Chapter 85

Public health policies for the private population of liberty: a case study

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1 INTRODUCTION

The municipality of São João del-Rei is located in the State of Minas Gerais, being part of the mesoregion of Campo das Vertentes. Its territorial area borders the municipalities of Santa Cruz de Minas, Tiradentes, Coronel Xavier Chaves, Ritápolis, Prados, Barroso, Conceição da Barra de Minas, Nazareno, Madre de Deus de Minas, Piedade do Rio Grande (IBGE, 2021). According to the latest ibge data (2021), São João Del Rei has a population of approximately 90,000 people, thus presenting a population density of 57.68 inhabitants/km².

According to data, from 2020, from PROADESS (Health System Performance Assessment Project), the total public expenditure on health per inhabitant in the municipality of São João Del Rei was R$1176.83. The infant mortality rate in 2020 was 3.06 deaths per 1,000 live births and, therefore, São João Del Rei ranks 549th within the 854 municipalities of the State of Minas Gerais. The MHDI (Municipal Human Development Index) assesses longevity (life expectancy at birth), education (average number of years of schooling and illiteracy rate) and income (adjusted average per capita family income). The MHDI

of the municipality of São João Del Rei increased in recent decades and in 2010 it was 0.758 (PROADESS, 2020).

According to data from the National Council of Justice (2022), currently the municipality of São João del Rei has 443 vacancies in its prison and holds 500 people deprived of liberty. In the APAC (Association for the Protection and Assistance of the Condemned), there is the presence of 90 vacancies in the female, with 72 currently recovering; and 200 vacancies in the male, with 218 currently recovering (TJ / MG, 2022). According to data from the Ministry of Justice, the State of Minas Gerais, the 2021 Ministry of Justice has a prison population of 69,270 and a total of 236 criminal establishments. The population deprived of liberty in the State of Minas Gerais was estimated, in 2021, at 323, 51 people per 100,000 inhabitants. Of the establishments, 134 (57%) apre sit doctor's office and 13 (6%) do not have any health module (minimum and complementary) (BRASIL, 2021).

We detail some services and spaces that these establishments have for the care of people deprived of liberty: 57% have a doctor's office, 43% have a dental office, 31% have collection of laboratory supplies, 64% have a dressing room, sutures, vaccines and nursing station, 34% have observation room, 69% have pharmacy or medicine stock/ dispensing room, 14% have sterile material center and purge and washing and decontamination room. In thenumber of people, 6% of these establishments do not have any health module (BRASIL, 2021).

In the territory of São João del-Rei, there are several for social reintegration. APAC (Association for the Protection and Assistance of convicts) is a "civilentity of private law, with its own legal personality, dedicated to the recovery and social reintegration of those sentenced to custodial sentences", as pointed out on the entity's website (APAC, 2013). This institution emerges as an alternative to the recovery of individuals deprived of liberty. According to the APAC website (2013), "this is a model of a more humanitarian prison system that seeks to develop labor skills in recovering and promote an environment of awareness, harmonious coexistence, playful practices and physical activity", among other points.

The association has a distinct dynamics from that observed in traditional prison institutions. Its action is centered on social reintegration, promoting work and leisure activities that turn to the formation of the recoverers. In this perspective, the institution's organizational culture has new organizational culture and the learning of new work functions, "such as work in the areas of food, construction, cleaning, crafts, administrative services and agriculture" (APAC website, 2013). It is worth noting that the APAC São João del-Rei currently has the female wing and the male wing, and within cad the sector there is subdivision by regime, organized according to the stage of compliance with the penalty, being: open, semi-open, closed and provisional.

Also, recently, the medical center was inaugurated with 5 offices, all infrastructure for medical, dental and psychological care, which are performed with adequate frequency. Thus, health is guaranteed to individuals deprived of freedom and consequently physical , mental and social well-being (APAC,

2022). Therefore, the importance of the humanized service developed in APAC is evidenced, being beneficial not only for people who make direct use, but also for society in general, considering that promoted activities have a direct impact on the social reintegration of these individuals later.

Furthermore, the association plays a valuable role in the question of social representation and guarantee of human rights for this historically marginalized population (DEMBOGURSKI, 2021). However, another perspective onthe work developed at APAC is its very close correlation with the Christian religion (APAC, 2013), despite being a civil entity of its own with sovereignty in view of its ideals, this position provided by the internal regiments themselves, removes the secular content, provided for in the constitution, from the prison agenda Brazilian. Moreover, another sensitive point is the organization through stock scoring (APAC, 2013), that is, if the recovering performs a behavior that APAC employees do not agree with, they receive punishment, through a points scheme, which can take with the expulsion of the recovering from the institution and return to the traditional prison system.

The city of São João del-Rei also houses a prison: the mambengo prison, whose responsible body is the Secretary of State for Justice and Public Security. It is a public entity where individuals are, especially waiting for trial proceedings. According to the ministry of justice database , from January to June 2021, 690 people arrested were counted in Mambengo (BRASIL, 2021). In search of information related to the management of this institution, its structure, the flow of prisoners, the prison itinerary of the institution, among others, access proved difficult. The information can be obtainedonly by direct formal communication with the prison board as seen on the official website of the State of Minas Gerais. In other words, the health of the prison population and even the organizational dynamics of the structure are presented as long agendas and health discussionsin the Sanjoanense community.

2 DEVELOPMENT

Brazil has in its history some milestones in the health care of the person deprived of liberty. The LEP (Criminal Execution Law) of 1984 was one of the first advances in guaranteeing the rights of the prison population of Brazil. It provides for the rights, duties, sanctions of discipline and evaluation of prisoners and aims at social reintegration, crime prevention and preparation of the person arrested for the return to social life. Among the rights provided for in the LEP is access to health, with the guarantee of medical, pharmaceutical and dental care and assistance to the entire prison population (BRASIL, 2005; LERMEN, 2015).

Another legal advance in access to health by persons deprived of liberty occurred in 2003 with the creation of the National Health Plan of the Penitentiary System (PNSSP) that was established by Interministerial Ordinance No. 1,777/2003. This plan came as a policy specifically focused on the prison population, seeking to understand the health problems of this part of society and, thus, follow the principles and actions of the SUS, such as universality. The PNSSP arises, therefore,with a proposal to guarantee

comprehensive health actions because it understands that "health is the right of all and the duty of the State" (BRASIL, 2003, p. 201), a right that is guaranteed by the Federal Constitution of 1988 and regulated by Laws 8,080 and 8,142 of 1990 (BRASIL, 2005; LERMEN, 2015).

The objective of the PNSSP was to ensure comprehensive care for the population of male and female prisons, including comprehensive mental health care. The care to this population takes place from theminimum composition of a multidisciplinary team: with a physician, nurse, dentist, social worker, psychologist, nursing assistant and assistant dental office (BRASIL, 2005). This conception of health promotion within prison unitsis based on comprehensive care, through prevention, care and health promotion and in the work developed by multidisciplinary teams. The PNSSP, therefore, aims to control and reduce the most frequent injuries that affect the prison population. For this, it provides preventive, curative and health promotion care from the definition and implementation of actions and services that follow the principles and guidelines of the SUS (BRASIL, 2005; LERMEN, 2015).

Despite representing a major advance in ensuring the right to access to health by the prison population in Brazil, it should be noted that the PNSSP has not yet been able to cover all persons deprived of liberty, because its health care actions are directed specifically for the prison population and, therefore, excludes from this care the rest of the prison system, such as people who serve time in open and provisional regimes, for example. Therefore, to comply with this lack, the PNAISP was created, which expands access to health to people collected in any prison environment (BRASIL, 2005; LERMEN, 2015).

The National Policy for Integral Health Care for Persons Deprived of Liberty in the Prison System(PNAISP), thus, is born from the evaluation of the ten years of application of the National Health Plan in the Penitentiary System (PNSSP), as an attempt to contemplate the entire prison itinerary, something that was not possible with the PNSSP. The prison itinerárioincludes from the moment of detention of the citizen and his driving to the police establishment until the completion of the sentence. Within the logic of the prison itinerary, in 2014, it had 518 penitentiary, 33 agricultural, industrial or similar colloniums; 29 hospitals for custody and psychiatric treatment (HCTP) and 285 police stations with running incarceration (BRASIL, 2014).

One of the main goals of PNAISP is to expand the health actions of the Unified Health System (SUS) to the population deprived of liberty, making each basic prison health unit come to be visualized as a point of network attention in the logic of care to health. Since all types of injuries that affect the general population are also found in the prison system, but can be enhanced due to the precarious conditions of confinement of most prisons and due to overcrowding (BRASIL, 2014).

However , the greatest difficulty in the effectof public policies aimed at the health of people deprived of liberty is overcoming the difficulties imposed by the confinement condition itself, which hinders access to health actions and services in an integral and effective way. The economicand social sequence of this non-conformity implied, on the part of the federal government, in the elaboration and

agreement of a policy that considered the principle of universal and equal access to actions and services for the promotion, protection and recovery of the health of people deprived of freedom.

Among the actions proposed by PNAISP, we can mention the attempt to ensure access to the health care network as more agility and quality; promote disease prevention actions; improve health surveillance actions; act in the prevention of alcohol and drug use in the rehabilitation of users; ensure prevention actions such as: vaccination, oral health actions and treatment; ensure access to mental health programs; manage the acquisition and transfer of medicines from the basic pharmacy to health teams and distribution of insumo for people in prison; in addition to multiplying basic prison health units and promoting their functioning in the logic of the SUS (BRASIL, 2014).

The implementation of the PNAISP and the qualification of health teams occurs through the agreement between states and municipalities with the Union. Initially, the state or municipal health department must sign a term of agreement and develop an action plan for health care for people deprived of liberty of that territory - composed of the diagnosis situational health in the prison system in the state or municipality, the actions to be carried out, as well as the goals and indicators that should be achieved. The processof the association is finalized through the analysis of the documents by the Ministry of Health, and is only validated after publication in a specific ordinance of the Official Gazette (BRASIL, 2014).

The procedure follows with the registration of the Prim aria Prison Care (eAPP) team in the National Registry System of Health Establishments (SCNES) - and the local management should request the qualification of the Primary Prison Care team (eAPP) in the System of Support for the Implementation of Policies (SAIPS), in accordance with the team previously registered with SCNES (BRASIL, 2014). The health services of the unit must be integrated into a UBS of the municipality in which the prison is located, with possible allocation of professionals fromthe local network of the SUS for the composition of the teams.

Finally, the proposals are analyzed by the Ministry of Health and, if technically approved, are published in the Official Gazette - only after the habilitation ordinance is published that the monetary resource will be passed on in the form of monthly costing by the Ministry of Health, transferred by the National Health Fund to the State, District and Municipal Health Funds. Moreover, in case the management is municipalized, the state should be 20%, in the account of the municipalities that have made the pnaisp (BRASIL, 2014). The amount of the financial incentive for costing for PNAISP's health actions and services is calculated according to the eAPP modality - defined according to the size of the prison unit, and the number of total establishment teams (BRASIL, 2014).

3 ANALYSIS

In Brazil, people deprived of liberty are in a situation of greater vulnerability, with the sum of social determinants of health and access to goods and services. There is a greater illness of this population,

both physical and mental, when compared to the general population (VALIM, DAIBEM, HOSSNE, 2018). A qualitative, descriptive and exploratory study carried out in an establishment in the State of Minas Gerais, in 2016, allowed a greater understanding of the theme. In it, they interviewed people of both sexes who were deprived of liberty for two years to ten years and nine months. According to the interview, it was observed that only 23.8% of the interviewees received consultation at the time of admission to the institution. In addition, 100% of the participants reported not having received any guidance on the functioning of the existing health service, nor on the types of care thatcan be provided to them (VALIM, DAIBEM, HOSSNE, 2018).

This study also exemplified the scarcity of care, as well as dissatisfaction with the conduct provided by the health service. In addition, observing the demographic data of the establishments of São João del Rei, 443 vacancies are offered by the State, but the data show the presence of 500 inmates. According to data from the Court of Justice of Minas Gerais (TJMG), 2019, prison overcrowding was evidenced in more than90% of prisons in Minas Gerais, making overcrowding a reality in the state. Consequently, unhealthy conditions are reinforced, which facilitates illness due to agglomeration and the absence of space to isolate people with communicable diseases, which further weakens the prison population (VALIM, DAIBEM, HOSSNE, 2018).

According to Moraes (2015), there are associations of factors that come from the incarceration itself, such as overcrowded cells, poorlyventilated and with little sun lighting, frequent exposure to parasitic diseases, lack of information and difficulty in accessing health services. This compromises the guarantee of rights and health promotion and contributes to experiences of illness esum of those who are deprived of liberty (MORAES, 2015; MARQUES, 2015). It is possible to observe that, despite the construction of the National Health Plan in the Penitentiary System - PNSSP, which emerged as a way to give visibility to the population that is inob custody of the State within the scope of the national health policy, and the National Policy of Integral Health Care of Persons Deprived of Liberty in the Prison System (PNAISP), which aims to ensure effective and systematic access of the prison population to health servicesand activities, with the mobilisation of more significant financial resources, as well as the allocation of management strategies and strengthening of local capacities, these policies are implemented in a way that limited and studies and investigations to be respect for this subject are still rare (MORAES, 2015; MARQUES, 2015).

Prisons are understood as places of great political and health challenge, but are not yet seen by most health managers as intervention spaces. Despite its link with the SUS, there is a scarcity of actions to promote health, disease prevention and comprehensive care, as recommended in primary care (FILHO & BUENO, 2016). The model of action is still centered on medicine and care occurs only by spontaneous demand, with bureaucratic delay to be realized, with scarcity of health planning and mapping. According to INFOPEN (2021), information on the number of people with transmissible injuries in prisons first presented HIV/AIDS, followed by syphilis, hepatites, tuberculosis and others. Such information is

dissonated with other data from SUS systems, representing the great health gap faced by the population deprived of liberty (FILHO & BUENO, 2016).

Brazilian prisons are within the world's highest authorities due to the inhuman conditions of living in which the population deprived of liberty is inserted (LENA & GONÇALVES, 2022), more than they are considered promoters of inequities, since the demographic profile of their members, with most people deprived of liberty being black or brown people, with low social income and schooling. They are also the demographic group with the highest indicator of homicide mortality, according to the 2019 Atlas of Violence. From the same time, there is an ineffectiveness of public policies to assist the prison population, violating the rights of these people (LENA & GONÇALVES, 2022).

In the same way that these data have their relevance in identifying the social determinants of the aúde todefine the factors that influence the health-disease process of a collective in social vulnerability, they are also fundamental in the analysis of necropolitical strategies, thus bringing a necessary reflection on the devices of power and the different forms of control bodies and life, where the State places itself in a position of producer of inequities in favor of the death of determined social groups (JESUS, 2014).

It is in this perspective that necropolitics isinscribed, a concept that ret oma the discussion of Foucaultian biopolitics (LENA & GONÇALVES, 2022). According to Mbembe (2018), necropolitics defines the state's strategies to make dying. In the case of persons deprived of liberty, there is extreme lack of resources , structural conditions, quality of stay, health care, among others), extreme precarious living conditions both before and after imprisonment, the absence of social reinclusion activities and the various types of violence in Brazilian prisons, all in order to make who is already more vulnerable, from the point of view of (LENA & GONÇALVES, 2022).

The strategies of necropolitics constitute a violation of human dignity, depriving people of the exercise of their citizenship and rights; health care is denied, even in the face of the evidence of numerous factors aggravating the health of the population pr isional; and especially from the moment the State weakens ways of making effective the policies and laws of care that it establishes for the persons deprived of liberty. In view of this, it is understood that the result of these actions takes place in the death and control of lives considered indifferent by the State itself (MBEMBE, 2018).

In addition to federal and state management, there are other devices that are attentive to the care of people within the Unified Health System , especially socialcontrol. Here in this study, we detail the municipal health council (CMS) and the state health council (CES). The CMS is a collegiate , deliberative and permanent body of the Unified Health System (SUS), present in each sphere of government (tripartite). As for composition, this collegiate is composed of representatives of the government segment, users, representatives of health professionals and service providers. This structure obeys the leislaction of law 8.142/90 and has as proportion of representation for users and users the total of 50% of the votes.

This entity has the scope to propose, monitor, monitor, monitor public health policies in its most different areas, bringing the demandas of the population to the public authorities, so it is called social control in health. The operation of this organization is through monthly meetings with registration through minutes and infrastructure that support its dynamics (MINAS GERAIS, 2011). In addition to these functions, the health council has as its duties to hold conferences, forums of social participation, in addition to approving the health budget and monitoring its implementation, evaluating every four years the Health (MINAS GERAIS, 2011). All this to ensure that the right to comprehensive, free and quality health as established by the 1988 Constitution is effective for the entire population in Brazil.

In addition to the Municipal Council, there is the State Health Council of Minas Gerais (CES-MG), whose performance was determined: by Decree No. 32,568, of March 5 , 1991, Decree No. 45,559, of March 2011, in CNS Resolution No. 453/2012, Complementary Law (Federal) No. 141, of 13 January 2012 and CES-MG Resolution No. 088 of 14 February 2022. The CES is an essential forum for the functioning of the SUS and its healthpolicies. In this perspective, we have that the State of Minas Gerais consists of an extremely populous and diversified federative, presenting various realities and specific needs. In the face of this, CES-MG has as its fundamental premise to defend and move the ideals of the Unified Health System throughout the territory miner. The Council constantly seeks an updated agenda in relation to the health needs of the population of Minas Gerais and even bringing and raising this agenda to the national health agenda (MINAS GERAIS, 2022).

According to the guidelines that determine the attributions of CES-MG, it is up to him to develop strategies for the execution and control of the most diverse public policies, from economic aspects to formulation. In addition, it is necessary to understand that the promotion of collective health is an exercise that requires the efforts of society as a whole, being a shared responsibility among the various atores involved. Therefore, the participation of the largest number of social segments becomes fundamental for the real functioning of the health council. The SUS has as a doctrinal principle equity, so social participation becomes an essential tool to understandthe specific demands and needs of the various groups (MINAS GERAIS, 2011).

According to Resolution No. 453 of May 10, 2012, the Plenary of the National Health Council establishes that the participation of organs, entities and social movements has as a choice factor the representativeness, scope and potential for complementarity in health promotion. Thus, the choice of representatives should take into account the specificities and needs ofthe representatives. Popular representations are contemplated in the following categories: Associations of people with pathologies; Associations of people with disabilities; Indigenous entities; Social and popular movements, organized (black movement, LGBT...); e) Organizedservices of women, in health; Retirees and pensioners; Entities brought together from trade unions, trade unions, confederations and federations of urban and rural workers; Consumer protection entities; M-speakers' organizations; Environmental entities; religious organizations;

Health workers: associations, confederations, councils of regulated professions, federations and unions, obeying the federative bodies; Scientific community; Public entities, university hospitals and hospitals field of internship, research and development; Employers; Entities of health service providers; Government (BRASIL, 2012).

With regard to the Health Council of the State of Minas Gerais, the regulation that provides for the organization is decree no. 45,559, of March 3, 2011. This determines the participation of 52 representatives of the various social entities, being: 13 representativesof the management and provision of services; 13 representatives of the entities of workers and health professionals; and 26 user representatives (MINAS GERAIS, 2011). Unlike national policy, the state of Minas Gerais specifically provides for an entity to which representatives are bound, from this participation is nominally attributed (MINAS GERAIS, 2011).

However, in this organization by sectors, there is the grouping of socially marginalized actors because they have certain confluent interests. However, this grouping allows the reduction of representativeness or social participation, because the perspectives are agglutinated into a unified representation. Among the various groups, we highlight the participationof direct representation of the population deprived of freedom. In relation to the Municipal Health Council of São João del-Rei, there is no provision of specific information on the organizational dynamics that governs this body on official websites of themunicipality. It is known that the CMS follows the national determinations of the municipal health councils, described and elucidated above, but the restriction of information in open and easily accessible communication channels stands out. The Municipal Health Department promotes access through formal communication as elucidated by the official website of the municipality.

In relation to the representatives who form the municipal health council, they comply with the guidelines of the SUS. In addition, it is valid to describe in whole numbers the number of board members, in total there are 24 members, composed of: 12 are users, 6 are health workers and 6 are composed of managers and service providers. It is also necessary to present the groups that form the council: in the group of users are composed of 4 members of the Association of residents of various neighborhoods of São João Del Rei, a member of the Union of Construction Workers, a member of the Union of metallurgical workers, a memberof the Society of São Vicente de Paulo, a member of the Association of Retirees and Pensioners, a member of the Central Directory of Students of UFSJ, a member of the NGO- Gay Movement of the Strands, a member of the Association of Patients with Diabetes, a member of the Rural Producer's Union, totaling 12 members. However, it is observed that the group composed of Persons Deprived of Liberty is not contemplated in the group of users (CMS SJDR, 2020).

In the workers ' group, there are 2 vacancies for the Union of Workerscontracted to the SUS and 4 health workers in general, totaling 6 members. And finally, the group of managers and service providers that are arranged as follows: 2 members of the Municipal Health Department, a member of the Regional Health Management (GRS), a representative of the Hospital das Mercês, a representative of Renalclin and

a representative of the Association of Relatives and friends dependent on chemicals-APADEQ (CMS SJDR, 2020)

The State Health Plan is an important planning instrument that explains the intentions and results to be sought over a four-year period, the most current being between 2020 and 2023. It being drawn according to the annual and population demands based on the epidemiological, demographic and socioeconomic profile to promote comprehensive health care and estimate its costs. This instrument is dealt with in Complementary Law No. 141 of January 13, 2012.

Thus, we consider that the proposal should translate advances in the implementation and consolidation of policies that expand access and quality in the field of promotion, prevention, surveillance and health care in the SUS of Enas Gerais, with qualified management practices, participatory and intersectoral action with the various actors who build and defend this System, to explain which and how long-term proposals will be operationalised. Set priorities in the health area and present the details of budget actions that will enable the achievement of the objectives and goals to develop the work in the coming years (MINAS GERAIS, 2021).

The Health Plan must present the intentions and results to be sought in the period of 4 years expressed in objectives, guidelines and goals. The Plan is composed in line with the 2030 Agenda proposed by the UN (United Nations Summit), in which Brazil, together with 192 other countries, jointly developed 17 Sustainable Development Goals involving diverse themes such as poverty eradication, security, health, education, inequality reduction and others (MINAS GERAIS, 2021). Thus, the Health Plan of the state of Minas Gerais is composed of 6 Guidelines, 18 Objectives and 128 goals, the State Department of Health of Minas Gerais sought to build the objectives and goals, especially those related to objective 3 – "Ensure a healthy life and promote well-being for all and all, at all ages" (MINAS GERAIS, 2021).

Thus, for better addressing and better coverage, each diretriz provides objectives to be met, as with regard to the Health of the Private Population of Liberty in the state of Minas Gerais is in Guideline 1, in Objective 1: "qualify primary health care, in order to consolidate this level of care with the coordinator of the Health Care Network, expanding access with resolution, equity and integrality" (MINAS GERAIS, 2021), as the following goals:

Goal 10: To promote the promotion of equity in health through financial incentives for the 70 municipalities that have an indigenous population and those that are adhered to the National Policy of Integral Health Care of People Deprived of Liberty in the Prison System (PNAISP).

Goal 12: To encourage municipalities that have prisons in operation and are not adhered to PNAISP (LENA & GONÇALVES, 2022, p. 13).

It is noteworthy that in order to achieve goal 12, one must take into account the requirements of a municipality to adhere to the PNAISP and thus promote equity in health, as described in the policy itself. The criteria for qualification of States and Municipalities to the National Health Plan in the Itenciário

Penitentiary System follow the national policy, with the sending of the following instruments: Term of Association to the Ministry of Health; construction of the State Operating Plan by the State Health Council and the Bipartite Intermanagers Commission; State Operational Plan for the Ministry of Health by the State Health Secretariats; Registration of health facilities and health professionals of prisons , through the National Registry of Health Establishments (CNES); Approval ofState Operating Plans by the Ministry of Health as a condition for states and municipalities to receive the Incentive for Health Care in the Penitentiary System; and Publication in the Official Gazette of the Qualification Ordinance (BRASIL, 2014).

The Municipal Health Plan of São João Del Rei, referring to the four-year period that includes the year 2022, was not available on the management platform of the Ministry of Health or on the website of the Municipal Secretariat, at the time of the research. This document enables management to guide its actions by the principles of the SUS and comply with its operational guidelines. It was possible to find the Municipal Health Plan of the year 2018-2021, but in this planning the Private Population of Liberty (PPL) is not contemplated specifically or in evidence. This absence is characterized as a public and collective health issue, since it compromises theaim of the imbilization of epidemiological data and demands of care and management of the SUS itself.

Not to mention the non-negotiable right to life and access to health guaranteed as international rights and constitutional law. Thus, the individual deprived of liberdade, ends not only with a punishment for freedom, but also for access to health, physical and moral integrity. After the wide discussion regarding the health of the individual deprived of freedom elucidated throughout the document, there is a reduced social representation and a scarcity of social participation. This, added to prejudice and disinformation regarding the rights of the recoverer, which is related to the maintenance of a violent and exclusionary structure.

Therefore, there is a need formobilizations by conferences or health plenary sessions on the theme Health of Individuals Deprived of Liberty, bringing this population to the center of the discussion, in order to ensure inclusion and integration in municipal policies. One of the guidelines ofthe SUS consists of popular participation. This community participation in health decisions was regulated by law 8.142/1990, considered a complement to the Organic Law of the SUS (Law No. 8.080/1990). This law, of no. 8,124, defines two collegiate instances of community participation: conferences and health councils, which must be instituted in each of the three spheres of government – municipal, state and federal (BRASIL, 1990). It is emphasized that the National Health Conferences are prior to the SUS itself, and in 1941 the First National Health Conference took place and only in 1986, with the VIII National Conference, which ceased to be restricted to a summit of the federal administration and began to have theexpanded articipation of the various segments (BRASIL, 1990).

It is essential to emphasize that the Conferences – and the whole process that involves the municipal, state and national stages – constitute unique moments of mobilization, reflection and debate for the nalysis , evaluation and formulation of public policies, so that, in the current context, they are even more relevant, because they are configured as one of the concrete collective practices of consolidation of democracy and effective citizen participation in the construction of a democratic, just, diverse and solidary society (RICARDI, SHIMIZU, SANTOS, 2017).

Therefore, it is evident the social importance of health conferences in order to assess the health situation and propose guidelines for the formulation of public policies in this sector. Health Conferences are an important tool of democracy and the SUS in order to ensure access to public, universal, comprehensive and equitable health for all. Finally, regional, state and national references on the health theme of private individuals with freedom of public health are added to the debate, with the purpose of supplanting the demands before technical and comparative views in relation to other regions and similar projects based on equity and supply of such structures and their quality.

4 CONCLUSIONS

According to the citizen constitution of 1988, health is a right of all and a duty of the State. To promotefull access to public health, there was the development of the Unified Health System (SUS), such a system has as doctrinal principles: Universality, Equity and Integrality; and organizational principles: Regionalization, Hierarchization,Popular Participation and Decentralization. In this perspective, in order to understand the feasibility of something complex, it was necessary to study and investigate spaces for the visualization of the theme and of people in situations of deprivation of freedom.

From this reflection in which we thoroughly describe the need for health promotion to the population deprived of liberty, this proposal is presented in order to sensitize the Council and the Health Management of São João del Rei about the importance of rethinking care and the health services offered in the city's prison system. For further discussions, we bring the following questions: planning and management of prison health care financing; study on the inclusion of prison health representatives in the Health Council; Regulation of the flow and management of persons deprived of liberty and, finally, reflection of the absence at the municipal level and the fragility of the state plan on the health of people deprived of liberdadand

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