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National Policy for Comprehensive Health Care for Adolescents Deprived of Liberty: an analysis of its implementation

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Abstract *The realization of the right to health of adolescents and young people deprived of their liberty in Brazil is a complex task that places us before health inequities and interventions on their social determinants of health. Therefore, this study sought to contribute to a discussion about the right to health of this population, based on the analysis of the implementation of the Comprehensive Healthcare Policy for Adolescent Offenders (PNAISARI). This is an analytical approach, using documentary analysis of legal frameworks and policy monitoring and evaluation data. In short, the results suggest that the policy strengthens the realization of the right to health of this population. However, its implementation must be promoted and qualified so that access to health care is, in fact, a reality in all states and municipalities.*

Key words *Institutionalized adolescent health, Health evaluation, Public health policies and intersectoral collaboration*

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Introduction

The 1988 Federal Constitution enshrined the principle of absolute priority for the access of children, adolescents and young people to social rights, thus placing the national legal framework in line with the international perspective of human rights. The Child and Adolescent Statute (ECA) consolidated a new model of guaranteeing rights: full protection[1].

Although the ECA considers adolescence as the age group comprised between 12 and 18 years of age, the Ministry of Health adopts parameters of the World Health Organization (WHO), which is the stage of life ranging from10to 19 years. This cycle of development is considered a priority for health, and is understood in its plural and diverse context, thus recognized as adolescences[2]. In Brazil, adolescents have an essential demographic representativity of approximately 18% of the population, with about 34 million Brazilians, in the 10-19 years' age group, according to the IBGE census in 2010[3].

When talking about adolescents' right to health, in general, a sensitive point is the invisibility of this population in health services, despite the relevance of the Family Health Strategy (ESF) towards adolescent health, within the principles of Unified Health System (SUS)[4,5]. Among the main hurdles are the lack of knowledge about services, the denial of care when not accompanied by parents or caregivers, or the lack of a health service that dialogues with this age group[5,6]. An aggravating factor is found in the access barriers when adolescents are under the socio-educationalmeasures since this carries with it preconceptions and punitive paradigms that reverberate directly in the way it is serviced in the health sector[7].

In the case of adolescent offenders who infringe the law, the ECA establishes six different measures that must be applied proportionally to the infraction and related to the capacity to comply with it. Such rulesare warning, the obligation to repair the damage, community service, probation, semi-confinement, and internment (deprivation of liberty in a socio-educational unit)[1].

In Brazil, a total of 26,450 adolescents were deprived of their liberty, with a predominance of male adolescents (96%), with a higher proportion of adolescents aged between 16 and 17 years (57%).Concerning ethnicity/skin color distribution, 59% were recorded as brown/black, 22% white, 2% yellow/indigenous, and 17% had no record. Among the most common offenses, 47% were classified as similar to robbery, 22% as similar to drug trafficking, 10% as similar to homicide, and 3% as similar to attempted homicide[8].

Concerning the condition of establishments that receive adolescents deprived of their liberty, a study carried out by the Institute of Applied Research (IPEA) portrayed a scenario of serious violation of rights in liberty deprivation institutions. It emphasizes that in some places the health issue is the most delicate point in the socio-educational service. The high rates of sexually-transmitted diseases, aggravated nutritional profile, dermatological problems and mental health impairment, with excessive prescribing that may indicate the use of psychotropic drugs as a type of control, are among the main problems[9].

Faced with the context of violations and considering the legal frameworks of guaranteeing the rights of adolescents, in 2004, the Ministry of Health, in partnership with the Special Secretariat for Human Rights and the Special Secretariat for Women Policies, published the Interministerial Ordinance Nº 1426/2004, which approves the guidelines for the implantation and implementation of the Comprehensive Healthcare Policy for Adolescent Offenders, under an internment and provisional internment regimen (PNAISARI). This regulation details the operationalization of the policy, providing specifications on financing, federal responsibilities, the organization of health and socio-educational services and the intersectoral work management tools[10].

In this perspective of standardization and definition of roles, the Socioeducational Assistance System (SINASE) was established in 2012 as a public policy[11], aiming at the articulation of the different social sectors through a System of Guarantee of Rights, and with a guiding principle of institutional incompleteness[12]. In chapter V, Section I, SINASE reaffirms that comprehensive health care for adolescents and young people will follow SUS guidelines and norms. Thus, the PNAISARI has been formulated and implemented to recognize the SUS rationale of service for adolescents under socio-educational care, and comprising primary care as the leading healthcare network provider and coordinator of care in the territory, with the role of articulating levels of care, as well as focusing on the determinants and conditions of health of the population served[13].

In spite of the few studies on the PNAISARI, intersectoriality has been discussed and shown as a crucial element for the change of the care model and reorganization of health care, which refers to the idea of territorial integration, equity, and so-

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cial rights[14,15]. In addition to being a fundamental tool in health care and the implementation of the policy, it is also a continuous challenge to ensure the right of adolescents under the socio-educational care and, more specifically, those deprived of their liberty[16,17].

Considering the challenge of intersectoriality between sector policies and guaranteeing the right to health of adolescents deprived of their liberty, this study intends to analyze the implementation of the PNAISARI based on changes in its normative framework and the policy monitoring and evaluation tools used by the Ministry of Health.

Methodological strategy

This is a study with an analytical approach, using documentary analysis of the normative policy frameworks and quantitative data of the PNAISARI monitoring and evaluation system of the Ministry of Health.

In the documentary analysis stage, we surveyed the policy's legislation through the official portal of the Ministry of Health, and we sought to identify the main changes, building realms of analysis and correlating them with the literature found.

For the quantitative data analysis stage, we requested the General Coordination Office of Adolescent and Youth Health, from the Department of Programmatic and Strategic Actions of the Ministry of Health (CGSAJ/DAPES/SAS/MS) to provide data related to the management of the municipal and state level, thus resulting in the following forms: Municipal Management of the PNAISARI and State Management of the PNAISARI. Thus, the CGSAJ / DAPES / SAS / MS facilitated the primary database of the second half of 2016.Data were collected via FormSUS from the PNAISARI Monitoring and Evaluation process forms. The forms are semi-structured, with objective and subjective questions, with auto-filling by the municipal and state health and socio-educational managers. Their structure consists of the following blocks: Identification; Municipal/State management; and Perception about the implementation of the policy in the territory.

In the Identification block, the area responsible for the implementation of the health sector policy was analyzed; in the municipal/state management, variables related to the identification of management tools of the working groups were examined, such as: meetings of the SINASE management group and meetings of the Inter-Sectoral Work Group (GTI) of the PNAISARI. Finally, in the PNAISARI Perception block, the closed-ended questions related to the follow-up, existence or not of co-financing and the comparison of health care before and after the implementation of the policy in the territory were analyzed, that is, information on the state-of-the-art of policies in Brazilian municipalities.

All duplicate forms were excluded from the data analysis, considering the most recent forms in the database. Data were tabulated and analyzed in the Office Excel 2010 program, where a descriptive method was adopted.

Results and discussion

The results and their discussion were organized in two parts: (A) Analysis of the Policy's norms changes and (B) State-of-the-art policy implementation, based on the results of the monitoring carried out by the Ministry of Health.

(A) Analysis of Policy's norms changes

In the research on the normative of the policy were identified the ordinances that regulate it, and they are: Interministerial Ordinance Nº 1426/2004; Ordinance SAS/MS Nº 340/2004; Ordinance SAS/MS Nº 647/2008; Ordinances GM/MS Nº 1.082/2014, Nº 1.083/2014 and Nº 1.084/2014. However, Ordinance SAS/MS Nº 647/2008 and Ordinances GM/MS Nº 1.082/2014 and 1.083/2014 were used for the analysis; the latter two were the most recent ordinances addressing the operationalization of the policy and financing, respectively, and which show discrepancies relevant to the implementation of the policy. Analysis dimensions and the description of the changes that occurred in the PNAISARI legislation were constructed, as can be seen in Chart 1.

In the *governance realm*, the amendment is related to the formalization of the Intersectoral Working Group (GTI), as an intersectoral space responsible for the elaboration of operational and action plans, as well as policy follow-up and monitoring. A study carried out in Acre makes it evident that the formalization of the IWG drives the federative entities towards intersectoriality[16].

Financing shows an update of the resources in all modalities of socio-educational service, and is guided by the number of adolescents served. In addition to the increased values, a specific financ-

Chart 1. Amendments to Ordinances SAS/MS Nº647/2008, GM/MS Nº1082/2014 and 1083/2014, Brazil, 2014.

Realm	Ordinance nº 647/2008	Ordinances nº 1082 and nº 1083/2014
Governance	It is the responsibility of the municipalities to establish their methods of policy governance.	The Inter-Sectoral Working Group (IWG), which is understood as an intersectoral mechanism for the negotiating table and decision-making, is expanded. States and municipalities qualified in the policy are responsible for its institutionalization.
Financing	Financing from the qualification of the states with transfers to either the state or municipal health fund, on a quarterly basis. Values based on the number of adolescents attended per month, per year: . > 40 = R$ 21.300,00 . 41 – 90 = R$ 51.120,00 . < 90 = R$ 85.300,00 . Semi-liberty = there was no incentive	Increased the incentive based on the parameters of the Family Health Strategy (ESF) team, transfer to the municipal/state fund as empowered, with monthly transfers and financial resources for semi-liberty houses. Values based on the number of adolescents attended per month, per year: . Up to 40 = R$ 89.838,00 . 41 - 90 = R$ 102.672,00 . < 90 = R$ 128.340,00 . Semi-liberty = R$ 38.502,00
Reference Team	Minimum team: . Doctor . Nurse . Dental surgeon . Psychologist or Social Worker Prioriza o atendimento pela Rede Local de Saúde, nos casos quando houver equipe de saúde dentro da unidade socioeducativa. Apresenta um anexo sobre como deve ser a estrutura física e de equipamentos.	Minimum team: . Doctor . Nurse . Dental surgeon . Mental health professional depending on the monthly number of adolescents attended at the facility. Prioritizes service in Primary Care, and in cases when there is a health team within the socio-educational facility, PHC reference health team should be articulated with the of the socio-educational health team. Does not mention the physical and equipmentstructure.
Architectural parameters of the health area in the socio-educational facility	Parameters defined as health area.	No description on parameters is available.
Modalities of socioeducational service	Internment and Provisional Internment	Internment and Provisional Internment, Semi-confinement and Open Environment Measures (Guidelines)
Interfederative articulation	Centralized State qualification.	Decentralization to municipalities with the possibility of state or local qualification.
Monitoring and Evaluation	State operational plan. State and regional seminars The State Health Secretariat must send to the Ministry of Health a copy of the chapter of the Management Report that includes POE's actions, which will serve as a basis for monitoring and evaluation until the definition of indicators and monitoring procedures. Criteria for suspension of the incentive (financing): . Incomplete minimum team or team not updated in the SCNES.	Operational plan and state / municipal action plan. "In loco" technical visits Completion of the PNAISARI Follow-up and Monitoring Form (Form SUS) by the authorized subnational partners semiannually. Criteria for suspension of the incentive (financing): . Incomplete minimum team or team not updated in the SCNES. . Failure to submit the annual action plan . Identification of other irregularities in the implementation of the policy at the discretion of CGSAJ/DAPES/SAS/MS

Source: Author's elaboration.

ing model for semi-confinement was inserted. It is important to emphasize that financing is a cost incentive transferred directly from the National Health Fund to the federally-owned fund responsible for the management of PNAISARI's actions.

Regarding the *reference team*, the main change identified was the inclusion of the mental health professional in the primary care reference team. It should be noted that this is a recurring demand from the sectors involved in the SINASE since it is one of the central health demands of this population, which corroborates with international studies[18-21]. The increased resolution capacity of the Primary Health Care – PHC using expanded services, adding a mental health professional to the team, allows the access to diagnostic and therapeutic means, seeking to avoid the discontinuity and fragmentation of the integrality of the care[22].

With regard to the *architectural parameters of the health space in the socio-educational facility*, a significant change in the ordinance consists in the suppression of the indication of structural parameters for the construction or expansion of health spaces within the socio-educational establishments, which reinforces the logic of politics and the importance of creating a bond of this teenager deprived of liberty with the health network. This adequacy is fundamental to overcoming the challenge that institutional incompleteness imposes on the work articulated with the local healthcare network, the socio-educational community and other vital sectors for comprehensive care to the adolescent. This principle is set forth and SINASE's legal framework[12].

Despite the normative changes and the effort to insert adolescents in the health network, we can observe that Chapter 7 of the SINASE[11], which addresses the structural parameters for care facilities that perform the provisional hospitalization and internment, provides for a health area, with the same proportions of a PHCFacility of a territory. It is worth noting that a Family Health Strategy team is responsible for the health care of 3,000 to 4,000 people or 1,000 families, and it is not economically feasible to reference a team or to build a structure in these proportions exclusively for the care of a small group of adolescents.

The existence of a health space within socio-educational establishments, regardless of the number of adolescents served, reinforces the vision of these facilities as a whole institution, as well as in prison facilities. It can be observed from the inspection surveys carried out, as in a document published by the National Council of Justice[23] that there is a misconception about the indispensable use of health teams within the socio-educational unit, as well as a negative perception about the referral of adolescents to the local health network.

Regarding the *socio-educational care modalities*, expanding guidelines to the open environment and semi-confinement reaffirm PNAISARI's commitment to adolescent health in socio-educational care, considering the importance of strengthening and qualifying care and assistance for adolescents under theseconditions. This expansion builds on the prioritization of the application of measures in open and semi-confinement environments, provided for in the ECA.

In the context of *interfederative articulation*, the main change observed is the possibility of direct qualification of the municipality. Thus, the decentralization of the policy is strengthened, favoring greater autonomy for the federated entity responsible for the actions and agility in the process of qualification in the PNAISARI. A study on health care for adolescent offenders points out that the articulation between the federative bodies, as in joint supportive actions, involving municipal health and the socio-educational system, are promising strategic procedures[24].

Among the changes observed in *Monitoring and Evaluation* are the *in loco* technical visits; the provision of an annual action plan, which is linked to the receipt of the financial incentive for the current year, signed by the municipal/state health manager and the socio-educational manager; and possible suspended transfer of the incentive in case of irregularities. The operational and action plans appear as indispensable strategic tools for the planning of the activities and the accomplishment of intersectoriality. The construction of plans with an explicit definition of responsibilities in the shape of an agreement is identified in the literature as a way to reduce gaps between the agreements signed and the federated entities to regulate themselves about their responsibilities vis-à-vis health[25].

The importance of strengthening the follow-up, monitoring and evaluation of the public policy provides the possibility of attending to the constant and structural changes in the dynamic process of its implementation, as well as to serve as a basis and lessons learned for application in other activities of the same nature[26].

(B) State-of-the-art of the implementation of the PNAISARI

To monitor the implementation of the policy, since 2014, the Ministry of Health requests subnational partners qualified in the PNAISARI to complete the forms for each profile on a half-yearly basis. The state-of-the-art is considered as the scenario of the PNAISARI implementation process in the different contexts.

In the second half of 2016, 33 municipalities were qualified in the PNAISARI, with 63 reference healthcare teams, for 68 socio-educational facilities. Twenty-seven municipalities authorized under the PNAISARI responded to the municipal management tool. Concerning the state management tool, nine of the eleven federal unitsresponded to the form. Data analysis considered an intentional sample of the municipalities and teams that completed the form and were qualified according to the policy. Table 1 was elaborated from the information on the area responsible for implementing the policy in the municipality/state.

Data suggest heterogeneity of the area responsible for the management of health sector policy in the country, not focusing on the coordination office accountable for the implementation of health policies for adolescents and young people. Such situation may hamper the visibility of this population in the political agenda and governance of the PNAISARI, since it contends with agendas of greater acceptance and social commotion, such as child healthcare. In Brazil, although a past moment has promoted the construction of health policies for several population segments, there is still no national health policy for adolescents and young people to this day, which further weakens contention in the political agenda and corroborates the deterioration of the general health situation of this population[27].

In the absence of a health coordination office of adolescents and young people in the health secretariat, a positive alternative for the implementation of the PNAISARI is PHC as policy manager. PHC is the main gateway to the SUS and is considered the coordinator of care and regulator of the health network, facilitating access of adolescents to the health network. It recognizes its territory, the epidemiological and social profile of its population, irrespective of where services are provided[28]. In this same perspective, European universal health models advocate primary care as the coordinator of the other levels, and with the objective of enhancing this first level of care[29].

Table 1. Area responsible for the implementation of the policy.

Sphere	Area responsible for the implementation of the policy	N	%
State	Adolescent health	4	45
	Primary Healthcare	2	22
	Child and adolescent health	1	11
	Other	2	22
	Total	9	100
Municipal	Primary Healthcare	13	48
	Child and adolescent health	7	26
	Adolescent health	4	15
	Other areas	3	11
	Total	27	100

Source: Ministry of Health, 2017.

Table 2 was elaborated from the data on the implementation of the PNAISARI in the municipalities/states.

Concerning the intersectoral and interfederative articulation spaces, it is inferred that, although SINASE appears as an intersectoral policy and articulation of different actors and areas, the collegiate body is not yet institutionalized, at both the municipal and state levels, which may be related to the low number of federated units that had a meeting of SINASE's Managing Collegiate Body. The body referred to in the normative framework[12] is an essential space for dialogue among the various players involved in the implementation of the rights of adolescents in socio-educational care.

In this regard, the role of health as an inducer of intersectoral work in the network of protection and care to the adolescent through PNAISARI's IWG stands out. As already reported in the normative changes, this appears as a privileged space for the management of health actions for this population. We understand from the results that the IWG has been conducting semiannual meetings in all municipalities. However, we identified that some federated entities are not participating in the meetings, which should be revived for the strengthening of intersectoral actions in these spaces. We also emphasize the importance of participating and holding meetings at the state level, reinforcing the importance of joint responsibility for the implementation of the policy.

Studies on intersectoriality in the health sector point out that such spaces favor the sharing of decision-making power and the explicit recogni-

Table 2. Data on the implementation of the PNAISARI.

Data on the implementation of the policy	Nº of Municipalities	Nº of States
Federated units that held a meeting of SINASE's Management Collegiate Body	8	3
Federated units that participated in a meeting of SINASE's Management Collegiate Body	8	2
Federated units that held a meeting of the IWG	27	7
Federated units that participated in a meeting of the IWG	25	6
Federated units that co-finance PNAISARI	14	3
Follow-up the implementation of the PNAISARI	26	8
Health services improved after the implementation of the PNAISARI	24	7

Source: Ministry of Health, 2017.

tion of the interdependence ratio between jointly responsible entities, facilitating the production of more effective actions for the complex problems that involve this population[30]. Among the evidence identified in a case study carried out in 18 countries, including Brazil, is the importance of intersectoriality in coping with health inequities and improving quality of life, highlighting this strategy for low- and middle-income per capita countries[14,31]. Among the challenges observed for effective intersectoriality are the identification of divergent agendas among stakeholders[32] and the need to change the practices of planning and realization in service delivery[15].

Regarding co-financing, 13 of the 27 municipalities and three of the nine states reported that they do not co-finance the policy, that is, they do not participate in the tripartite financing of the actions and services provided for in Ordinance Nº 1082/2014. It should be emphasized that the right to health is a direct duty of all entities and the federative pact cannot be imposed against the citizens, but only be considered among the parties to the agreements themselves. The Ministry of Health must review this matter with the federated entities since the policy is subject to importantagreements in the interagency committees and strategic councils before being approved.

Respondents reported that they had followed the implementation of the PNAISARI through the following strategies: IWG, follow-up actions of health teams, *in loco* technical visits, operational and action plans, monitoring and policy evaluation actions, joint support and case studies, as well as professional advice through telephone contacts and videoconferences. The examples cited corroborate the management tools recommended for shared practices and health knowledge among the teams, seeking to assist them in managing or solving clinical and health problems and adding practices in PHC that expand the scope of their services[33].

Regarding policy evaluation, most municipalities and states reported improved health care for adolescents under socio-educational measures after the implementation of the PNAISARI. In this context, it is vital that the CGSAJ/DAPES/SAS/MS, which is the policy manager at the central level, carry out further evaluations and studies on the policy implementation process considering the results obtained and the cost-effectiveness of these outcomes.

Addressing the challenges of the right to health of adolescents and young people in Brazil is a complex task that confronts us with health inequities and interventions on their social determinants of health. Thus, the implementation of policies that are articulated in intersectoral fashion, with horizontal governance and with clear counterparts of the participation of each sector and federated entity in its planning and monitoring are essential for the approximation of the universes of formulation and implementation, which traverses the very process of democratization and the realization of guaranteed social rights.

Final considerations

This study sought to contribute to a discussion about the right to health of adolescents deprived of their liberty from the PNAISARI implementation analysis. In short, the results suggest that the policy strengthens the realization of the right to health of this population. However, its implementation must be fostered and qualified to ensure that access to health care is, in fact, a reality in all states and municipalities.

As limitations of the study, we can point to the lack of more information about the implementation of the policy and the results achieved, allowing the identification and correlation between the strategies used, governance models and comprehensive health care for adolescents deprived of their liberty.

As a suggestion to improve the PNAISARI, we recommend to strengthen intersectoral participation bodies such as the IWG, the institutionalization of SINASE's Managing Collegiate Body, the recognition of the joint responsibilities of the federated entities for their co-financing, as well as the understanding of the organizational rationale among the sectors involved in the implementation of institutional incompleteness and the guarantee of the rights of Brazilian adolescents and young people. Finally, we also recommend further analyses and studies in the area, considering in the evaluation not only the perception of the state and municipal health managers but all those involved, especially the assisted population, namely, adolescents.

Collaborations

All authors participated in the design and accomplishment of all stages of the research, as well as this paper's design, elaboration, and review.

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