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INCARCERATED WOMEN: CHANGES IN THEIR HEALTH DURING THE IMPRISION SITUATION

Luiz Henrique Corrêa Baggio
Acadêmico de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0001-9717-0345
http://lattes.cnpq.br/8483719173624603

Alexandre Bachietti Scaramussa
Acadêmico de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0002-4548-0242
http://lattes.cnpq.br/4530685793649335

Bruna Vale Leal
Acadêmica de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0002-2124-1474
http://lattes.cnpq.br/4530685793649335

Luana Emanuele Bidoia Garcia
Acadêmica de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0002-5331-2919
http://lattes.cnpq.br/6054279571664291

Paulo Henrique Enzele
Acadêmico de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0001-6362-1259
http://lattes.cnpq.br/3890592441955866

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Joanna d'Arc Lyra Batista
Professora de Saúde Coletiva no curso de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0002-3703-2845
http://lattes.cnpq.br/8303196324134986

Maíra Rossetto
Professora de Saúde Coletiva no curso de Medicina da Universidade Federal da Fronteira Sul (UFFS), campus, Chapecó, Santa Catarina Brasil
https://orcid.org/0000-0002-5683-4835
http://lattes.cnpq.br/3984617008760337

Abstract: Goal: to analyze the main changes that have occurred in the health of women in prison in a regional prison complex in western Santa Catarina. Methodology: qualitative research carried out in March 2019 through interviews with 10 women in prison, they were applied in a private place, in a room provided by the health unit within the prison complex, with an average duration of 40 minutes. The analysis was performed using thematic content analysis. Results: the women were between 20 and 39 years old, six of them had children, 7 of them were married or dating, and six had a job prior to their incarceration. The participants' speeches were divided into three main categories: "family dynamics, intimate visits and interpersonal dependence"; "food, prison hygiene and infrastructure"; and "mental health and access to health services in prison". Final considerations: the participants reported worsening in different aspects of their physical and emotional health, contrary to what guide public policies.
Keywords: Women's health; Prisons; gender analysis; Right to health; Access to health services.

INTRODUCTION

The discussion of the Brazilian prison reality is a paradigm to be faced by society, with few public initiatives or interventions aimed at guaranteeing the health of individuals deprived of liberty. Even smaller are the initiatives aimed at women in prison, a population that becomes invisible in this context [(1)].

There is a constant growth of the prison population and, in the same proportion, the increase of inappropriate health conditions. The situation in Brazil is alarming, as the number of women in prison increased by approximately 675%, considering the number of 37,828 inmates at the end of 2017, with a

growth in the rate of female imprisonment 5.4 times greater than the 2000 data [2].

With this, there is an emergency in considering gender inequalities in the prison system, whether in imprisonment or in the conditions to which women are exposed when they are arrested [3]. The female social role is surrounded by many stereotypes and predetermined standards, which constitute power relations, where women are, in general, inferior or subaltern beings, restricted to the role of partner and mother in the domestic space [4].

Data from Infopen (2019) show that black, young women with low education are in the majority in the Brazilian penal system [5]. And that, among imprisoned women, drug and narcotics trafficking may have been seen as an opportunity for social ascension, to complement their income and to be present at home performing traditional roles of care, in particular raising children, given that which allows them to work without being away from home for long periods [6].

However, being a woman and being in prison must not limit access to health, as this is a right guaranteed to all Brazilian citizens [7]. In this sense, the search for care within the prison system has been faced and guaranteed by the National Policy for Comprehensive Health Care for People Deprived of Liberty in the Prison System [7] and from the guarantee of this right, it was outlined as a research question: what are the main changes that have occurred in the health of women in prison in a regional prison complex in western Santa Catarina? And the objective is to analyze the main changes that have occurred in the health of women in prison in a regional prison complex in western Santa Catarina.

METHODOLOGY

The research was developed through a qualitative approach, characterized as a descriptive and exploratory study [8]. The study site was the prison complex of a city in the western region of Santa Catarina, which receives prison population from neighboring cities and other states.

The study population consisted of 10 women who experienced the prison situation in the prison system and who agreed to participate in the research. As inclusion criteria, women over 18 years of age were selected, with a medical appointment scheduled at the health unit of the prison complex during the month of March. As exclusion criteria, the absence of the woman at the medical consultation or leaving the prison complex to resolve legal issues was considered.

Data collection took place in March 2019, through an interview, carried out in medical office where health care is provided, available within the prison complex. The interviews were conducted by a professor and a medical student, lasting approximately 40 minutes. The interview script included questions to define the women's profile and health trajectory before and after entering the penitentiary, related to health treatments, specific care for previous illnesses and intimate visits. Data were collected during four visits to the prison complex, and data saturation was obtained at the time of the interviews, with repetition of the participants' speeches. Participants were identified with the letter P, followed by the number corresponding to their interview, ranging from P1 to P10.

The interviews were recorded on a recording device by the researchers and saved on the teachers' personal computers. Afterwards, the interviews were transcribed and there was no return for the participants to read, due to restrictions on access to women. To carry out the data analysis, the study used the content analysis method proposed by Minayo, considering the possibility of perceiving in a systematic and reliable way

Participant	Age	Children	Marital status	Profession
1	27	1	Married	It does not work
two	36	3	Affair	Day laborer
3	20	Uninformed	Single	Massage therapist
4	27	3	Married	Kitchen help
5	33	Uninformed	Single	Sex worker
6	38	Uninformed	Married	Administrator
7	22	Uninformed	Married	It does not work
8	29	3	Widow	Housewife
9	22	1	Married	Housewife
10	39	1	Married	day laborer

Table 01: Sociocultural aspects of the interviewees.

Source: Own elaboration.

the results and responses obtained within a recognized and conceptualized scientific analysis system for qualitative analysis of interviews [8]. This method consists of three phases: pre-analysis, material exploration and treatment of results, inference and interpretation [8].

The research is part of an extension program developed in partnership between the Federal University and the prison complex, with actions for prevention and health promotion, testing and vaccination of STIs, and actions for workers' health and oral health. To maintain the extension program, every six months, undergraduate medical students go to the complex to carry out theoretical and practical activities, receiving training/qualification to carry out all care and research/extension activities.

The research project was approved by the management of the prison complex and then submitted to the Ethics and Research Committee of ``Universidade Federal Fronteira Sul`` (CEP UFFS) and was approved under opinion nº 3,066,970, CAAE nº 97030618.1.0000.5564. All participants signed the Informed Consent Form in two copies, leaving one copy for the woman and another for the responsible researcher. This research followed the COREQ framework for qualitative studies, for theoretical and methodological adequacy of the composition of the research team, the study concept, selection of participants, data collection, analysis and presentation of results.

RESULTS AND DISCUSSION

10 women in prison aged between 20 and 39 years old were interviewed. The board 01 summarizes data such as age, number of children, marital status and occupation.

The women interviewed were between 20 and 39 years old, six of them had children, seven of them were married or dating, and six had an employment relationship before their incarceration.

The data collected show socioeconomic information similar to that of other women in prison in Brazil, repeating certain patterns: mothers at a young age, married or in a stable relationship, low education, low pay and incarcerated due to involvement with drug trafficking [5].

And, it was from the data analysis exercise it was possible to arrive at discussion categories: "Family dynamics, intimate visits and

interpersonal dependence"; "Food, hygiene and prison infrastructure"; and "Mental health and access to health services in prison".

FAMILY DYNAMICS, INTIMATE VISITS AND INTERPERSONAL DEPENDENCE

The women's speeches clarify how the family distance, fragile family configurations and few visits received are frequent:

> [...] My husband doesn't come to visit me [...] (P1)

> [...] Here I have been feeling bad, because I feel very alone and I don't have friends here. I don't see my son and this is being very bad for me [...] (P1)

> [...] I've been here for about 4 months and I hardly ever have a visit [...] (P2)

> [...] This medicine I didn't take anymore because they don't have it here, only if the family brings it and mine didn't come. No one comes here and I don't want to either. [...] (P2)

> [...] I'm not even from Rio Grande, my family is not from here, I don't have visitors [...] (P5)

> [...] Do you usually receive visitors here?". "No, not here, my city is far from here. [...] (P7)

Family configurations are diverse, fluid and unique [9]. Affective bonds and family relationships are developed throughout life, and are strongly affected by incarceration. Often, the inmates are abandoned by their partners, but, on the other hand, those who maintain or replace them present themselves in a varied context, sometimes the partners are in other prisons, the end of affective relationships occurs and homoaffective relationships are built. in prison [1]. The social constructions of gender support the practices of violence in marital relationships when they naturalize sexist and patriarchal attitudes [10].

Then, the separation of the mother and her baby is also common. In these situations, the child may be referred to a shelter institution or remain with relatives. In either case, children need to readjust to their mothers during visits to prison complexes. Furthermore, the permanence of children together with their mothers in the prison environment is a controversial topic [11]. This way, family distancing plays a central role in the life of women in prison and their families as a whole.

Furthermore, women in prison are inserted in a context marked by a "family" environment, while the male environment is known for extreme violence. Women are much more concerned about their children than their fathers when they find themselves in the same prison situation. This occurs due to the father's thought that there will be a family member or spouse taking care of his/her child while he/she is incarcerated [12]. It is important to emphasize that families must not be seen only as collateral victims of the criminal process and that restricting the freedom of a family member wears out all the other components of this core, especially children [13].

Some statements highlight the culture of marital abandonment of women when asked about their sexual practices within the prison complex:

> [...] No, quite capable. My husband doesn't come to visit me [...] (P1)

> [...] No laughs). After I came here I didn't have any more... I've been here for about 4 months and I hardly ever have a visitor... not even my boyfriend. He didn't come here [...] (P2)

> [...] We have visits, but I don't have intimate visits[...] (P3)

> [...] Well, you don't have intimate visits, right? Then no. [...] (P5)

> [...] No, I don't have a husband, my husband died when I went to jail [...] (P8)

As for intimate visits, studies already carried out in other prisons diverge, showing that 27.6% of prisoners do not receive intimate visits [14] and in another publication, that 10% have visits from their relationships [15].

Women only achieved the guarantee of receiving visits from their partners in 2001 [10]. Despite this, there is still a discrepancy in the treatment of intimate visits according to gender, benefiting men to the detriment of women [15]. There is an assumption that the lack or limitation of intimate visits often favors the development of homoaffective relationships among women in prison, even among those identified as heterosexual [11].

Besides, regarding the influence of the prison situation on family dynamics, some demands are listed by the women:

> [...] I didn't take this medicine anymore because they don't have it here, only if the family brings it and mine didn't come [...] (P2)

> [...] So I needed to buy it, in this case I asked my family to buy it. So, for me it would be bad because my family cannot afford to buy [...] (P3)

> [...] It's like, I'm from Rio Grande, my family isn't from here, I don't have visitors" [...] "I can't take the medicine or buy it [...] (P5)

According to participants P2, P3 and P5, it was also possible to perceive that women are very dependent on third parties, mainly financially, and imprisonment tends to exacerbate socioeconomic vulnerability [16]. Still, family ties change over time and present themselves in the most diverse ways among individuals [17].

In interpersonal dependency, family members or close people often have twice as much responsibility, as they need to solve the problems of women in prison outside and inside prisons. It is through letters, phone calls and visits that these mothers, sisters, friends, cousins or aunts are included in the decision-making of the family core [12].

Family relationships need effort, time, imagination, emotional labor, and other resources to maintain. And, the arrest of the family member causes changes in care for the house and children, obtaining resources, constant trips to the prison. And, facing the difficulties that occurred with prison, families often turn to solidarity networks. This search for others helps in solving some of the problems imposed in the new routine [16].

FOOD, HYGIENE AND PRISON INFRASTRUCTURE

When questioned about their health conditions within the prison complex, some women stated that the infrastructure conditions such as mattresses, bathrooms, cells, in addition to hygiene, do not provide a good adaptation and cause the development of health problems:

> [...] But the mattresses, here, they are very torn, they are very moldy [...] I suspect that it has been causing health problems for me [...] (P4)

> [...] How is the bathroom?". "It's like a hole like that, it's not a vessel, you know, and there it joins the proliferation of various types of disease, infection, right [...] (P8)

> [...] The mattress would have to be changed because they are so moldy, we have to put them in the sun, these things, there's a lot of mold, it draws a lot of moisture [...] (P9)

> [...] Hygiene comes from each one, you know, like we get a hygiene kit from each one, like every month we get a hygiene kit, you know, there's also a list that we pass on for us to buy and stuff, and that's what people can say what kind of hygiene comes

from each one [...] (P9)

Although cleaning is the responsibility of the women in prison, the high number of them in the cells makes it difficult to maintain hygiene, contributing to the spread of diseases. Regarding infrastructure, it is known that the Brazilian prison system, in general, does not have adequate facilities to guarantee the basic rights of inmates. Overcrowding, poorly ventilated, humid and dimly lit environments are routinely witnessed [18].

In the place studied, despite the topic of overcrowding not being frequently mentioned in the interviews, the infrastructure problems mentioned above are present according to the speeches of P4, P8 and P9.

There were also statements about food:

> [...] The food here is not good, always the same and very bad. I can't eat much and I don't like the food, I've lost weight and I feel weaker [...] (P1)

> [...] A few days ago we complained, from another cell, that there were some bugs in the salad, we complained... Today I went to eat the chicken and it had some chicken feathers... It was poorly cooked... I don't know [...] (P3)

The situation reported in women's prisons, regarding food, is repeated in other places in Brazil. In a study, some women in prison in state penitentiaries in Paraíba reported similar experiences with the participants of this research regarding the quality of the food [3].

Hunger and malnutrition manifest themselves as a central phenomenon, the scarcity of food infringes the citizen's constitution and, in addition, from a biological perspective, the damage represented by malnutrition can result in irreversible physical and neurological damage, accompanied by disorders in cognitive and emotional areas. In this process, in addition to freedom, women in prison are also deprived of the possibility of quality food, being exposed to several risk factors and vectors that can culminate in health problems. This scenario is reproduced throughout Latin America, where those who are in conflict with the law receive worse living conditions from the institutions, in the perspective that these lives are precarious and painful [3].

MENTAL HEALTH AND ACCESS TO HEALTH SERVICES IN PRISON

In these reports they talk about their mental health:

> [...] Here I have been feeling bad, because I feel very alone and I don't have friends here. I don't see my son and this is being very bad for me [...] (P1)

> [...] My husband doesn't come to visit me [...] (P1)

> [...] I've been here for about 4 months and I hardly even have a visitor" [...] "My boyfriend, he didn't come here [...] (P2)

> [...] But since I came here I haven't been able to eat [...] I have no appetite [...] (P10).

The female gender is more vulnerable to illness, since issues inherent to it contribute to physical and mental illness. Therefore, mental health is associated with many variables, making its understanding complex. In the Brazilian prison system, women in prison are five times more likely to have mental disorders compared to women in freedom [19].

Although prison has the function of being an educational disciplinary device for people who have committed crimes and the objective of reinserting the individual into society in an integrated way, it is not fulfilling the role, with many failures and sometimes aggravation of health situations [20]. This outcome is related to the conditions of life in prison, anxiety, stress, changes in appetite and sleep and, mainly, feelings of abandonment and separation from family members [19].

In the interviews, the lack of access to health services and medications, mostly antidepressants, was widely discussed:

> [...] I took diazepam for nerve problems before I came here, but now I don't take anything [...] (P2)

> [...] I'm complicating myself a lot is that I take controlled medication. [...] So I'm not able to take the medicine, or buy it, right [...] (P5)

> [...] I take medication for depression and stuff, so until now, they didn't tell me to see a psychiatrist [...] (P9)

> [...] Without my medication I am [...] I cry a lot, a lot, a lot, you know [...] (P10)

Among the ten women in prison who participated in the interviews, at least four said they had already used antidepressants outside prison. They also said that they stopped treatment when they were arrested. This lack of attention to the basic needs of human beings results in an imbalance in the health-disease process [15].

Also, medical care in penitentiaries is mostly restricted to acute conditions, being supported by general practitioners. Statements about medical care in prison were divergent:

> [...] There are people who feel sick and no one attends [...] (P1)

> [...] In fact, you have to let them know that you're sick and there's a doctor who comes to see you, but it's not always when we need it, it's when they call [...] (P2)

> [...] The person doesn't choose to get sick, we don't choose to get sick, we always do, but we often don't get care, I think health is very bad [...] (P7)

> [...] Because I always observe when the girls need it, they call health, there's a doctor, there's a nurse [...] (P6)

> [...] Now there are more medicines, there are more appointments [...] Now they provide good care [...] (P8).

Consultations with specialists are scarce, especially with psychiatrists. This affects both women in prison who need first care and those who were already using some psychoactive drug, requiring reassessment and follow-up [21].

The absence of medical assistance by spontaneous demand is notable, being a multifactorial condition that can be understood by the association of the stigma with the inmates, the low wages of health professionals and the inappropriate conditions for carrying out the work [15].

Research in a prison environment may have environmental and organizational influences for its operation. In this sense, it is understood as a limitation the presence of a prison guard at the door of the office during the interview. This may have limited some of the participants' responses, as they could feel embarrassed or afraid of retaliation later.

FINAL CONSIDERATIONS

The profile of the participants is of young women, mothers, with marital relationships and employment ties prior to prison. They reported changes in their health situation: lack of visits and dependence on families, low-quality food, poorly structured cells, insufficient hygiene items, as well as difficulty in accessing medical care and medication.

Female incarceration has far-reaching implications, impacting not only their physical and mental health, but society as a whole. It is essential to guarantee women's right, both to quick judgments and access to the health system, preventing the development or aggravation of health situations.

It is essential to emphasize that prison presents itself as an opportunity for prevention and health promotion. Thus, it is necessary to carry out intervention studies in this environment, seeking to improve the quality of

life of the female prison population, essential for expanding the understanding of women in the prison context. Other research on access to the health services network is essential to understand how women in prison are cared for regarding chronic diseases, access to the use of hygiene items, STIs, pregnancy and childbirth.

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