Telemedicine as a health care strategy for persons deprived of liberty: an experience report

A telemedicina como estratégia para o cuidado em saúde das pessoas privadas de liberdade: relato de experiência

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ABSTRACT
Introduction: Telemedicine is a tool for overcoming geographical and physical barriers in the process of guaranteeing health care. **Objective:** To report the experience of medical care mediated by information and communication technologies to persons deprived of liberty at two penal units in the west side of Paraná, Brazil. **Methods:** This is a quantitative, qualitative, descriptive experience report. **Results:** Medical care mediated by information and communication technologies is an additional tool, based on multidisciplinary care practices, in the search for the right to health care to persons deprived of liberty. **Conclusion:** This experience allowed a reflection on the health and health care of the prisons' population, with information and communication technologies placed as a tool to bring the academic environment and the penal unit together in the search for comprehensive health care.
Keywords: prisoners; prisons; health; telemedicine.

RESUMO
Introdução: A telemedicina constitui uma ferramenta para superação das barreiras geográficas e físicas no processo de garantia de assistência em saúde. **Objetivo:** Relatar a experiência de atendimento médico mediado por tecnologias de informação e comunicação às pessoas privadas de liberdade de duas unidades penais do extremo oeste paranaense. **Métodos:** Trata-se de um estudo descritivo quanti-qualitativo, do tipo relato de experiência. **Resultados:** O atendimento médico mediado por tecnologias de informação e comunicação constitui-se de mais uma ferramenta na busca da garantia do direito de cuidado em saúde das pessoas privadas de liberdade, a qual se alicerça em práticas de cuidado multiprofissional. **Conclusão:** Esta experiência propiciou a reflexão da saúde e os cuidados em saúde da população prisional, na qual as tecnologias de informação e comunicação se colocaram como ferramenta de aproximação do ambiente acadêmico e unidade penal na busca da integralidade do cuidado em saúde.
Palavras-chave: pessoas privadas de liberdade; prisões; saúde; telemedicina.

INTRODUCTION

Health care is a right guaranteed to persons deprived of liberty (PDL) in Brazilian national legislation, including the Penal Execution Law of 1984[1], the Constitution of 1988[2] and Law No. 8080 of 1990[3]. It has been reaffirmed in specific policies for the health care of PDLs, the National Health Plan in the Penitentiary System (PNSSP) of 2004[4] and redefined by the current National Policy for Comprehensive Health Care of Persons Deprived of Liberty in thePrison System (PNAISP), of 2014[5].

By the same token, health care in the prison context is aligned with the principles and guidelines of the Unified Health System (SUS) and is a component of primary health care, as defined in the National Primary Care Policy (PNAB), dated from 2017. Health services in prisons are a hub of the health care network, configured as gateways and organizers of care for PDLs to be carried out through the prison health team[6].

In Brazil, there are 357 prison health teams, of which 91 are state and 266 are municipal[7]. The penal units in Paraná count with 216 health professionals, of which 28.23% (60) are physicians — considering the prison population of 50,029 PDLs[8]. The extreme west of Paraná does not have teams registered with PNAISP and/or physicians hired by the Penal Department, currently counting with only one professional provided by the municipal health network to serve approximately 2,335 PDLs[9].

Given this context, the telemedicine medical care project emerges as a possibility of expanding access to health care for PDLs in the far west of Paraná, especially to medical consultations. The concept of telemedicine that guides the action is explained by the World Health Organization (WHO) as the provision of health services using information and communication technologies (ICTs) for the purposes of diagnosis, treatment, prevention and health promotion for individuals or communities. One must consider that the objectives of telemedicine are to provide clinical support while overcoming geographical barriers, with the use of ICTs, aiming to improve the health condition of population groups[10].

The great potential of digital health care is pointed out by the Pan American Health Organization (PAHO), especially for addressing chronic non-communicable diseases and when health services are interrupted, as observed during the Covid-19[10] pandemic.

Medical consultation using ICTs (telemedicine) is regulated in the Brazilian context through CFM Resolution No. 1,643/2002 and reinforced in Resolution No. 56/2020, which addresses medical care by telemedicine during the Sars-Cov2/Covid-19 pandemic[11,12].

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OBJECTIVE

To report the experience of medical care to the PDLs of two penal units, mediated by ICTs, in the extreme west of Paraná.

METHODS

This is a descriptive, quantitative and qualitative experience report that describes medical care mediated by ICTs offered to PDLs in two penal units of the extreme west of Paraná, with a view to clarifying positive and negative points. This type of analysis aims to accurately describe a given experience, professional practice, in order to contribute to the discussion, exchange and proposition of ideas to improve health care. It allows the description of situations experienced by the authors, which reinforces the importance of the deed in the building and remodeling of scientific and popular knowledge[13,14].

The experience reported was lived by the physician and professor of the Medical School of Universidade Federal da Integração Latino-Americana (UNILA) and by two nurses who are members of the prison health teams in the units targeted by the action. The process of of medical care mediated by ICTs was based on two extension projects developed by the professor of UNILA with the collaboration of the Regional Administrative Coordination and health professionals from the penal units:

1. "Medical care for seropositive patients deprived of liberty" — started in the second half of 2020, with the objective of continuing to provide follow-up medical care to all PDLs living with HIV in both penal units (16 PDLs), considering the non-removal of users to the specialized service in order to avoid risks of contamination with the new coronavirus.
2. "Telemedicine as a medical care strategy for the vulnerable population, in Foz do Iguaçu (PR), during the covid-19 pandemic" — started in the first half of 2021, meeting the basic care demands inherent to the prison context, intended for all PDLs from both penal units, according to spontaneous demand for care. A total of 110 consultations were performed in the study period.

The Mymedi platform was used as support for ICTs when mediating medical consultations, which were done free of charge. It is noteworthy that the consultations were performed with prior delimitation of date, time and number of users. Both projects remain in effect.

The legal precepts of Resolution nº 466/2012, by the National Health Council, were followed in the building of this text. As this is an experience report, approval by the Ethics Committee for Research Involving Human Beings is not required.

RESULTS

From June 2020 to March 2021, 126 PDLs were evaluated in a medical consultation mediated by ICTs, of which 16 mentioned HIV treatment control and the remaining 110 to frequent health problems in primary care, with prevalence of: digestive system (21.8%), musculoskeletal system (19%), integumentary system (12.7%), non-communicable chronic diseases (10.9%), among others.

The action was organized between sectors and involved: academic environment (UNILA), public security (regional administrative coordination and health professionals from penal units), and the Specialized Assistance Service (SAE) in HIV/AIDS, a reference in the municipal network. The consultations were planned and scheduled by the actors involved, starting with the joint scheduling of SAE appointment in the penal unit for the collection of HIV control and monitoring tests (viral load, CD4 and routine tests), later delimiting the date and time of the calls.

The second project, which contemplated monitoring of chronic and acute diseases prevalent in primary health care, had the dates and times planned between the physician and the penal unit. Prior to the medical consultation, a nurse welcomed the users and performed physical examination, a facilitating element in the process.

The nursing team of the penal units was a key link in the process of interlocution between the PDLs and other services. The nurses' consultation raised the users' needs, as well as data from the physical examination, which was the basis of the care together with the exams and the user's report, and became the foundation for the execution of actions.

The first moment of action execution was a challenge, as it was an initial moment of adaptation of both the professionals and PDLs themselves to the modality of health care mediated by ICTs. Despite being receptive to the service, the users were apprehensive, at first, to report their complaints, seeking the figure of the nurse with whom they had a bond through verbal and non-verbal expressions and, sometimes, requesting the help of this professional to express their needs.

This initial strangeness by users was minimized as consultations took place. We understand that being acquainted with the ICT used and even with the physicians who assisted them may be a cause. It should be noted that deprivation of liberty and, consequently, the limitations imposed by this context may also have interfered in the beginning.

It should be noted that the action resulted in good clinical and laboratory results for the PDLs. Of users living with HIV, 93.75% maintained an undetectable viral load (one user had been diagnosed less than 30 days earlier). Of all PDLs assisted, including 110 with primary care demands, none required referral for external care and/or hospitalization in the study period.

The intervention was made up of a multiprofessional team, with the important role of prison officers, who collaborated with the displacement and follow-up (internal escort) of users in a timely manner, and the care performed by four hands (physician and nurse), with integration of interprofessional knowledge and the possible care for PDLs as a guide.

This modality of health care implies responsibility on the part of executors so as to promote the awareness of public administration, such as health secretariats, about the implementation of this modality, mainly by specialized physicians, which could reduce the time of wait and be complemented by face-to-face consultation after initial assessment, if necessary.

It is worth mentioning that medical care mediated by ICTs has made it possible to overcome physical barriers, especially those imposed by the covid-19 pandemic; decrease the waiting time for medical appointments, providing timely care; and reduce the delay in consultations, as there was no need for external escorts to the penal unit.

A limiting factor in this process was the access to medicines not available in the penal unit, as some require prescriptions by physicians who are members of SUS in order to be obtained in the public

health care network. The Constitution is taken up again when it addresses equality of all before the law and health as a fundamental right, once it is linked to the access to medicines in the Municipal List of Essential Medicines.

DISCUSSION

This experience highlights the relevance of medical care to a population whose health care is historically neglected. It is worth recalling Gois et al.[15], according to whom although there are national and international laws and treaties that contribute to the quality of care for the prison population, there is still a lack of operationalization of health care, which is reflected in disregard for the physical and psychological health of PDLs[16]. Costa[17] points out that the penal units in Paraná are aligned with this perspective, as there is a scarcity of conditions and resources for health care.

Telemedicine in the prison environment can reduce health inequities and improve access to health and quality of care for PDLs. The possibility of broader benefits such as reducing transportation costs; improving safety for the community, health workers and security staff (preventing leaks); avoiding movements between health services, increasing patient satisfaction, team qualification, facilitating access to specialists and overcoming the difficulty of hiring professionals[18,19].

The systematic review by Edge et al.[18] found evidence that telemedicine care is equivalent to face-to-face care in terms of quality of care. It is, however, a complex task, since its success requires the involvement of various actors on the front line and in upper positions such as directors of prison units, which implies intersectoral actions in the field of health and safety. Both elements are reflected in our telemedicine practice.

Health care via telemedicine was present in 415 of the 1,384 penal units in the United States of America in 2004, according to a study by Larsen et al.[20] In Brazil, it was implemented in the Federal Bureau of Prisons (DEPEN) in 2020, which explains the possibility of use and expansion in the context of Brazil and Paraná[21].

The element to be overcome is that patients often do not trust in the modality of care mediated by ICTs or are concerned about privacy, as pointed out by Edge et al.[18]. However, Portillo et al.[19] found 1% of refusal to telemedicine care; in our study, the adherence was at 100%. Our experience shows that the bond between the user — in this case, the PDL — and the health professional is crucial for health care in prisons, even when mediated by ICTs.

The penal unit is highlighted as part of the health network, whose action must take place with a prison health team in a multiprofessional way, directed to the population within the territory — in this case the population in question is the PDLs under this umbrella. Acting in this context aligns primary care with actions of health promotion, prevention, protection, diagnosis and treatment. So, despite telemedicine being the focus of this study, it is worth mentioning that the service involved a multidisciplinary team.

Therefore, medical care mediated by ICTs was shown to contribute to the perspective of expanding access to health care, and was consolidated as complementary to face-to-face appointments. And, as pointed out by Gois et al.[15], the settings of deprivation of liberty is an opportunity for therapeutic approaches, prevention and health promotion.

Strengths

This paper provides opportunities for reflection on prison health and the use of ICTs as strategies to reduce marginalization in health care for PDLs.

Limitations

The limitations of this study are related to its time frame, which may imply the possibility of not identifying pathologies, their progression and eventual difficulties in the delivery of care mediated by ICTs.

CONCLUSION

We could evaluate the experience of telemedicine with PDLs as positive, as it provided an important opportunity to reflect on health and health care for this population group, considering new strategies, tools and theoretical-practical models for the care process in the face of specific needs of the prison population — in this case, the use of ICTs for medical care. Multiprofessional work and the bond with the users were also essential in this scenario.

We consider that both projects were received satisfactorily by the PDLs, directors and servants of the penal system, and that they were successful in overcoming the marginalization of access to health services for this population group following deprivation of liberty, expanding the LDPs' access to health services and maintaining an effective and efficient health care.

We must emphasize the approximation of the academic environment with the prison unit as fundamental for the defense of the prison population's right to health, which raises a discussion around the theme also in the academic context and could expand it to society, being an intersectoral action.

One limitation of the process was the requirement of a consultation with a physician from the public health system for dispensing medications, which bureaucratizes the process, increases the difficulty of access by the population, and intensifies demand.

Participation of each author

Authors Marta Cossetin Costa and Wilma Nancy Campos Arze participated in all stages of the study. Author Adriel Chihyun Chung Campos participated in data analysis, elaboration and text revision.

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Conflict of interest

The authors declare no potential conflicts of interest regarding the research, authorship and/or publication of this article.

Approval by the Human Research Ethics Committee

As this is an experience report, certification by the Ethics Committee for Human Beings is not necessary.

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