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Grids as Health Limitants: Sexually Transmitted Diseases in People Deprived of Liberty

Short Communication

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Summary

Introduction: People deprived of liberty have higher rates of infectious diseases than those found in the community, and despite imprisonment, they maintain the right to care equivalent to other citizens. Purpose: to reflect the Sexually Transmitted/Human immunodeficiency virus in prison populations (IST/AIDS).

Method: Reflective analysis carried out through a narrative review of the literature, with a view to reflective learning through immersion in practical-theoretical contexts on the subject.

Results and Discussion: Prison is an important point for the detection of STI/AIDS in PDL, since the marginalization of access to health services seems to precede the deprivation of liberty. Thus, the initial screening, prevention and health promotion actions, as well as timely treatment in line with current guidelines, can also have an impact on the improvement of STI/AIDS rates outside prison. Final considerations: Health care for PDL living with STI/HIV needs to be equivalent to that given to people in the community. Whose promotion, prevention and treatment actions should be part of the routine of prison health professionals and in constant integration with extramural public health.

Introduction

Health care in prisons should be equivalent those provided in the community, including the promotion, prevention and recovery of health, which must be integrated with public health in general, in order to guarantee the right to health, which is also delimited for prison populations in the Universal Declaration of Human Rights [1]. It should be noted that the PDL have higher rates of physical and mental problems, as well as the risk of becoming seriously ill than those presented by people in the community, rates are higher for both communicable and non-communicable diseases, and also for substance use. Thus, the health of PDL is inferior to that of free citizens. Since, the management of illness conditions in PDL will also reflect on public health in general, as these will return to society, as well as to reduce health inequalities [1,2].

In this sense, entering prison constitutes a unique moment for the initial assessment of the health situation of Persons Deprived of Liberty (PPL), in particular, related to infectious and contagious diseases, since this population group presents an increased risk for HIV, Hepatitis B and C, related to their social and environmental vulnerability, use of injecting drugs and risky sexual practices, both before and during incarceration [1,3]. Therefore, this short communication aims to: Reflect the Sexually Transmitted Infections/Human immunodeficiency virus (STI/HIV) in prison populations.

Method

It consists of a reflective analysis carried out through a narrative literature review with a qualitative approach, in which the selection and interpretation of studies may be subject to the subjectivities of researchers, appropriate to analyze the development of a given subject [4].

Results and Discussion

Prisons are high-risk environments for spreading infectious diseases, related to the previous marginalization of PDL, as well as tattooing without sterilized materials, unprotected sexual practices, injecting drug use, and whose risk is greater for people who use injecting drugs. The prevalence of HIV/STI is several times higher in the prison system than in the general community, especially in regions with a high

prevalence of injecting drug use and where drug use is criminalized. And it can still maximize these diseases within the prison environment and also in the community, when these PDL are released, related to inadequate prevention and treatment [3,5].

Ahmadi Gharaei, et al. [6] and collaborators point out in a systematic review the increase in the prevalence of these infections in PDL in recent decades, signaling the need for better screening and treatment programs aimed at this vulnerable population group. It should also be considered the possibility that the prevalence is underestimated related to non-diagnosis. However, this context can offer valuable opportunities for access to diagnostic, control and treatment programs for this high-risk group of people that were not previously offered [6].

However, it is necessary to point out that, although prisons may be the only point of access to health for many prisoners, they may often not be trained enough to carry out non-coercive tests, respecting consent and confidentiality, as well as keep proper records. Thus, it is essential that prison health teams are duly qualified and act based on patients rights and professional ethics; and that institutions can ensure proper nutrition, hygiene and cleanliness [7].

In the prison context, barriers such as insufficient resources for treatments, failures in the supply of medications, as well as compromised health due to poor nutrition, precarious conditions and violence are still limitations to health. PDLs are often unaware of their health problems and these remain undiagnosed in prison. Discrimination against other prisoners and employees of the penal system can also have repercussions on medication adherence [7]. The naturalization of the lack of health care in prison is pressing in society, not limiting the sentence to deprivation of liberty, but extending the deprivation of the right to health, adequate food and access to healthy environments.

Routine initial screening of PDL for HIV/STI at the entrance to penal units, as well as proper management and access to treatment according to the delimitations of the 2016 World Health Organization guidelines in this context are essential for quality care. However, in many prisons, mainly in low- and middle-income countries, this care remains less than ideal [3,5]. The initial screening must be conducted by a health professional in order to map the PDL's needs, existing illnesses and care demands, directing them towards treatment if necessary and constituting a unique moment for the link between PDL and the health professional, the which may favor possible adherence to treatment and preventive measures.

In this perspective, a Thai study demonstrated that a universal testing and treatment approach for Hepatitis C led by prison health professionals was highly effective and well accepted by PDL, which can also be understood as extensive in the approach to other STI/AIDS [8]. The bond between the user/PDL and the health team is also fundamental for care in prisons, this it can facilitate adherence to the therapeutic plan and change in behavior patterns, and, consequently, in the improvement of living conditions [9]. Carrying out preventive measures, such as harm reduction, such as access to clean needles; Hepatitis B immunizations for the uninfected; access to condoms; health promotion actions with individual and collective health education activities that address the STI/AIDS theme; human rights; equity and ethics are essential practices to be implemented in penal units [6].

A tool that can facilitate and expand the access of PDL to quality care, and that can be a coadjuvant in the treatment of STI/AIDS is the service mediated by Information and Communication Technologies, via Telehealth, which allows overcoming physical and geographic barriers, in particular to the service of specialties. Possibility of benefits such as: reducing transportation costs; improve safety for the community, health workers and security staff (avoiding escapes), avoid transport between health services, increase patient satisfaction, team qualification, facilitated access to specialists and overcoming difficulties in hiring professionals [10,11]. It should be noted, however, that measures for the control and treatment of HIV/STI cannot focus only on those in the prison context, but implies considering the post-release context of the PDL, which are involved in a cyclical context of marginalization, recidivism, imprisonment and poor health. Thus, the transition from the penal unit to the community is challenging and essential for the continuity of care [2].

Final Considerations

Health care for PDL living and/or diagnosed with STI/HIV in prisons presupposes understanding them as subjects with equal rights to people in the community, that is, comprehensive and quality health. STI/HIV promotion, prevention and treatment actions must be part of the routine of prison health professionals, who must be qualified and work to improve the quality of life of PDLs. The prison health unit must integrate with the extramural health services so that they act in harmony and that continuity of health care is guaranteed when the PDL leaves prison, with links to reference services prior to release.

Conflict of Interests

There is not.

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