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# Emergence of a Policy, closure of a sector: regarding the management of penitentiary health care in Brazil

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**Abstract** *The aim of this study is to understand recent transformations in penitentiary health care management in Brazil, during the implementation of the National Policy for Comprehensive Health Care for People Deprived of Liberty in the Prison System, and the closure of the National Sector for Penitentiary Health Care. The scientific problem investigated is the language of penitentiary health care policy. The theoretical-methodological framework adopted is Pierre Bourdieu's genetic structuralism. In this manner, we carry out an analysis of documents and public statements in search of State categories and classifications. We note the consolidation of a state classification that separates the 'penitentiary' domain from the 'prison' domain, as well as the creation of the State category of 'person deprived of liberty in the prison system'. Penitentiary health care management constitutes itself as a question of primary care.*

**Key words** *Prison health care, Public policy, State, Prisons*

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## Introduction

The National Policy for Comprehensive Health Care for People Deprived of Liberty in the Prison System (NPCHCP) was instituted through the Interministerial Ordinance nº 1, 2nd of January, 2014[1]. In the last decade, the Health Ministry instituted other policies targeting specific segments of the Brazilian population. These include the Comprehensive National Policy for Men's Health Care and the Comprehensive National Policy for Health Care for the Afro-Brazilian Population in 2009, as well as the National Policy for Comprehensive Health Care for Lesbians, Gays, Bisexuals, Transvestites, and Transsexuals (LGBT) in 2011. There are also multi-sector initiatives, amongst them the School Health Care Program with the Education Ministry in 2007, and the National Plan for Physical Activity with the Sports Ministry in 2009.

The National Plan for Penitentiary Health Care (NPPHC), instituted through the interministerial ordinance nº 1.777, 9th of September, 2003[2], preceded the NPCHCP in guaranteeing the right of people deprived of liberty (PDL) to health care, both ordinances having been undersigned by the Health and Justice Ministries.

According to a case study developed in the state of São Paulo, there are three types of intersectional policy related to health care. These are: 1 – coordinated by the health care sector but requiring other sectors to be effective; 2 - coordinated by another sector, but requiring the participation of the health care sector to be effective; 3 genuinely intersectional, not being led by any one sector but rather by an intersectional agency created specifically for its coordination[3]. Taking this typology as a model, as much in the case of the NPPHC as for the NPCHCP, we could categorize them into the first type, since the Health Ministry coordinates them in collaboration with the Justice Ministry. However, when we leave the federal level and move toward state management of the NPPHC, it is more adequately described by the second type. This is because the health secretaries frequently leave the responsibility of contracting human resources, as well as the organization of the budget to justice secretaries, restricting themselves to a facilitating role with the prison unit's health care teams.

The agencies responsible for management of the NPPHC (simply the Plan) at the federal level, were the Technical Area for Penitentiary Health Care in the Health Ministry and the Support Sector for Judicial, Social, and Health Care Assistance in the Justice Ministry. The already mentioned Technical Area was divided into the Department for Strategic and Programmatic Initiatives (DSPI) of the Health Care Secretary (HCS) and the previously referred to Sector in another Department, the 'Department for Social Reintegration and Teaching', part of the Penitentiary Policy Directorate in the National Penitentiary Department[4]. This same agency was maintained as administrator of the NPCHCP, (simply the Policy), in the Justice Ministry, while the responsible department in the Health Ministry was renamed the Technical Area for Prison Health Care and subsequently the National Sector for Prison Health Care[5].

In May, 2015, I visited Brasília-DF and was surprised on entering the Health Ministry in search of the National Sector for Prison Health Care. The room was empty of people but full of boxes! Given that the door was locked, a staff member from the Department of Primary Care (DPC), separate from the DSPI but which also makes up part of the HSC, escorted me in. In a little less than one year since the implementation of the policy, they had closed the sector.

With the objective of understanding these recent changes to management of penitentiary health care (PH) at the federal level in Brazil, we will bring together publications from the scientific PH field in the section "The Problem". Here, we do not intend to carry out a comprehensive literature review, but only intend on articulating a scientific question: the language of PH policy. We will present the contributions of Pierre Bourdieu to the analysis of state categories, such as PDL, in the 'Theoretical-Methodological Reference' to outline a genetic, structuralist framework for this "bureaucratic field"[6]. We will develop an analysis of the documents and public statements regarding PH in the subsequent section, 'Results and Discussion'. Lastly, in the 'Final Considerations' we will outline the continuities in federal level PH management.

## The problem

According to a systematic review (SR) of publications regarding PH between 1993 and 2010, studies are predominately quantitative, "showing a possible gap in the qualitative perspective"[7]. They were carried out in Rio de Janeiro and São Paulo with male PDL, seeking to identify their socio-demographic profile and health conditions, as well as the incidence of tuberculosis, aids, and hepatitis in prisons. We brought together more

than 1000 articles from 5 continents, selecting in total only eleven national articles for analysis, concluding that PH is "a public health care problem in which the very situation of the detainees' confinement represents a singular opportunity for the implementation of therapeutic programs, preventative measures, and specific educational initiatives".

John Howard, an English reformer from the 18th century, was already concerned with sanitation problems related to inmates in prisons[8]. As such, we can consider PH a centuries old public health care problem. Quali-quantitative studies investigating the judicialization of PH in Rio de Janeiro (RJ) show not only that PDL are more predisposed to acquire tuberculosis than the rest of the population but also that transmission generally takes place in the prison itself, and not prior to admission. This underlines the need to prevent people from acquiring diseases while incarcerated, the so-called "second sentence" as it is known[9]. Confinement is bad for health, it is not in itself an opportunity. At the same time, national evaluative quali-quantitative research undertaken with managers, workers, researchers, and prison system inmates highlights the need to protect the health of PDL[10].

What have post 2010 publications told us regarding PH? A quantitative study carried out with secondary data derived from the Disease Notification Information System[11] included the entire country and not just "large centers"[7]. In the list of notified cases of illness in prison units, between 2007 and 2014, tuberculosis, aids, and hepatitis occupy respectively the first, third, and fourth positions, a finding in agreement with the SR. The second disease on the list is dengue and the unexpected sixth is anti-rabies care. How do we explain these results? Poor conditions and torture in prisons? According to the SR, "quantitative methods allow the evaluation of the size, seriousness, risk, and tendencies of diseases and threats… However the health care field is the outcome of a complex reality… which also demands research using a qualitative approach"[7].

There are also studies, including qualitative research, into female PDL. One such study carried out from 2011 in a unit located in the Federal District (FD), showed the sparse presence of 'white coats' in comparison with the *dona gente* (local slang referring respectively to health care professionals and penitentiary agents) in day-to-day institutional life[12]. In another unit located in Paraíba (PB), eight women interviewed indicated faith, children, work, hope for freedom, music, and prison companions as ways to overcome adversity, or as a form of resilience[13].

Understood in the SR as a "potential gap", the "qualitative perspective", appears equally in studies with male PDL, such as one developed in Minas Gerais (MG) in 2011, with PDL, penitentiary agents, and health care professionals[14]. The fulfillment of the right to health care is defined as a "guarantee of total access to quality health care services" restricted to the "part of the population that can pay for such services". This however, is problematic in that it "is only legally formalized but not concretely realized", given that, as health care professionals recognize, access is mediated by penitentiary agents. Interviews with tens of health care professionals in Mato Grosso (MT), conducted in 2013, indicated a contrast between job security owing to selection through public competition, and day-to-day insecurity due to the localization of health care services within the penal establishment[15].

The focus of these studies is PH, and the tensions between health and security, and care and custody, something found in quantitative studies[16,17] after 2010 and in previous qualitative research[18]. A documentary analysis of the NPCHCP seeks to explain this tension, affirming that the need for care can signify fragility, and "in an essentially masculine environment, health care is the last attribute given to virile masculinity. There is a control of these bodies which contradicts those who demand care"[19]. Another analysis of NPCHCP documents, comparing it with the NPPHC and the Penal Procedure Law of 1984 (PPL), has as its objective "the presentation and discussion of the nomenclature used in these three norms to refer to the incarcerated population, considering the socio-historical moment in which such policies were promulgated"[20]. The results were the following: "person deprived of liberty", "temporarily under the custody of the State" and "beneficiaries" at the current moment of the debate regarding the reduction of the criminal age minimum was "person deprived of liberty" and "population confined to prison units" by the Welfare State, during the research period starting from the 2000's. During the period of Brazil's redemocratization in the 1980's on the other hand, these terms were "prisoner" and "condemned". We argue, "Such terminological changes are directly tied to the socio-historical context in which they emerged". "Condemned" is absent from the NPPHC and the NPCHCP and PDL begins to be used in the first period, and is consolidated in the second. We can also observe

terminological continuities however, finding the term "prisoner" in the three norms for example.

Both these analyses of the NPCHCP point out that it integrates not only PDL as beneficiaries of health care initiatives as with the NPPHC, but also penitentiary agents, family members, and other workers and visitors to the prison system. Documentary analysis such as this, makes -up the HP research area prior to 2011. However, given that they do not present methodology, it hampers their inclusion in the SR. An evaluation of the NPPHC, for example, showed the marginal position of health care in national penitentiary policy, by way of a comparison of financial investment in the sector, which included health care in the Justice Ministry, and investment in the construction of prisons. The first represents approximately 2% of the later[21]. The tension between health care and security is considered "false". This is because it "represents a simplistic vision of security, understood principally as an absence of conflict rather than as a situation in which prisoners have 'access to their rights to assistance and feel themselves to be included, given their condition as subjected to the laws and custodial measures of the State'…". In this sense, they recommended a conjunction of health care initiatives, education, and work in the day-to-day life of penal infrastructure.

Quali-quantitative analysis of the implementation of the NPPHC shows that DF and MG were seen as exemplary in terms of the PH management, in both cases owing to the initiative of their health secretaries. The PH teams in MG achieved a far wider population coverage than the other states of the federation[22]. Other comparative studies regarding PH management in Brazil, such as research regarding the implementation of the NPPHC in Piauí, made MG a reference owing to this particularity[23]. While research into PH care emphasizes barriers to access, these analysts of the NPPHC focus on the expansion of the teams. While the first therefore, tend to consider the lack of specialized care (dependent on collaboration with health care networks outside the prison unit), the later focus on the extension of primary care (included in the presence of the PH teams).

According to the already considered analysis of the NPCHCP, some of the principals of primary acre "are not included in the National Plan for Comprehensive Health Care in the Prison System"[19]. According to the previously mentioned norms, this is not necessarily the name of the Plan, something which calls our attention to the language of health care policy. At one moment it is characterized as "universal health care" (LGBT) at another moment as "comprehensive health care" (Men), and on another occasion targeting "populations" (Afro-Brazilian), and now "people" (deprived of liberty). Quantitative research already cited is also mistaken, regarding the name of the NPPHC, designating it the Health Care Policy for National Penitentiary System[11]. It is not simply a matter of correcting the name of the Plan, but of underlining this dimension of the analysis relative to the nomenclature of PH policies[20]. The terminological change from 'prisoner' to 'person deprived of liberty' was strategic for certain segments involved in the elaboration of the Policy. "Refusing the self-designation 'criminal justice militants', members of the civil society recommended that the policy be addressed to 'people deprived of liberty' (including those who did not find themselves in the prison system, such as 'falsely imprisoned victims of violence')"[24]. Also, the terminological change from 'insane perpetrator' to 'adult person carrying a mental impairment in conflict with the law' underlines a process of inclusion of a population previously understood to be intrinsically dangerous, admitting that they can be understood as worthy of care and not just imprisonment[4].

In the PH area, we can consider relevant not just the health care in prison units, but also the analysis of public policy. In this scientific field the connections in attendance between education, work, and health care, and in management between health care and justice, can be as relevant as the tensions between health care and security, care and custody, primary care and specialized care, and civil and social rights. I seek to highlight the language of PH policy in these analyses for two reasons. Firstly, I experienced selectivity in access to health care for PDL as a Plan manager, its restriction to sentenced PDL and to infrastructure such as prisons, excluding therefore detained PDL and holding cells[25]. Secondly, I conceive the terminological changes in PH policy based on certain of Pierre Bourdieu's concepts, such as the categories of state classification[24] and official nomination[4].

**Methodological-theoretical framework**

Research into the institutionalization of Family Medicine in Brazil and Argentina, as well as a grounding in Pierre Bourdieu, and the synthesis of debates in a non-line group, highlights a controversy regarding the name of the specialization[26]. While family health care ceased to be a

program simply to achieve a strategic benchmark for the Brazilian federal government during the transition between the 20th and 21st centuries, the doctors involved began to consider the expression 'general community medicine' highly restricted to represent them as a group. To this end, they made use of a series of alternative terms: Familial and Communitarian Medicine, Medicine for families and communities, Family and Communitarian medicine, and Comprehensive Familial and Communitarian Medicine. This attempt to create a group identity also demarcated and solidified a professional one, establishing itself in 2000 during the 1stLuso-Brazilian Congress of General Family and Community Medicine:

*In the name and objective of the congress, we already perceive the effect of the situation, which made the unification of different groups necessary. The name includes, amongst the words 'general' and 'communitarian', the word 'family'. This had as its aim to overcome a dispute according to names, because, by integrating 'family', they included the Niterói Family Medical Program, which was one of the organizers, and the family doctors from Portugal*[26].

This change in denomination to refer to governmental programs and initiatives, as well as scientific specializations, reflected conflicts around group identity. In family health care, as with PH, there are situations in which conflicts between groups emerge and denominations consequently become inadequate[24].

Along with other modes of analysis for health care policy, Bourdieu also prioritizes statements put forward in institutional documents and official speeches[27]. In his research regarding the State, he underlines the "public drama"[6] and not "what is hidden"[27], highlighting therefore the stage and not the behind the scenes. Having as an empirical object research into housing policy in France in the 1970's, France's welfare assistance, and particularly the commissions constituted to develop it, Bourdieu invites his readers to also consider Social Security, indicating other ways in which oral and documentary sources gain significance. I adopt the theoretical and methodological perspective elaborated by Bourdieu to describe and analyze documents and public statements regarding PH, amongst them directives, information packs, and leaflets published since the promulgation of the PPL, in 1984, as well as talks by managers at congresses and forums regarding the promulgation of the NPCHCP between 2012 and 2015.

Starting with the hierarchy between the two dictionary definitions of the word State, the State-territory anteceding and creating the State-administration, the first being equivalent to the human grouping fixed in a determined territory and the second to the sovereign authority which exercises itself over that group, Bourdieu goes on to interrogate it. He points out how it has as its foundation a democratic conception, according to which it is the group delegating power to the authority, or the organized people/civil society/nation, mandating the government/State/public service[6]. Bourdieu seeks to invert this hierarchy. In this manner he underlines the role of certain institutional agents in the construction of the State, given that they exhibit a "…conjunction of specific resources which authorize its holders to say what is right for the social world as a whole, enunciating the official and speaking words that are, in truth, orders, because they are backed by official power". This is the case with the principles and directives of the SUS, repeatedly referred to by its managers. The State-administration is further defined as "…a conjunction of ministerial departments, a form of government (…) conjunction of bureaucratic institutions…"[6].

In this way, the process of formulating public policy generates a set of statements, which contribute to the constitution of the target-population itself, its agents, and institutions. These expressions have as their backing the force of institutionalization, and function by way of a process of 'euphemism'. They are generative denominations that go through a process of judicial consideration, such as in the case of the substitution of the word *veado* for "homosexual"[6]. For Bourdieu the genesis of the State occurred through a process of 'officialization', the creation of a point of view as particular as it would be universal, just as with census categories[6]. We find an example of 'officialization' of singular points of view and the universalization of social classifications in schools. When pronounced by a representative of the State and addressed toward a citizen, such as when a professor evaluates a student, an idiotic word ceases to be a particular point of view and gains universality and legitimacy, making the moral judgment an "authorized insult"[6].

For Bourdieu the State is a bureaucratic field, distinct from the field of power, the first being that in which one has "…the work necessary to guarantee the participation of the citizen in public life…"[6], the second strictly connected to the dominant classes.

I hope to elucidate some principles concerning the conceptions and structure of the social world, through this research into the generative denominations used in documents and state-

ments articulating the result of the judicial work of the commissions, as well as of the legitimized insults spoken by authority figures. In this way, I aim to accompany this process of "making the sate" immersed in "governmental recommendations"[6], taking the PH bureaucratic field as a specific object of investigation, distinct from its already considered scientific field[7]. Therefore, I intend on describing and analyzing governmental statements regarding PH in search of State categories and classifications.

## Results and discussion

In a subsequent visit to the Health Ministry during December, 2015, I became aware through another staff member that the agency at the federal level, responsible for the management of the NPCHCP had been the General Coordinator for Primary Care Management at the DPC. Its whole team was given the responsibility of managing the new Policy, after the initial period during which members of the disbanded Sector had been exclusively responsible for its implementation. How should we understand this change in the Sector's name from 'penitentiary health care' to 'prison health care', as well as this shift in the management of the NPCHCP from the DSPI to the DPC, and of the "strategic and programmatic initiatives" for "primary care", in the context of the roll out of the Policy and the closure of the Sector?

The analyses of PH policy generally include the PPL, the NPPHC, and the NPCHCP, and on rare occasions, four other norms. These are: the ordinance nº 485/1995 promulgated by the Health Ministry, that instituted an assistance committee for the area of the penitentiary system in the at that time National Department of STD/Aids of the Health Ministry. Secondly, the Interministerial Ordinance nº 2.035/2001, which instituted an interministerial commission that had the role of defining strategies and alternatives for the promotion and assistance of health care at the national level of the penitentiary system, promulgated by the Justice and Health Ministries. Thirdly, there was Interministerial Ordinance nº 1.679/2013, which instituted the interministerial working group for the elaboration of the National Health Care Policy for the Prison System and the technical committee for assistance and accompaniment of this Policy. This was promulgated by the two already cited ministries as well as by the Sector for Social Development and Reduction of Hunger, as well as 3 policy secretaries for Women, Human Rights, and for the Promotion of Racial Equality, these last joined together to form a single secretary in 2015. And fourthly, the Interministerial Ordinance nº 628/2002 (Chart 1).

We understand the first ordinance to have initiated the NPPHC[28], whose aim was to monitor a specific disease: aids. The second ordinance details the composition of the working group that elaborated the first version of the NPPHC, showing us that one of the DPC's members was also a part of it. The third demonstrates the multisector character of the NPCHCP's development. The revocation of the fourth ordinance testifies to two changes, one in the type of funding for the NPPHC, (from *per capita* to by team), and the other in mental health initiatives, (which stopped including the treatment and psychosocial rehabilitation of PDL)[10]. This second change significantly prefigured the recent Ordinance nº 94/2014, which instituted an evaluation and monitoring service for therapeutic measures available for people with mental impairment in conflict with the law. The constitution of committees, commissions, and working groups, as Bourdieu showed us, is one of the ways of "making the State", of constituting bureaucratic fields, with the institutional agents who make them up frequently being immersed in judicial processes, that is to say the elaboration of those statements, which carry official force: euphemisms, generative denominations, and authorized insults.

All the cited ordinances concern systems, on one hand "penitentiary systems", on another "prison systems", in such a way that the first universalized social classification in these governmental collectives was the division of the incarceration system into 'penitentiary system' and 'prison system'. The second is more far reaching than the first owing to its inclusion of more diverse types of penal infrastructure. However, both are distinct from the SUS, which is also a system; walls and bars marked the frontier between the health care and penitentiary systems, beyond the reiteration of this frontier via the State categories.

During a national meeting in 2012, an NPPHC manager hinted at the growth of the government initiative's target population as a difference between the NPPHC and the subsequent Policy. This population only included those condemned and sentenced in the NPPHC ("health care in the penitentiary system"), restricted to prisons, penitentiaries, colonies, and custodial and psychiatric treatment hospitals (CPTHs),

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**Chart 1.** Norms and Institutions for Penitentiary Health Care by year.

| | |
|---|---|
| 1984 | Penal Procedure Law (PPL): health care assistance |
| 1988 | Federal Constitution1988: complete attendence |
| 1995 | Health Ministry Ordinance / Minister's Office (MS / GM) nº 485: assistance committee for the prevention of STD/aids in the penitentiary system |
| 2001 | Health Ministry Interministerial Ordinance / Justice Ministry (HM/JM) nº 2.035: commission for the promotion and assistance of health care in the penitentiary system |
| 2002 | Interministerial Ordinance HM/JM nº 628: National Health Care Plan in the Penitentiary System (NPPHC), was revoked |
| 2003 | Interministerial Ordinance HM/JM nº 1.777: NPPHC |
| 2003 | Creation of the Technical Area for Health Care in the Penitentiary System in the Department of Programmatic and Strategic Initiatives of the Secretary of health Care for the Health Ministry (SISPE/ DSPI/SAS/HM) |
| 2007 | Creation of the Support sector for Social, Judicial, and Health Care assistance In the General Department of Social Reintegration and Education, from the Directorate for Penitentiary Policy of the national Penitentiary Department (CAAJSA/CGRSE/DIRPP/DEPEN) |
| 2013 | Interministerial Ordinance HM/JM/ Ministry for Social Development and Reduction of Hunger (MSDH)/ Special Secretary for Human Rights (SSHR)/ Secretary for Women's Policy (SWP)/ Secretary for Policy and Promotion of Racial Equality (SPPRE) nº 1.679: Working Group for Elaboration and Technical Assistance Committee for the National Policy for Health Care in the Prison System. |
| 2013 | Technical Area of Health Care in the Penitentiary System is renamed National Sector for Penitentiary Health Care |
| 2014 | Interministerial Ordinance HM/JM nº 1: National Policy for Comprehensive Health Care for People Deprived of Liberty in the Prison System (NPCHCP) |
| 2014 | Ordinance MS /GM nº 94: Evaluation and Monitoring Service for Therapeutic Measures Applicable for People with Mental Impairment in Conflict with the Law (EAP) |
| 2014 | National Sector for Penitentiary Health Care is renamed National Sector for Prison Health Care |
| 2015 | National Sector for Prison Health Care is closed at the DSPI |
| 2015 | General Department for Primary Health Care Management at the Department of Primary Care (CGGAB/DAB/ SAS/MS) undertakes the management of the NPCHCP |

as well as provisional prisoners in the NPCHCP ("health care in the prison system"), which included jails and police stations. This manager and others present, identified themselves as from "prison health care", and no longer from "penitentiary health care". This reinforces, in the name of the sector, the state classification. Further, there was the National Department of Prison Health Care and no longer the Technical Area of Penitentiary Health Care. And, in the title of one publication *Legislation in Health Care in the Prison System*[1] and no longer Legislation in Health Care in the Penitentiary System[28]. In the words of another manager of the NPCHCP during one forum in 2015, "The Plan only dealt with a restricted incarceration itinerary, while the Policy dealt with the whole incarceration itinerary".

As previously stated, members of organized civil society who participated in a national encounter, rejected the nickname 'criminal justice

militants'[24], given that they self-identified as 'family and friends of PDL', (the name of an association in MG), to explicitly reinforce the state category PDL[10]. In this work of officializing singular points of view, the target population of the Policy ends up limiting itself to 'PDL in the prison system; and not the whole PDL cohort, that is to say, only "those older than 18 (eighteen)…"[1], adults carrying out a sentence depriving them of their liberty and a measure of their security, and not the adolescents and youths carrying out socio-educative sentences. In other words, while the managers consider the prison itinerary of the Plan to be restricted, other participants in the formulation of PH policy point out restrictions also present in the Policy, partially attenuated via a norm promulgated 4 months later, the Ordinance nº 1.082/2014. This redefines the directives of the National Policy for Comprehensive Health Care for Adolescents in Conflict with the Law (NPCHCACL).

In this manner, the State category 'PDL in the prison system' is a characteristic of the NPCHCP, but not necessarily the more general category of 'PDL'. The federal government initially reserved the right to health care for adults "fulfilling their sentence" in the NPPHC and subsequently for those "deprived of liberty in the prison system" in the NPCHCP, therefore firstly the adults and subsequently adolescents and youth in situations of deprivation of liberty. Just as the Ordinance nº 1.777/2003, which instituted the NPPHC, followed the Ordinance nº 1.482/2004, regarding health care for adolescents in conflict with the law, the NPCHCP was followed by the NPCHCACL.

In this manner, the state classification dividing 'penitentiary' from 'prison' (health care and system, technical area and department), is reiterated, just as the state category 'PDL in the prison system' is reinforced. To understand therefore one of the recent changes in Brazilian PH management, the change in name of the PH Technical Area, I consider these divisions to be the outcome of judicial work of the committees, commissions, and previously considered working groups.

Another alteration, the change in management of the NPCHCP from the DSPI to the DPC, due to the closure of the Sector, relates not so much to demographic terms, but rather to institutional terms. Even though we could already consider primary care the focal point for health care service proposals and initiatives in penal institutions in the NPPHC, the "health care teams in the prison system", of 2 and 3 different types, are referred to as "primary health care prison teams" in the NPCHCP[1]. Further, "the initiatives for the promotion, protection, and recuperation of health care" to be carried out by the Ministries and state and municipal secretaries should always happen as such "at the primary care level". Finally, the NPCHCP brochure is presented as a "compilation of ordinances that orient the implementation of primary health care" of PDL. In other words, a commission, of which members of the DPC were a part, developed the NPPHC, having taken place in a specific technical area for its management in the DSPI. Subsequently, when it becomes the NPCHCP, its management firstly underlines the need for a national coordination, and subsequently, for the general initiatives of a department in the DPC. With the emergence of the NPCHCP, and the need for its primary health care teams and actuation to occur at the primary care level, the Department closed. Therefore, PH management ceased to be specifically the prerogative of agents and institutions and became a generic activity for teams.

Further, in the PPL, health care is one of the forms of "assistance", but as with the judicial, not exactly the "comprehensive health care" prescribed equally by the NPPHC as by the NPCHCP. Health care assistance in the PPL includes measures of a "preventative and curative character", but this norm does not mention the "promotion of health care" such as in the NPPHC[2]. These norms operate via a different state classification: 1 – a binary logic which only includes prevention and cure in the PPL; 2 – the triad of "prevention, promotion, and health care assistance" in the NPPHC[2]; 3 – the inclusive "promotion, protection, prevention, assistance, recuperation, and monitoring for health care" in the NPCHCP[1]. In this way, the NPPHC does more than "just seek to prevent and reduce the indices of sexually transmitted diseases"[19], given that this type of perspective is closer to the Ordinance nº 485/1995.

The "prevention, promotion, and recuperation of health care" frequently alluded to in managerial documents and public statements, are common State classifications in the health care sector. We continue to ask ourselves however, if prevention is not "for diseases" rather than "for" or even "in health care", even more so when we read in information regarding the NPCHCP that one of its main initiatives is to "undertake measures for the treatment of diseases…"[5]. When we look once again at the PH scientific field, we continue to ask ourselves if a large part of the research does not operate from a basis in the PPL, investigating "health care assistance" more than the

promotion of health determined in the NPPHC.

These state categories and classifications reflect the administrative logic orienting the content and form of health care service provision for PDL. The promotion of health care only reflects NPPHC HP policy, different to the prevention of disease, already explained in the PPL. In the NPPHC the possibility of "imprisoned people" acting as "agents promoting health care"[2] including a continuity with the community health care agents and with the family health care strategy. That is to say, health care promotion is one initiative that emerges as a duty of the State together with detainees in some prison units only from the moment in which health care is considered a right, distinguishing itself from assistance. Beyond this, this emergence points toward ways of thinking reinforced in the day-to-day of PH management, associating health promotion as an initiative, family health care as a model, and primary care as a priority. I consider that the NPCHCP accentuates these social classifications, since it includes family members and penitentiary agents amongst the beneficiaries of only some initiatives, precisely for the promotion of health care, but not assistance. Beyond this, these classifications contributed to PH management being considered the prerogative of primary care.

## Final considerations

An informal conversation with members of the governmental agencies provided an explanation for the closure of the Department: the shift of one of its members to another Ministry. Subsequently, during another chat, a further explanation emerged, the firing of another team member. Finally, in research into a different health care policy, it was found that a member of the HCS determined the closure of the Department in April, 2015, as well as the reallocation of the management of the NPCHCP to the DPC[29]. In other words, the reason for my surprise, the coincidence in time between the emergence of the Policy and the closure of the Sector, had the following explanation: it was the result of changes, firings, and decisions made, and the effect of attitudes taken by institutional agents, basically, people occupying governmental positions.

Rooms emptied of people but full of boxes, the implementation of a Policy, the closure of a Sector, the modification of the name of the Sector from 'penitentiary health care' to 'prison health care', from a target population of 'people deprived of liberty' to 'people deprived of liberty in the prison system', from the service of 'health care team in the prison unit' to 'prison primary health care team', incorporation of the management of the Policy by primary care: these are some of the changes at the federal level, of management of penitentiary health care in Brazil. Considering the explanations presented above, I will seek to explore other possibilities for analysis, having as a base the theoretical-methodological grounding previously presented.

The approach I adopted contributed to highlighting the changes, rather than the continuities (which I do not however ignore) in PH management. The NPCHCP, just as with the NPPHC for example, operates via Terms of Adhesion for the federation states, both being in conformity therefore in this sense. Further, there are differences between the NPPHC and the NPCHCP, which were not considered, such as funding for PH initiatives: in the Plan, the Health Ministry took responsibility for the greater part of the value of financial incentives for penitentiary health (70%) and in the Policy for the remainder of the value. That is to say, for twenty years, between the appearance of penitentiary health care on the Health Ministry's agenda in 1995, and the promulgation of the NPCHCP in 2014, the Justice Ministry officially ceased being the sole agent responsible for the allocation of monetary values in "health care assistance" determined in the PPL of 1984.

In this way, the recent changes in management at the federal level of penitentiary health care in Brazil, highlights changes and continuities, something that possibly contributes such that future texts like this one will no longer refer to PH, through taking into consideration the scientific field, but rather to prison health care, when considering the bureaucratic field.

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