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RESEARCH

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HEALTH OF WOMEN DEPRIVED OF LIBERTY: CONCEPTS OF WORKERS AND HEALTH PROFESSIONALS IN A PRISON UNIT

Saúde de mulheres privadas de liberdade: concepções de trabalhadores e profissionais de saúde em unidade penal

Salud de las mujeres privadas de libertad: conceptos de trabajadores y profesionales de la salud en unidad penal

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ABSTRACT

Objective: to understand how health care workers and professionals in a prison setting provide care to women deprived of their liberty. **Method:** exploratory, descriptive and qualitative study conducted in a prison located in the central region of Rio Grande do Sul. Data collection was carried out through semi-structured interviews. Bardin's theoretical framework was used for data analysis. **Results:** two categories were built: The invisibility of women deprived of liberty in health care networks; and the care of women deprived of liberty: the pain of isolation, loneliness and fragility in the health-disease process. **Conclusion:** health care within the prison system is fragmented and requires organization, effective communication and horizontality to improve care, as well as the need to strengthen the support and care network in relation to gender.

DESCRIPTORS: Women comprehensive health care; Freedom; Nursing care; Nursing; Prisons;

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RESUMO

Objetivo: compreender como os trabalhadores e profissionais de saúde de uma unidade penal efetivam o cuidado de mulheres privadas de liberdade. **Método:** estudo qualitativo descritivo exploratório, realizado em uma unidade penal da Região Central do Rio Grande do Sul. A coleta de dados foi realizada por meio de entrevista semiestruturada. A Análise dos dados utilizado foi o referencial teórico de Bardin. **Resultados:** construída duas categorias: A invisibilidade das Mulheres Privadas de Liberdade: nas Redes de Atenção à Saúde e o cuidado as mulheres privadas de liberdade: a dor do isolamento, da solidão e da fragilidade no processo saúde doença. **Considerações finais:** a Atenção à Saúde dentro da unidade penal é fragmentada, necessitando de organização, comunicação efetiva e horizontalidade para a melhoria do cuidado, bem como, a necessidade do fortalecimento da rede de apoio e cuidados em relação ao gênero.

DESCRITORES: Assistência integral à saúde da mulher; Liberdade; Cuidados de enfermagem; Enfermagem; Prisões;

RESUMEN

Objetivos: comprender cómo los trabajadores y profesionales de salud de una unidad penitenciaria brindan atención a mujeres privadas de libertad. **Método:** estudio cualitativo descriptivo exploratorio, realizado en una unidad penal de la Región Central de Rio Grande do Sul. La recolección de datos se realizó a través de entrevistas semiestructuradas. El análisis de datos utilizado fue el marco teórico de Bardin. **Resultados:** se construyeron dos categorías: La invisibilidad de las Mujeres Privadas de Libertad: en las Redes de Atención a la Salud y el cuidado de las mujeres privadas de libertad: el dolor del aislamiento, la soledad y la fragilidad en el proceso salud-enfermedad. **Consideraciones finales:** la atención de salud dentro de la unidad penitenciaria se encuentra fragmentada, requiriendo organización, comunicación efectiva y horizontalidad para mejorar la atención, así como la necesidad de fortalecer la red de apoyo y atención en relación al género.

DESCRIPTORES: Atención integral à la salud de la mujer; Libertad; Atención de enfermería; Enfermeira; Cárceles.

INTRODUCTION

The number of women deprived of liberty has increased significantly. In 2017, there were 37,828 women deprived of liberty (WDL) in Brazil, according to the Ministry of Justice and Public Security.[1]

The Law on the Execution of Penal Sentences (LEP) defines how the sentence of deprivation of liberty and also the restriction of rights must be carried out, and in its article 10 it states that "Assistance to prisoners and detainees is the duty of the State", which aims at the prevention of crimes and the behavior of the individual to return to coexistence in society, It is also addressed to women deprived of their liberty.[2]

The right to health for the population deprived of liberty is guaranteed by the Federal Constitution, which is responsible for the legal and constitutional right of access with equity, integrality and universality.3 For example, health interventions and services are planned and implemented in prisons in collaboration with the Ministry of Health and the Ministry of Justice.

Interministerial Order No. 1 of January 2, 2014, implementing the National Policy of Comprehensive Health Care for People Deprived of their Liberty in the Prison System (PDLPS) in the Unified Health System (SUS)[4], which guarantees the right to health for all detained people. The policy guarantees these citizens access to SUS, in accordance with the principles of human rights and citizenship.[5]

The Prison Health Unit is configured as a place within the Health Care Network (HCN) of SUS, which trains primary care in the prison context with other HCN. Each prison unit has a Basic Health Unit (BHU) and a multidisciplinary team that carries out health promotion and disease prevention activities. In the absence of a BHU in the prison, the territorial BHU is responsible for these actions.[1]

The prison environment can cause or aggravate illnesses in people deprived of their liberty, whether they are pre-existing or not. In the female universe, prison causes even greater inconveniences, such as estrangement from the family, negative stigma from society, and major health problems, the most important of which is mental suffering.[6]

The study is justified by the gradual increase in the incarceration rate of women and the need to improve health care within the Brazilian prison system. It is hoped that this study will contribute to the visibility of the care provided to women deprived of liberty (WDL), for the society, the academy and managers in the strengthening of public policies.

Based on these considerations, the research question of the present study is: "How do health care workers and professionals in a prision unit of the prison system provide care to women deprived of liberty?"

Objective: To understand how health workers and professionals in prision units provide care to women deprived of liberty.

METHOD

Exploratory, descriptive and qualitative study, conducted in a prison in the Central Region of the State of Rio Grande do Sul, with technical capacity for 258 prisoners. In March 2021, the prison population was estimated at 268 prisoners, women and men, serving sentences in closed, semi-open and open regimes.7

It has accommodation for both women and men. Article 82, paragraph 2 of the LEP allows the existence of different establishments if they are isolated. In this way, the women are held in the same architectural space as the men, but in separate cells. The WDL reference is a BHU located in the South Region, about 500 meters away from the prision unit.

Workers and health professionals of a prision unit, composed of five subjects, participated in the study. For the composition of the subjects, the following inclusion criteria were established: professionals working in the prision system, working for more than one year, working directly with the female public, due to their experience with them.

Exclusion criteria: professionals not involved in the WDL health process and on leave of any kind. Two subjects were excluded, one of whom was on medical report and the other on vacation.

Data collection was carried out in November 2021, through semi-structured interviews, used as a technique for data production and recording. The interviews were conducted in an informal dialogical manner, developed through the Google Meet platform, to protect the subjects from exposure to SARS-COV 19. Speeches were recorded with a digital audio recorder and transcribed in full during the conversation on Google Meet.

The interviews were prearranged and conducted individually with each participant, first by telephone contact to arrange the date and time, and later by emailing the Google Meet address.

In order to maintain confidentiality, the interviews were conducted in a meeting room with the virtual presence of the researcher and the study participant, in order to maintain the privacy and comfort of the interviewees and to obtain a better result of the interviews.

The data of the study were meditated by Bardin's analysis of content8, the pre-analysis consisted of three stages: in the pre-analysis, the recorded interviews were completely transcribed in Microsoft Word, arranged in a table and organized in the order of the questions asked, which were read exhaustively, and the answers were highlighted using chromatic analysis, with different colors that made it possible to highlight repeated and/or similar information that was relevant to the study.

In the exploration of the material, 22 registration units were identified by frequency and similarity, which are: mental health, drugs, access, referrals, depression, anxiety, health networks, HIV, tuberculosis, diabetes, hypertension, support network, breast cancer campaigns, Yellow September, Psychosocial Care Center (PCCs), pregnant women, materials, drugs, Emergency Care Unit (ECU), Emergency Care (EC), BHU, family, and isolation.

In the treatment of the results, inference and interpretation occurred. Two categories were idealized from the registration units: Care for women deprived of liberty in the health care network and care for women deprived of liberty: the pain of isolation, loneliness and fragility in the health-disease process.

The subjects who met the inclusion criteria were informed about the study, participated voluntarily, read and signed the Free and Informed Consent Form (FICF), which was taken to the prison by the researcher, after signing the questionnaire, she returned to pick it up and conduct the online interviews. In order to maintain the anonymity of the participants, they were identified by the letter P for professional and a number in ascending order.

The research project was approved by the Ethics Committee of the Federal University of Santa Maria, CAAE: 52124821.40000.5346, Opinion No. 5.046.520.

RESULTADO E DISCUSSÃO

Based on the participants' testimonies, two categories were constructed and described below.

Category 1: The invisibility of women deprived of their liberty in health care networks.

Access to health care in the WDL is first provided in the prison itself by the workers who refer them to the nurse. When the nurse is not able to provide answers to the demands, she refers them to the health care points that make up the HCN, where the demands are not always met, access is not institutionalized, there are no established flows, and there are weaknesses in the governance system, as shown below:

> *Sometimes it is the prisoners themselves who, when they go for a break in the yard to sunbathe, talk directly to the prison officer to go to the health sector, once they get here in the health sector we do the historical report.* (P3)

> *We identify the care needs, or they request care, we send the names to the infirmary, and the infirmary, already with the care plans, calls the inmates for care, all are referred to the infirmary. The nurse does the assessment and sees what she really needs, all in the ward.* (P1)

> *The WDL are referred to the prison health department, where we have a nurse, a dentist, and monthly scheduled medical care.* (P4)

> *We see the needs and make the referral to the municipal health network, sometimes it is done directly to the network, other times if we are not sure we leave it up to the doctor, here for us he comes as a general practitioner, other times depending on the urgency we refer him directly to a gynecologist or to women's health.* (P3)

> *We do not have access to hospital units, referrals are made to the community network, through the BHU or Urgent and Emergency cases to the ER or UPA, Mental Health and PCCs.* (P3, P5)

The HCN have constructive elements for qualifying care. It can be seen that they are fragmented by isolated points of health and there is no effective horizontal communication, which makes it impossible to achieve longitudinal and comprehensive care, as evidenced by the following statements:

> *We often have difficulty accessing medical care. Sometimes even in the BHU, in the health network itself, access is*

difficult, you don't always get an opening or it takes a long time to get access, you have to resort to the UPA, as well as a more emergency case, even of medication or some situation of suicide risk, as well as more serious things, you mainly go to the UPA, SAMU. (P3)

At PCCs, they will only accept to send patients if these people have sought care prior to incarceration, and if they have the registration there, a link, then I schedule it and forward it. If these people didn't have contact prior to arrest, they don't accept it, then I can't refer these people there for follow-up. (P1, P2)

The municipality has a suicide care service, if the person here is at risk of suicide, I have been able to refer them to the psychiatrist there, but then the issue of suicide has to be on the agenda for them to be able to accept it. And mental health is these places that we have at the moment. (P1)

According to Schultz6, a study that analyzed the limits and challenges for the access of WDL and ex-prisoners in the HCN, noting that the prison unit is the main gateway, but lacks the organization to be the organizer of care, as well as the lack of follow-up, especially in mental health care, requiring the expansion and optimization of more equitable and comprehensive, encouraging the use of care tools and other devices of the HCN.

Considering Graça[9], the referral and counter-referral systems are management systems that the SUS brings to its strengthening. They are part of the scope of each component of the HCN and are organized through established flows and means of performance to ensure comprehensive care for users. In order for these systems to be effective, it is essential that the levels of care are interconnected and that the means of their organization are firm.

In Schultz's view[6], the link between the health care system, the prison system, and the criminal justice system is relevant in order to develop possible strategies to reduce the harm caused by incarceration and to implement policies to provide comprehensive health care to the incarcerated population. In short, the construction of data related to the obstacles to the effectiveness of health care in the condition of female incarceration, with regard to issues related to access to social rights, mental health and better living conditions, is in itself pertinent, since the structure of prisons and the means of coexistence in prison are rarely adequate to the demands of women.

There are points of health care to which the WDL have easier access and there is continuity of care, already incorporated over time by public policies for the care of women, according to reports.

Some other diseases, like HIV, are referred to, and it would be more of a specific health issue, it is the issue of HIV, AIDS, the treatment kits that they receive, we access them with peace of mind. (P1, P2)

There are the issues of pregnant women, prenatal care, it is done at BHU, they are taken there, they do all the prenatal follow-up, they do all the necessary exams, the whole prenatal schedule is done. (P1)

In contrast to our study, the research conducted by Chaves and Araújo[10] discusses the need for prenatal care, which is an adversity according to the reality of pregnant women incarcerated in Rio Grande do Sul, where the non-periodicity of the prenatal service and the obstacles to access to consultations are observed. It is also evident that, during pregnancy, the embryo absorbs all the physical and psychological demands to which the pregnant woman is subjected. In prison, women are more exposed to events of stress and helplessness, increased by the feeling of fear typical of prison, and therefore the health of the pregnant woman and her child is even more fragile.[10]

It can be seen that the partnership between the Municipality and the Prision Unit, with the presence of a medical professional, has facilitated the care of the WDL and many of the needs are solved on the spot.

It is important to note that before we did not have doctors. Now, for some time now, we have managed to establish a partnership with the City Hall. We have a doctor who comes every two weeks, he comes and does the care right here, in the infirmary. It made it a lot easier, all the questions were directed to the BHU, which is our reference, which is close to the prison, so we had to take the inmates there for consultations, this decreased due to the fact that the doctor came here every two weeks. (P3)

The deputies' reports identified weaknesses in the support systems in the HCN, including the pharmaceutical care system, which hinder the comprehensiveness and quality of care, especially in terms of access to and control over medicines. In addition, the care of women, especially WDL, requires a unique and specific approach that takes gender issues into account.

The medication, if it is brought by the family, if it is a medication that requires a prescription, they only get it here with a doctor's prescription, self-medication would not be able to tell you because the nursing controls all of that. Maybe a self--medication more of these common remedies, like for pain, but this use of controlled certainly doesn't. (P1)

They do self-medicate when they have access to medications from other inmates who use them, they share the medications, they do not always go through medical or nursing care to get the medications. They switch and end up self-medicating. A lot of people use self-medication, sometimes because they suddenly miss it, sometimes they haven't had an appointment yet, or someone is in need, they end up giving in to these others, so it's very common. (P2)

They don't have access to self-medication, painkillers, they come to the health sector, and we provide them with those medications. Now other medications are only available from doctors. (P3)

All the medication for the prisoner is her responsibility, and she receives it once a month, and before that it is not provided, we advise her to take care of her medication, not to sell

it, not to lose it, because before the time she does not receive it, because there is a lot of exchange and trade of medication, if we don't do it this way, we always provide medication. (P3)

This study corroborates the study by Santos11 on the mental health of women in prison, who in different situations use medication on their own initiative, not always under medical supervision, with the need to solve their individual difficulties.

According to the informants, the difficulties in providing health care in the WDL are due to the inadequate environment and permanent equipment, the lack of health personnel in the prison and the transport logistics.

We don't have a prison health unit, the prison health program should be taken over by the city government. (P3)

The biggest difficulty is access, sometimes for security reasons, logistical problems, lack of personnel to accompany, this also happens. When there is an appointment, which we have seen recently, we have tried to maintain so that these consultations are carried out, at least the PCCs ones, they have always happened, unless there is an interruption, but in general they have been maintained. (P3)

The biggest difficulty we face is the lack of prison health staff, the lack of health professionals. Another difficulty is the physical space, we only have one room that is for the doctor's office, nurse's office, dressing, injections, vaccines. Our environment has more than doubled in size, because before it was a cubicle, it barely fit me and the prey togethe. (P3)

The population deprived of liberty faces various challenges, including the conditions and supply of services, overcrowding of cells, precarious environment, unhealthy environment, structural factors and health teams.12

Thus, it is understood that, in addition to access to health, WDL requires quality and comprehensive care, as it is a multi--dimensional issues.

Category 2: Caring for women deprived of their liberty: the pain of isolation, loneliness and fragility in the process of health and illness

Imprisonment leads to a lack of social support, women's loneliness, injustice, abandonment, and the pain of family separation, all of which are reportedly exacerbated by the COVID-19 pandemic.

The visits that those who have companions receive are minimal, they are very few, because they are usually abandoned when they are arrested, especially by their companions. (P1)

They end up being more fragile than the others who are free, because since they are away from their family, from their children, in short, from their support network, from living together, this ends up weakening them more, also in a closed environment to which you don't have access, you have care in general, of course, but I say this, you don't have that freedom of constant or frequent care. (P2)

Many family members do not visit, sometimes the partners abandon them, now because of the pandemic it has become even more difficult, then visits were cut off, access to the family became more complicated and they became more fragile. (P2)

The care is for the women in prison, we have no support or care for the families. (P1)

According to Furtado13 this population is vulnerable, both intra- and extramural, due to the loss of freedom, the precariousness of the prison system, prejudice in society, lack of support, and it is necessary to implement public policies and a strong support network to strengthen family ties, improve quality of life and new opportunities. The maintenance of the bond with their relatives, a support network adjusted in affection, listening and welcoming, as well as the basic needs in assistance with basic hygiene products, ensuring the minimum necessary comfort.

The prevalence of diseases and injuries, acute conditions and chronic and chronic conditions, especially HIV, mental health, depression, anxiety, insomnia, hypertension are present, requiring care with an attitude, singularized, humanized, integral, making gender issues present.

The issue of HIV, AIDS, they ask a lot about the psychiatric and mental issues, substance use, in short, the history of chemical dependency, they often need care. (P1, P4)

Mental health is what is most present, I see depression, anxiety, insomnia, and there is also a question of hypertension, diabetes, HIV, tuberculosis appears, they are also phases, maybe here at least. (P2)

Urinary tract infections, allergies and respiratory problems. (P5)

It ranges from urgent psychiatric needs, gallstones, kidney stones, bleeding, injuries from fights in the yard, abscesses, hypertensive crises, drug abuse, diabetes, hypertension, menstrual cramps, lumps in the breasts, which have already been to the doctor. Sexually transmitted infections (STIs), such as syphilis and others, are enough not to know and not to protect themselves. (P3)

A large part of the population deprived of liberty is exposed to numerous health risk factors, resulting in a significant number of cases of STI/AIDS, dermatoses, pneumonia, mental disorders, tuberculosis, hepatitis, trauma, infectious diarrhea, in addition to other diseases prevalent in the Brazilian adult population, such as diabetes mellitus and arterial hypertension.[14]

This study shows that most of the professionals interviewed responded negatively in relation to mental suffering, bringing mental health as a matter of concern, especially for WDL, who are five times more likely to have mental problems than women who are free, with prison being a determining social place where

they go through stressful factors, increasing anxiety, impotence, fear, rejection, helplessness, isolation and decreased self-esteem. In view of this, it was felt that the WDL needed specialized care, especially from the mental health service, to ensure the preservation of their health during the time of imprisonment.[11]

The professionals of the penitentiary unit carry out actions to promote health and prevent diseases, especially during the months in which campaigns for women are carried out.

> *There is always a campaign, breast cancer, self-examination, the issue of syphilis, sexually transmitted diseases, tuberculosis, these issues and care are always addressed.* (P1)
>
> *Mental health as prevention, some actions have already been carried out, such as the one in September, the fight against suicide, we have also done it, in fact now groups of restorative justice, in which different topics are discussed, in short, both related to imprisonment and family, they bring their interest in debate and it is also a way of prevention.* (P2)
>
> *Lectures in the month of Pink October, self-examinations and transmission of sexually transmitted diseases.* (P3)
>
> *The health team, together with the technical sector: social worker, psychologist and legal, promote lectures on depression, mental health, Pink October, sexually transmitted diseases, among others.* (P4)
>
> *The promotion of oral actions, the FLU and COVID vaccines are carried out according to the campaign, the COVID vaccines have already been done, the first and second dose. The Hepatitis vaccines, as we depend on everything from the Health Unit and Health Surveillance, I did one year and never did it again because there are three doses, the first dose and the second dose are usually no longer here.* (P3)
>
> *There are rapid tests and treatment if positive.* (P5)

Prevention and health promotion can be defined as a means of preparing the community to improve its quality of life and health. In this logic, it brings in its practice values such as: equity, democracy, solidarity, participation, citizenship, development and partnership, which is established in a mix of strategies involving several actors: individual, family, state and community. Health promotion actions do not depend solely on the performance of public health agencies but involve the integration of the various sectors of government, which play an essential role in health promotion, as the skills and knowledge that intervene in people's behavior are developed, in relation to preventive actions of collective and individual health problems.[15]

It is understood that the WDL needs to address the dimension of the health-disease process that goes beyond the biomedical model to care for the construction of welcoming relationships, bonding and co-responsibility.

CONCLUSION

It has been demonstrated that in the HCN, the health actions and services aimed at the female prison population are fragmented and disjointed, present difficulties in access and continuity of care to the various health points, fragility in effective and horizontal communication among professionals to improve the governance system, and it is necessary to institute flowcharts, protocols, line of care, management of the health status of points of different technological density to support the penal unit and improve the quality of life of the WDL.

It is necessary to provide effective care, especially in relation to mental health, chronic diseases and STIs, through intersectoral support for professionals in the penal unit, as well as increasing the number of professionals, improving continuing education in health and health education.

This study demonstrated the need to give visibility and voice through care, based on the specificity of gender issues for professionals and managers. Health workers and professionals understand that the care of WDL is fragile and requires improvements that go beyond structure, process and outcomes.

This study shows that the care of WDL needs to be improved, mainly by strengthening primary health care as an organizer of network care and specialized care with established and optimized flows, especially for the female population.

The subject is not exhaustive, and it is necessary to be on the agenda of academics, health professionals, managers and public safety.

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