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Planning Primary Heath Care in Prisons: pilot project

Planificação da Atenção Primária à Saúde nas prisões: projeto piloto

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ABSTRACT
To describe the experience of implementing health care planning in the prison system in the state of Rio Grande do Sul. Experience report of a pilot project for the primary care reorganization developed with a prison health team, with content adapted from the Primary Care Planning Project developed in the state. The activities took place in six thematic workshops, from June to September 2019, on the premises of the prison, with the participation of health and safety workers. Ten workers participated in the workshops that led to the problematization of the practices experienced, reflections on their attributions in the penal institution and the worker's role as a protagonist of change. Planning Primary Care in the prison system is a pioneering project and can enhance the actions of prison health teams in the Health Care Network.

Keywords: Continuing education. Patient care team. Primary health care. Strategic planning. Prisons.

RESUMO
Descrever a experiência de implementação da planificação da atenção à saúde no sistema prisional do Rio Grande do Sul. Relato de experiência do projeto piloto de reorganização da atenção primária desenvolvido com uma equipe de saúde prisional, com conteúdo adaptado do Projeto de Planejamento da Atenção Básica desenvolvido no Estado. As atividades aconteceram em seis oficinas temáticas, de junho a setembro de 2019, nas dependências do presídio, com a participação de trabalhadores de saúde e segurança. Dez trabalhadores participaram das oficinas que levaram à problematização das práticas vivenciadas, reflexões sobre suas atribuições na instituição penal e o papel do trabalhador como protagonista da mudança. A Planificação da Atenção Básica no sistema prisional é um projeto pioneiro e pode potencializar as ações das equipes de saúde prisional na Rede de Atenção à Saúde.

Palavras-chave: Atenção primária à saúde. Educação continuada. Equipe de assistência ao paciente. Planejamento estratégico. Prisões.

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INTRODUCTION

The health service offered to the População Privada de Liberdade (PPL,

Population Deprived of Liberty) was incorporated into the Sistema Único de Saúde (SUS, Unified Health System) after implementation of the Plano Nacional de Saúde no Sistema Prisional (PNSSP, National Health Plan for the Prison System) in 2003. Rights guaranteed to the entire Brazilian population, provided for in the Constitution of the Federative Republic of Brazil of 1988 and in the Organic Laws 8080/90 and 8142/90, until then, were suppressed to people deprived of liberty. However, despite the PNSSP guaranteeing access to health for PDL through basic prison health units, only convicted prisoners could enjoy this right, thus excluding 33.29% total population[1-2].

In 2014, with the enactment of the Política Nacional de Atenção Integral à Saúde das Pessoas Privadas de Liberdade no Sistema Prisional (PNAISP, National Policy for Comprehensive Health Care for Inmates of the Prison System), the SUS principles included the PPL. Through the inclusion of all incarcerated people in the system, universality, integrality and equity were guaranteed through the implementation of prison primary health care teams (pPHCTs) in penal institutions. This policy, alone, did not guarantee the effectiveness of the pPHCTs within the prison system, as the adherence of municipal managers is required. In the state of Rio Grande do Sul, co-financing for municipalities that adhered to the policy, boosted the growth in the number of pPHCTs from 8 to 36, between 2010 and 2016, which enabled the expansion of coverage in the service, including almost 70% PPL in closed conditions[2-3].

The pPHCTs are constituted according to the quantity of the population to be served, defined by the PNAISP. Institutions with less than 100 prisoners may refer to the health unit in the territory where the prison is located; above that number, teams must be deployed within penal institutions. The minimum composition of the team must guarantee the employment of a physician, nurse, dentist, psychologist, social worker, nursing technician and dental assistant. This minimum team can be complemented by other professionals with higher education, defined by the program[4-5].

Despite all the advances achieved through the inclusion of the PPL in SUS, there are still difficulties in accessing health services and in the inclusion of pPHCTs in the Health Care Network (HCN). The pPHCTs must use other services in the network to provide comprehensive care. In this sense, the engagement and sharing of responsibilities between the sectors of health, justice and safety are essential to guarantee the necessary and safe mobility for this purpose[4-5].

Aiming to qualify and strengthen primary health care teams, the Conselho Nacional de Secretarias Municipais de Saúde (CONASEMS, National Council of Municipal Health Secretaries) published, in

2011, the Health Care Planning of States[6-7]. It is a set of workshops and dispersion activities that encourage the active participation of their members, promoting the appropriation of knowledge, skills and attitudes through planning, group debates and decision-making. Dispersion, an activity that complements the workshops, consists of the practical application in loco of theoretical knowledge acquired during the process[8].

Health planning is being gradually implemented in several Brazilian states. So far, few studies on the subject are available in academia. An experience report published in 2017, by a multidisciplinary residency team, reports its implementation in the fourth health region of the state of Rio Grande do Sul, highlighting the team's empowerment, the motivation for group work and the commitment of all as strengths in the search for qualification of work processes and care[8]. The content covered in the workshops was validated by a scientific study[9]. There are no reports on the implementation of health planning in penal institutions, which makes this project pioneer and innovative. Therefore, adaptations to the daily reality of the services were necessary, enabling the effective involvement of everyone in the proposals for the reorganization of work routines and processes.

In the prison system, safety is a priority, aiming to prevent rebellions, confrontations and escapes. The pressure suffered by workers, exposure to violence and the feeling of impotence often experienced by pPHCTs professionals bring negative consequences to the guarantee of health rights by PPL. It is therefore essential to invest in the qualification of teams by offering training programs. Spaces offered for the development of new practices and knowledge are capable of causing changes in habits, empowering professionals, making them the protagonists of their work, and consequently, positively impacting the quality-of-care provided[10].

Thus, this study aimed to describe the experience of implementing planning health care in the prison system in the state of Rio Grande do Sul.

METHODS

This was a descriptive study, experience report, regarding the intervention stage of the pilot project to implement the Planning Primary Health Care in the prison system with an pPHCTs in a medium-sized prison in the state of Rio Grande do Sul.

According to PNAISP regulations, the accreditation of a team depends on the number of prisoners that will be under its responsibility. The team qualified at the institution is type III, which must work at least 30 hours a week and have at least 11 workers responsible for a population varying between 501 and 1,200 in custody[4]. The pPHCTs, the focus of this study, is

composed of professionals linked to the Municipal Health Department through emergency contracts or public tender, and employees of the Superintendência dos Serviços Penitenciários (SUSEPE, Superintendence of Prison Services) of the state of Rio Grande do Sul. The nurse, the two general practitioners, the nursing technician, the oral health technician, and a dentist are linked to the Municipal Health Department. The two psychologists, two social workers and a dentist are linked to SUSEPE.

Activities related to the intervention were implemented by the researchers, through immersion, interviews and application of six thematic workshops, with the active participation of health and safety workers, which took place between June and September 2019, on the penal institution facilities.

The Regional Prison has the capacity to house 166 men in 4 different galleries and 40 women, in an annex built in the institution courtyard. During the project development period, there were an average of 400 male inmates, with an occupancy rate of 240.96% and 25 female inmates. Aiming to ensure the service of this population, a pPHCT was implemented in 2011 in the institution, which operates in cells that were renovated for this purpose. In the year of its implementation, in addition to prisoners in a closed regime, the health team was responsible for the PPL, which was in semi-open condition, which made the population assisted in a total number exceeding 500 in custody.

The project was approved by the Research Ethics Committee of the University of Santa Cruz do Sul, under Opinion 3.044.200 and CAE 03079418.5.0000.5343.

RESULTS

The health team, composed of eleven members, was represented by ten workers who agreed to participate in the project. A prison guard, a member of the safety team and appointed by the prison management, was also integrated into the group. During the workshops, two members withdrew from the project. One of them, a member of the health team, left the institution during the period in which the activities were taking place, and the other, a safety agent, withdrew from participating in the workshops.

CONSTRUCTION OF THE WORKSHOP ROADMAP

In order to facilitate the activity and encourage the participation of health and safety workers, meetings were held with the State Coordination of SUSEPE, Municipal Health Department and the Community Council to present the proposal for pioneering work to be implemented in the institution and in the prison system in the state of Rio Grande do Sul. There was great

interest in making the activity viable, encouraging and facilitating access to workers and the penal institution. Subsequently, the organization of the immersion activity in the pPHCT and the application of pre-intervention interviews with workers was started. After these steps, arrangements were made with the work team and prison management about the period, location and workload of the workshops.

The content made available for the workshops was adapted from the schedule of the State Health Department of Rio Grande do Sul regarding the Health Care Network Planning Project[10]. Adjustments to the workload, methodology, theoretical content approach, material used for research in practical activities and group dynamics were necessary, seeking to meet the specific needs of the prison health service, as listed in Box 1.

Box 1. Topics covered and objectives of the Health Care Network Planning Workshops.

Period	Workshop theme	Objective
1st meeting	Health Care Networks (HCN)	To analyze the importance of organizing health systems in care networks.
2nd meeting	Primary Health Care (PHC)	To understand and analyze the main foundations for organizing the access and qualification of primary health care.
3rd meeting	Health and Territory Surveillance	To identify and integrate health surveillance actions in the institution territory. To know the epidemiological profile of the enrolled population.
4th meeting	Organization of care for acute events and chronic conditions in primary health care	To analyze care models and macroprocesses for the organization of care for acute events and chronic conditions in primary health care.
5th meeting	Pharmaceutical Assistance in Primary Health Care	To develop strategies for organizing and integrating pharmaceutical care in primary health care.
6th meeting	Monitoring and evaluation in primary health care	To understand the fundamentals of monitoring and evaluation. To recognize the importance of monitoring and evaluating health actions in primary health care.

Source: Adapted from the Health Care Network Planning Workshops of the state of Rio Grande do Sul, 2019.

In the immersion activity, it was possible to monitor the routines and care provided by the health team in the Prison Basic Health Unit. Pre-intervention interviews, in which each employee answered questions related to the team work process, knowledge of the work carried out by the other and personal impressions about the functioning of the service, also contributed very concisely to the understanding of peculiarities experienced by workers of that service. The change in the focus and objective of some workshops, such as the third and sixth meetings in which knowledge of statistical data on the population was essential for carrying out health actions, were examples of adaptations perceived during the process.

Workshops were held in the prison classroom, at the request of the institution management. The day of the week chosen for the activities was Wednesday, the day of

external visits to prisoners and a period in which routine visits to users are not scheduled. The adjustment of the workload, from 8 hours to 4 hours per meeting was the most impactful change, as changes were needed in the original version of the Planning for Care Networks of the Health Department of Rio Grande do Sul in all stages of the project. Theoretical approaches underwent changes in relation to the approach, and practices were linked to the particularities of the institution.

EXPERIENCE REPORT OF THE PREPARATION AND DEVELOPMENT OF THE PLANNING WORKSHOPS

Activities began with a dialogued expository class about the HCN, followed by a debate addressing the insertion and role of pPHCTs in this network. The debate in two subgroups was encouraged by current reports related to health care in Brazilian prisons that were delivered to participants at the beginning of the activity. The task was to identify problems and raise possibilities for intervention.

At the beginning of the second day of activities, a rereading of the reports delivered in the previous meeting was requested, thus facilitating the beginning of the discussion. The group debated intensely the role of each worker within the health service and their responsibilities. The topic provided a deepening of the content and some conflicts related to the *health-safety* and *patient-prisoner* context came to light, demonstrating that there are different points of view between members of the health and safety team. That same afternoon, after a brief break, the attributions of primary care in the HCN and the types of pPHCTs teams provided for in Brazilian legislation were debated.

The third meeting made it possible to *look inside the institution*, with the aim of getting to know the workplace and the enrolled population. After a brief theoretical explanation about the concepts of territory and health surveillance, the members were asked to build a model of the prison territory with identification of risk areas and number of patients with chronic diseases per gallery of the institution. We can highlight this practical activity as the one that motivated most the participants, as some team members did not yet know the physical area of the institution.

The organization of care for acute events and chronic conditions was the topic addressed at the fourth meeting. After a brief expository-dialogued introduction, the Manchester protocol and the risk classification protocols for patients with diabetes mellitus and systemic arterial hypertension in the state of Rio Grande do Sul were presented to the group. At that time, the debate was centered on the importance of identification of patients with chronic diseases in the prison, which constitutes a step prior to the use of protocols. The team reported that it was still

unable to gather information about those with chronic non-communicable conditions in the prison population, due to the prioritization in organizing other service activities as well as difficulties in the work process related to recording this information, which generated tasks and referrals among the group members in order to fulfill this stage of the process.

The fifth workshop was one of the most awaited by the health team, as it is an issue that still needs an important intervention in work processes. Pharmaceutical care is performed in a very precarious way and the actions were not adapted to the good practices of health services. In order to broaden the debate and seek suitable solutions for the development of the work, a pharmacist from the municipal health network was invited to make up the team of facilitators for that day. Sharing information, listening to a professional outside the group and pointing out feasible actions made the moment of reflection very rich and productive both for the health team and for the workshop facilitators.

On the last day of activity, ways to carry out the evaluation and monitoring of actions were discussed, using as a data source the information available on digital platforms for easy access to the health team. Assistance provided by the pPHCTs, vaccination coverage and an estimate of patients with chronic diseases at the institution were the information used to develop the practical activities of that meeting. The participation of the pharmacist from the Núcleo Ampliado de Saúde da Família (NASF, Family Health Care Center) of the Municipal Health Department expanded the debate and the possibilities of interventions in pharmaceutical care carried out in the institution.

DISCUSSION

The workshops provided an exchange of experience, knowledge and perceptions among the participants, making the activity an important space for debate, mainly on activities inherent to PHC that have not yet been carried out by the pPHCTs. The knowledge of team members about their attributions does not guarantee their effectiveness, as in the prison space, immediate assistance to acute situations of illnesses, which are often consequences of acute chronic conditions, are prioritized. In this way, the right to curative health is effective and gaps in disease prevention and health promotion are maintained[5-6,10].

A qualitative study carried out in the state of Minas Gerais identified that the nursing staff of penal institutions maintains their thinking centered on the medical-curative model and that there are weaknesses in the processes of administrative organization[11]. This situation was also identified in French prisons, where many primary inmates arrived in poor

health and untreated health conditions, many had a risky lifestyle, including excessive consumption of alcohol, drugs and promiscuity. Nevertheless, in England and France, there are prisons identified as Health Promoting Prisons that seek to change from a pathogenic to a salutogenic model, in which the joint work between health, justice and other broad systems can positively impact the lives of PPL and their families, helping to reduce recidivism. It is understood that penal institutions offer a unique opportunity to invest in the health of disadvantaged and marginalized people, which can reduce inequalities and social exclusion[16].

A survey carried out in three prisons in the state of California, USA, identified communication gaps among healthcare providers as one of the main causes impacting the increase in healthcare expenses, interruptions in treatment and preventable injuries. The study discusses the proper collaborative practice, mainly related to effective communication between health workers, as a way to change the fragmented structure of the system[17].

Continuing education workshops held with the nursing staff in a prison in the state of Paraná demonstrated that the rereading and reorganization of the health team and work processes motivates workers to qualify the care provided, a fact that in this study led to an increase in diagnoses and tuberculosis treatments within the Prison Unit[18].

In Brazil, the physical structure of health units does not provide adequate exchange of information between professionals, perceived in the prison where the activity was carried out, as care takes place in separate rooms adapted for this purpose, connected only by a corridor which is also used as a passage for prisoners, family members and employees of the institution. As reported by some team members, the few meetings held also do not encourage the necessary changes in the work routine. The absence of action planning causes workers to become involved with the spontaneous demand that is also presented as a focus of action for prison guards. These, in turn, bring to the unit the urgent demands of the day often listed by the own inmates, and the programmed prevention activities become secondary to this action[3,10]. Thus, promoting health in the prison environment may have broad repercussions outside this system, which is not isolated. Thousands of people enter and leave penal institutions every day, so that the diseases prevalent in PPL are not confined to prison walls. In this way, PPL health care affects the health of the entire community.

Work processes were also widely discussed, always with the aim of improving them. Important changes that organize and qualify the service were planned during the planning activities, as this was an important meeting point for the members of the health team, which made it

possible to assess the quality of care provided to the user and the search for improvement. An example was the registration of patients with chronic health conditions, which included patients with diabetes mellitus, systemic arterial hypertension, patients with the acquired immunodeficiency virus, tuberculosis, syphilis, hepatitis and users of controlled-use drugs, which until then had not been instituted at UBSp[7,10].

The withdrawal of the safety professional demonstrated the institutional barrier present in the prison environment and prevented the convergence of practices. Understanding the differences in the performance of health and safety teams contributes to the construction of solutions to the problems that constantly arise. The safety team is responsible for the lives of prisoners and health workers, and must ensure their physical integrity, just as health workers need to be aware of injuries that can affect safety workers[3,5]. A study carried out in the state of Rio Grande do Sul demonstrates that safety workers have satisfactory knowledge about prevalent infectious diseases, such as tuberculosis and HIV, but they maintain sexual practices that are not consistent with the knowledge demonstrated[12]. Health workers are also concerned about the safety of actions due to characteristics of the service[13], so that the exchange of experiences and collaboration between teams could bring benefits for both and for the system as a whole.

For PPL health care, cooperation between the health and safety teams is also essential. In tuberculosis control, essential activities such as the active search for respiratory symptoms, diagnostic tests and directly observed treatment are only possible with the support and participation of the safety team[14-15].

The study had as limitations the scarcity of material and studies available for the improvement of the workshops, as it made difficult the necessary foundation for some topics that are specifically experienced by primary care workers who work in the prison system. The limited time for carrying out the activities and the difficulty of bringing the group together for the dispersion activities compromised the application of some practical stages of the project, such as the survey of patients with chronic diseases, the survey of demands for care and the construction of the model of the prison territory.

The report contributes to the development of continuing education activities in the area of health promotion, especially with regard to continuing health education, organization of routines and work processes in primary care. This experience can be replicated in prisons with health teams, with adaptations aimed at the practices of each service, being able to direct educational actions according to the characteristics of each team, service and population assisted.

CONCLUSION

Planning Primary Care in the prison system is a pioneering project and can enhance the actions of pPHCTs in HCN. The process that involves the readjustment of work flows and routines requires a broad search for theoretical knowledge regarding the activities carried out in health services. The experience lived through the adaptation and implementation of theoretical-practical activities of this educational intervention went beyond the scientific basis, as it required immersion in the context of the prison system teams, adding unique experience to all involved and raising the need for readjustment of postures, concepts and understanding of the work performed.

The use of the structure of the health planning project, adapted to the prison context, provided important moments of reflection through the problematization of experienced practices. The difficulty of access to the health service for PPL, especially for monitoring chronic conditions, was a clear moment of reflection and search for alternatives experienced by the workers, bringing them to the forefront of the actions. Group discussions constituted an important tool that helped redirect workers to their true mission, that of service in the PHC, within the HCN. Promoting health from the care of vulnerable populations, in addition to reinforcing the principles of integrity and equity of SUS, represents care for the entire population.

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