thinking was officially introduced in the Organic Law of Health, which regulates the Unified Health System (SUS), also emphasizing that health actions also intended to ensure that persons and the community physical, mental and social well conditions.[5]

The concept of health and disease from the social perspective is referred to as the social context interferes with health conditions. The discussions about the social determinants of disease remained on the margins of global discussions and only from 1960 broader discussions on the subject began, from health education, the development of disease prevention actions and increased care practices basic to the poor, revealing social inequities and their relationship to the health of communities.[6]

From this assumption, it becomes relevant to consider the serious situation in which they are incarcerated individuals in our country, considering that the known health problems resulting from confinement conditions have not been the subject of resolving actions that allow people access attached to the effective service with full attention. The need to implement a public policy of social inclusion to watch out for the promotion of human rights of persons deprived of liberty shows the importance of the reorientation of the care model in prisons in order to meet the health needs of these people.

It is necessary to understand what the health needs of the prison population from being convicted are, in addition to imprisonment, deprivation of citizenship, as regards the right to health. Thus, we sought to

- Understanding the concepts and needs perceived of the inmates of the penitentiary system of the State of Paraiba.

METHOD

This is a descriptive study with a qualitative approach conducted between February and November 2012 in six prisons subject to Department of Corrections of the State of Paraiba qualified to the National Health Plan for the Prison System - PNSSP.

The number of subjects who provided the sample was determined based on the technique of saturation of information. Thus, it was concluded the collection with 53 detainees, adopting the following inclusion criteria: minimum of 12 months imprisonment; two or more visits in the health facility to their respective prison unit; and agreeing to participate freely and consciously study.

The implementation of data collection occurred from visits to prisons to recognizing the routine of prisoners, identifying those who met the criteria for inclusion retro mentioned and invitation to participate in the study. After previous scheduling, data collection itself was made possible considering the convenience and the convenience of the subject of prisons and researchers. In individual meetings and under escort of prison officers, as provided for routine services, applied a semi-structured interview, from adapted tool containing 13 questions, about demographics, concepts and perceived needs about the health-disease process[7].

The speeches obtained through the interviews were recorded with the aid of an mp4 player and fully transcribed, and later analyzed in the light of Content Analysis[8], comprising three simultaneous and mutually exclusive phases: pre-analysis, exploration of

the material collected and treatment of results.

At all stages of the study, the recommendations of Resolution 196/96 of the National Health Council were followed, as regards the ethical aspects. Thus, to protect the confidentiality rights and the anonymity of the subjects was adopted a code identification system, and the municipalities identified by Greek letters α, β, λ, δ, prison, when located in the same city, by Roman numerals (I and II), followed by the letter "A" and the Arabic number corresponding to the order of the interviews. The research was approved by the Research Ethics Committee of the State University of Paraiba, under CAAE No 0400.0.133.000-09.

RESULTS AND DISCUSSION

The sample of inmates selected for the study consisted largely of young adults, that is, aged between 20 and 29 (35,84%), both from Paraiba (83%) and other states (Pernambuco, Rio Grande do Norte, Piaui, Ceara and São Paulo), data corroborate another study that aimed to evaluate the presence of hepatitis C in Brazilian prisons, where the majority of the sample was made up of young adults (18-29 years old)[9]. Regarding religion, 45,29% were evangelicals and Catholics 30,18%, 24,53% presented still claiming to have no religion. With regard to education, the majority (54,7%) of the inmates did not finish elementary school, and still 7,5% were illiterate, with a small portion (5,7%) that started or completed higher education. There are several studies showing the strong presence of subjects who only had elementary education (complete or incomplete).[9]

Regarding the profession exercised before they weredetainee, the most cited were the farmers (15%), Mason (9,4%) and hodman (9,4%), and most (39,6%) with family incomes below the minimum wage, 24,5% with income of a minimum wage, 22,7% with 02 minimum wages and only 13,2% with incomes between 03 and 08 minimum wages. It is noteworthy that in the minimum wage study period was R$ 545,00[10]. Nevertheless, 66% lived in their own houses, 18,8% in courtesy house and 15,2% paid rent.

With regard to marital status, 56,6% were single, divorced or widowed and 43,5% reported being married or maintain stable union, situation similar to another study belonging to the same theme, in which there was a greater presence of convicts single over those who have some partner.[9]

Among 86,8% of the subjects receiving visits, 54,3% receive wives/partners more frequently, 32,6% said that mothers are visitors, and also, 30,4% reported the presence of children during the visits.

About the arrest information, ranged from 04 months to 14 years the time in which the subjects were arrested, 81,13% of inmates being had been detained in the past five years with penalty time out between 2 and 44 years. It was also observed that 18,9% of study subjects also met during pre-trial detention and the other, that is, 81,1% in closed regime. Only 35,85% were arrested for the first time and, consequently, 61,15% are repeat offenders.

Regarding leisure available to inmates, development of handicrafts (22,64%) was the most often mentioned activity, followed by reading (20,75%) and football game (13,20%). Only 28,30% of respondents said inmates develop some labor activity during their period of seclusion in prisons, more frequent general services (33,33%) and activities in the kitchen (33,33%). The other subjects perform various functions, including the role of Promoter Health Agent (APS), which contributes to the implementation of the National Health Plan of Prisons (PNSSP).[11]

In the analysis of research results the following categories were identified: conceptions of health and illness and health needs.

♦Opinions about health and disease

To explain the causes of disease, various interpretive theories about the health-disease were being forged throughout history, as a result of rational human activity. These theories translate several philosophical projects and are ultimately expressions of certain ways of thinking the world.[12]

According to this understanding, there is no single way of representing health and disease, since factors such as culture and socioeconomic status interfere on such meanings[13]. In this sense, understanding of illness portrayed by inmates was wrapped from the religious views, to the current concept of social determinants of health-disease process. Interviews snippets demonstrate the presence of religion in the development of health problems:

> *Yes, some diseases are through sin and some are unclean spirit, malignant, but there is also pray to banish that demon. λ- A1*
>
> *A thing of evil. I think it's a spiritual thing that passes to flesh. Because everything that we live, do, have, is the issue of spiritual part. λ- A2*
>
> *They are punishments exactly. Disobedience to the heavens in carries. The first sentence*

comes from heaven. And then is performed by the men of Justice. B2- A4

The magical-religious conception discoursed by the subjects above assumes that disease is associated with sin or curse, resulting in the action of forces beyond the body that are introduced in this. Thus, disease was sign of disobedience to divine command, as in the case of leprosy, being a contagious disease, it is implied, therefore, that the contact between bodies showed sinful connotations.[1]

This religious vision prevailed strongly until the development of ideas of Hippocrates (460-370 BC), who presented a rational view of medicine, although it returned in the early Middle Age, when medicine was practiced almost exclusively in monasteries, with a strong influence of the Catholic Church, which condemned scientific researches.[14]

Advances in medicine have been reached between the seventeenth and eighteenth centuries, because of the profound social and scientific transformations of Modern Age[15]. From then on, the pathological phenomena are explained based on observation and experience, morphological, organic and structural changes. In this sense, health is understood by the absence of disease. This design that will lay the foundations of the theoretical system of the biomedical model, the explanatory power is responsible for attending to the current days[15], as seen in the participants' speech:

Health is the person lives normal, feel no symptom of cough, pain, those things that I have a lot, you know?B1- A2

Health for me is the guy be a healthy person, not having any disease, health for me is that there. B2- A1

Be a sick person is when he's on of a bed, a state that one depends on the others, so, I think so! a2- A1

Note, then, that even today, health and disease appear as divergent concepts and antonyms. This understanding can be defined as minimalist, where health comes down to just the absence of disease, contrary to the care model of health perspective proposed by the Unified Health System, in that health should be recognized and assisted in its various aspects[13].

This view excludes the theoretical basis of health and disease to the economic, social, cultural and psychological dimensions, in that it believes that only biology and pathology can provide objective data to its definition, even discarding the clinical experience as a viable reference[16]. In this sense in an attempt to overcome this negative view of health, WHO, in its document creation, in 1948, defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity ".[15] This concept was also evidenced by the inmates of the study:

Health is nothing more than a well-being in all respects in all directions. Be well not only with yourself, as you have all. λ- A3

Health is a thing of leisure ([...]) a healthy person he must be with a well-being in harmony, in joy, love ([...]). λ- A7

Based on the WHO definition, it becomes almost impossible to think of someone with complete absence of conflict, suffering and discomfort, because this concept does not take into account that such aspects are essential parts of life, which is the well-being related at the level of satisfaction of individuals with other concepts, such as: need, freedom, happiness, adjustment, control, predictability, feelings, suffering, pain, anxiety, fear, boredom, stress and health.[3]

Many were critical taken to this concept of health, all related to his utterly subjective perspective, utopian and with little applicability[13].Faced with this reality, in the end of the 1970s, the Alma-Ata Conference put highlighted the theme of social determinants. While in the 80s has returned the design focused on individual health care, with the predominance of the approach to health as a private good, the next decade, the debate on the Millennium Development Goals, again gives space for discussions on social determinants, that materialize in 2005 with the creation of the Commission on Social Determinants of Health by WHO.[2]

In Brazil, it was established in 2006 the National Commission on Social Determinants of Health (CSDH), which describes these determinants as "linked to individual behavior and the conditions of life and work, as well as related economic macrostructure, social and cultural".[17] In this sense, the inmates also revealed their views on health and disease expressing conceptual relationship with this theoretical current, even if it is incomplete.

Take care of yourself, go to the doctor, do not use drugs, preventing, there are many kinds of disease, we can get many kinds of illness, then one has to prevent it. λ- A6

Don't need medication; don't run the risk of dying prematurely, because disease it's all that, it's a risk you run. B2- A4

I don't know that I can't say no, but I think there are a lot of things that make the person ill. B1- A2

Understanding, even if reductionist, that health has multiple causes, is a great advance; since it is a relatively new concept

and that the subjects are isolated from society. On these aspects, vulnerability to a particular disease is related to pre-established biological determinants that interact with the consequences of social stratification processes based on criteria such as gender, ethnicity, economic class, skill level and age.[18]These processes reflect in divergent possibilities of life and access to essential services for the protection and health promotion. Thus, the convicts even not aware of all the social determinants of health, as conceptualized by CNDSS, understand that the health-disease associated with many factors, although not associate this process to the social conditions in which they live.

The social, economic scenario and living conditions are important for the formulation of the concepts of health and disease, as they are able to influence the health of people[13]. When considering the prison environment, where health care has always had reductionist approach, the implementation PNSSP represented a great step forward, as it represents a policy for social inclusion of these individuals incarcerated to the current model of health care, which aims to reorient undertaken assistance from the comprehensive and the multidisciplinary care.[11]

Thus, while the changes in the health care model are / will be felt by the users of the prison, it is possible that the understandings about the determinants of health disease process and also changing the perception of health as a well-formed by several aspects is then understood.

• Health needs

Epidemiological studies carried out in different scenarios, have long pointed out that the prison system is in itself a potential public health problem. Therefore, it is not cause surprise finding that the health needs are neglected. Prisons concentrate individuals who certainly could not achieve the minimum levels for access to cultural and / or services goods and therefore constitute the group of "particularly vulnerable" to the infectious diseases.[19]

Thus, the primary challenge to undertake the analysis of this section is theoretically reflected on how to understanding what health needs is. Although there are different definitions and theoretical perspectives, considering a broad sense, it is not only the need related to attention/health care, but the various dimensions that make up the human being individually and collectively.[20]

Another taxonomy[21], where health needs are based on the assumptions: a) guarantee good living conditions, whether environmental factors described by Leavell and Clark in the Natural History of Diseases, whether those related to the production process in capitalist societies, proposed by authors like Laurell and Breilh (in both explanations is evident the fact that the way we live it "translates" different health needs); b) access to technology (light/light hard/hard) health can improve and prolong life[22]; whereas the use value which assumes each health technology is always defined from the need of every person, in every single moment living; c) creation of links (a) effective between each user and a team and/or a professional, in addition to the Convention calls simple ascription to a service or a formal application to a program, means establishing an ongoing relationship in time, personal and not transferable, and, finally, d) recognition that health information and education are essential to ensuring the construction of autonomy of subjects, including the recognition of their needs and broader aspects.[23]

Health needs relate to health care needs, and can be classified as perceived (related to expectations), expressed (concerning the recognition of demand), normative (indicated after evaluation by health professionals) and comparative (between subjects with equivalent socio-demographic characteristics).[24]

If we consider the agglomeration and the enduring confinement in prisons, easily recognize that the prison population has, from the birthplace of the institutions, the greatest risk of becoming ill because they are not completely isolated from the outside world and live together in unsanitary conditions. Therefore, visible health needs suppressed. Thus, it was possible,when analyzing the lines, to identify that the health problems faced reveal themselves as needs; for these subjects:

> *What I really need is a solution to my problem of health. I have a bad back and sleep on the floor doesn't help at all. In addition, I've become hypertensive after I entered the jail, to there doing treatment [...] But what about the food. Do I like to not eat salt?al- A5*
>
> *Here's a health problem when it's not careful, will come from many, in an instant. Also under these conditions. You want what? There are people here with a cough, they say it's tuberculosis[...] But the people here are difficult. Solve problem of health here is difficult [...] neither the place nor the*

> *prisoners help[...]. "The biggest health problem is the place". δ - A3*
>
> *Not that I will debunk the work being done here, the job automatically he is limited because of the place, I can't demand a different treatment for me. Why has health problem that they know exists, recognize the need, the rights but how to solve in here?" λ- A3*

The need for health can be regarded as the absence of something, or something that needs to be corrected in its current socio-critical state[25]. The health needs may vary from organic and physical changes to the lack of structure and poor environmental information. Note that the environment is referred to as a key.

To ensure comprehensive assistance with resolving actions, it is necessary that the network services (re) meet the health needs of this population group. Therefore, it is essential that professionals consider the concepts of health of the population and identify their needs, helping to address the grievances of situations.[13] Therefore, professionals and users can realize the health needs of detached way; however, makes it essential that there is cooperation between the two parties to the communication to be effective and that, therefore, the problems of health are resolved.[13]Thus the actions will result, in part, on improving the quality of life respecting one of the principles of SUS, recognized in the Brazilian Constitution, and which proclaims the PNSSP.

It is clear that the fight against health needs of inmates and the efficaciousness of problems requires change in the model of care, which shall not become effective without a change in the management of health services model, without effective performance of health teams deployed in prison units, beyond the fulfillment of a national plan or public policy. It also requires training and strengthening the network of services and agreement of the management for the liabilities assumed in regard to sufficiency in health care, according to peculiarities of services. According to the Ministry of Health, do not just have a terminating health system if it cannot contemplate the care of the interests and needs of the population, legitimate solutions compatible with the different realities of each region of Brazil.[26]

Finally, it appears that, regardless of the theoretical current that is adopted to understand health need, in the concrete reality of prison, setting of this study, we note that the health needs were actually considered dissatisfied because the inmates do not recognize the actions provided as necessary for the solution of the problem experienced[24]. For the authors "the need for unmet health is related to the process of access to services, which include the perceived needs, but that are not converted into expressed needs".[24]

The making of PNSSP sent by the Ministry of Health in partnership with the Ministry of Justice and implementation of the actions of health care based on the principles of the Unified Health System (SUS), to watch out for the promotion of human rights of persons deprived of liberty already reveals itself as recognition of perceived needs, the needs expressed by this population.[11]

Although the speeches reveal unmet needs, it was possible to cut lines that refer to the use of health services to ensure medical care medical care and medication dispensing. Thus, it is clear recognition of convicts that access to medical guarantees when necessary continuity, which is important for treatment and rehabilitation of subjects.

> *We're just looking for more when you know that the doctor or dentist huh [...] because the other doesn't solve much. We only; comes when you die I die [...] in serious situation, that no more holding, you know [...] when we can handle in the cells right [...] one says one thing another, another and so we're working on the disease. δ- A6*
>
> *The health service in and out is only searched for who's sick really [...] Even more than just man goes to the doctor in the past? When the person is sick.aI-A9*

When proposing the establishment of health facilities, along the lines of family health strategy, in prison units, the objective PNSSP promote the transition from the care model of primary care, fulfilling a constitutional provision and in accordance with the principles of SUS[11]. Thus, the units have a dynamic differentiated performance and shared responsibilities.

The deployment of the teams should be able to, like the FHS teams, working properly, solve 85% of health problems of the subjects, performing preventive, curative and promotional.[27] However, the lines point out that, although health facilities prisons have been implanted, they have also impacted the reality with the change in the medical model, centered on the production of care and cure.

The challenge is to change the current model that infers that consultations, exams and dispensing drugs are equivalent to solutions to health problems faced[28]. In this sense too, reveals the importance to the

paradigm shift related to medical appointments, as these spaces constitute appropriate times to promote health, from qualified listens and respect the integrity of the subjects.[29]

For the reorientation of the care model becomes effective, not just create PNSSP and recommend deploying units. It is necessary, firstly of achieving educational activities so that the subjects seek the demand for services spontaneously for health promotion and on the other, that the training of professionals is replacement in forming apparatus with revision of the curriculum of professionals of health. Otherwise, the care model will not be in the reality of day-to-day health services.

Considering this context centered care medical model, it is easy to deduce that the consultations manage prescription medications, as demonstrated by the following lines:

> *When we need they deliver straight, the medicines. For high blood pressure, diabetes, leprosy and[...] These same diseases, I'm not talking about little beast. For diseases they have doctor and medicine. Is an own detainee where he makes this function out of the cells, the person with an illness has been consulting then they pass the remedy and already have a person in the function of delivering the medicine. For other things[...] There just watching. ð A8*
>
> *We have received the medicines, but not all. Because there are people selling and doing other things. And also why, when the magazine comes, everything loads. Then they pick up, deliver the medicines, but only a few [...] The others are with the agent. Sometimes they deliver all the treatment, sometimes gets some to get then [...] those who remain with the agent he who delivers on time to take [...] but I'm afraid of him making mistakes, change his meds. I'd rather I stay. But I understand why they don't let. al- A2*

The scenario points to a difficulty in ensuring the regular availability and proper use of medications. According to the National Drug policy of the country, the rational use of drugs involves a series of steps, namely: the appropriate prescription, timely availability, affordability, dispensing / right guard and consumption as recommended.

Have access to health care and medicines does not necessarily imply better health or quality of life, for the wicked prescriptive habits, failures in the dispensation, inappropriate self-medication can lead to ineffective treatment and little secure[30]. One has to consider that in the reality of prison, not the rare medicines often are not in possession of the subject, for security reasons. The authors also point out that, in the specific case of dispensation, the absence of pharmaceuticals in public units is a critical factor in the implementation of rational drug use.

Health facilities in the prisons classified as prisons, jails or penal colonies, according to PNSSP (BRAZIL, 2005) among prisoners may be selected subject to work as health promoters, who will work under the supervision of the health team and will the following responsibilities: health promotion and the prevention of most prevalent diseases; identify and report the health team of health problems and or problems that may be encountered during their educational activity and monitoring of long-term treatment, such as tuberculosis, AIDS and diabetes, among others, checking the conditions of membership, abandonment and the inadequacies, including the distribution of medicines daily for supervised dose.

Finally, it is wise to reflect on the natural invisibility of other health professionals. The implanted teams adopt the multidisciplinary composition of recommendation consisting of: doctor, nurse, dentist, psychologist, social worker and nursing assistant. And they do so by recognizing that in the reality of prison, there is a set of problems very well defined, related to skills and competencies specific professional categories,[11]but unfortunately the invisibility of professionals, except doctors and dentists, may indicate the fragmented care practices and health surveillance in this scenario. No way means not performing daily activities, just invisible to some inmates.

It is worth mentioning that by establishing links commitment and responsibility to the enrolled population, all professionals of the prison health teams must be visible, accessible and resolute. It is essential that there is a cultural change of the population and health professionals to the care practices be executed, modified and recognized.

CONCLUSION

As referred to the conceptions of health and illness of inmates, it was observed that the understanding of the subjects ranged from magical-religious idea to the reflections, even surface on the social determination of the health-disease, although one has prevailed theoretical framework that is very close the biomedical model.

As perceived needs, the subjects emphasized the aspect of health care as a fundamental point to be prioritized under incarceration, especially when it comes to

solving their problems, highlighting once again the idea that present health as absence of disease and the assistance focused on the medical professional figure. Thus, there are recommended health promotion actions within prison, to enable significant advances in system qualification, enabling the formulation of health policies with effective activities that meet the real needs of this segregated population. It is further necessary to stimulate recognition of the social determination of the health-disease process and collaboration that each subject can give your health and the collective.

To further reflectingabout subjective aspects of being, such as health and disease, the study also presents the contribution of promoting discussions on incarceration, with special attention to the conditions of the inmates, but also the possibility of promoting research to examine incarceration conditions and the information and awareness strategies to cope with the situation.

In order to encourage research in this direction, it would be important to the inclusion of this theme in the list of priorities of development agencies as a way to leverage the scientific production in the sector. It is believed that a strategic point for such achievement is the incorporation of health in the prison system in the National Agenda for Research Priorities.

It should be noted that still need to understand the health-disease process by inmates may be limited by the fact that the national prison environment itself a limiting agent of effective health interventions, whether educational, assists, rehabilitative and / or promotional.

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