ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

CONCEPTS OF HEALTH, ILLNESS AND ASSISTANCE FROM THE VIEWPOINT OF WOMEN DEPRIVED OF FREEDOM

NOCIONES DE SALUD, ENFERMEDAD Y ASISTENCIA A PARTIR DE LA OPTICA DE MUJERES EM SITUACIÓN DE PRIVACIÓN DE LIBERTAD

NOÇÕES DE SAÚDE, ADOECIMENTO E ASSISTÊNCIA NA ÓTICA DE MULHERES PRIVADAS DE LIBERDADE

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ABSTRACT
Objective: To know the notions of health, illness and assistance from the perspective of women deprived of their liberty. **Method**: Case study developed in a prison in the south of the country, in which 11 women deprived of their liberty participated. The data were produced through interviews, observation and document analysis, between July and October 2017, and the statements were submitted to thematic analysis. **Results**: Concerning the notions of health, the women highlighted the absence of diseases and limiting physical symptoms associated with the non-use of drugs and poor diet. Regarding to illness, the interviewees evidenced precariousness in the prison system, anguish and concerns with their children and families. The assistance provided in the health services was considered good and resolute, with easy access, despite the barriers in accessibility, due to the logistics of the prison system. **Conclusion**: The prison precariousness and inadequate care for basic needs negatively affected the female health-disease process. Improvements are suggested in the prison unit with a view to promoting health, human rights and citizenship for women deprived of their liberty.
Keywords: Women; Women's Health; Prisons; Comprehensive Health Care; Nursing.

RESUMEN
Objetivo: Conocer las nociones de salud, enfermedad y asistencia a partir de la óptica de las mujeres en privación de libertad. **Método:** Estudio de caso desarrollado en un presidio en el sur de Brasil, donde participaron 11 mujeres en privación de libertar. Los datos fueron producidos mediante encuesta, observación y análisis documental entre julio y octubre de 2017, y las enunciaciones sometidas a un análisis temático **Resultados:** cuanto, a las nociones de salud, las mujeres destacaron la ausencia de enfermedades y síntomas físicos limitantes asociado al no uso de fármacos y mala alimentación. En lo que se refiere a las enfermedades, las deponentes evidenciaron las precariedades del sistema carcelario, angustias y preocupaciones con los hijos y familia. Relacionado a la asistencia prestada por los servicios de salud, fue considerada buena y resolutiva, con acceso facilitado, a pesar de que las barreras de accesibilidad por la logística del sistema carcelario. **Conclusión:** la precarización carcelaria y el atendimiento inadecuado de necesidades básicas afectaron negativamente el proceso de salud-enfermedad femenino. La sugerencia es que se implemente mejorías en la unidad carcelaria a buscar a la búsqueda de promoción de la salud, de los derechos humanos y de ciudadanía de mujeres en privación de libertad.
Palabras clave: Mujeres; Salud de la Mujer; Prisiones; Atención Integral de Salud; Enfermería.

RESUMO
Objetivo: conhecer as noções de saúde, adoecimento e assistência na ótica de mulheres privadas de liberdade. **Método:** Estudo de caso desenvolvido em um presídio no sul do país, em que participaram 11 mulheres privadas de liberdade. Os dados foram produzidos mediante entrevista, observação e análise documental, entre julho a outubro de 2017 e as enunciações submetidas à análise temática. **Resultados:** quanto as noções de saúde, as mulheres destacaram a ausência de doenças e sintomas físicos limitantes associado ao não uso de fármacos e boa alimentação. No que se refere ao adoecimento, as depoentes evidenciaram precariedades no sistema prisional, angústias e preocupações com os filhos e a família. Já a assistência prestada nos serviços de saúde foi considerada boa e resolutiva, com acesso facilitado, apesar de barreiras na acessibilidade pela logística do sistema prisional. **Conclusão:** a precarização prisional e o atendimento inadequado de necessidades básicas afetaram negativamente o processo saúde-doença feminino. Sugere-se melhorias na unidade prisional com vistas à promoção da saúde, dos direitos humanos e de cidadania de mulheres privadas de liberdade.
Palavras chaves: Mulheres; Saúde da Mulher; Prisões; Assistência Integral à Saúde; Enfermagem.

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INTRODUCTION

Female imprisonment is a growing problem worldwide, in which Brazil ranks fourth, preceded only by the United States, China and Russia. In the country, between 2000 and 2016, this rate increased by 656%, while the male rate in this period was 293% [1]. In June 2017, 37,828 women were deprived of their liberty in the 1,507 registered penitentiaries, corresponding to an occupancy rate of 118.8% and a total deficit of 5,991 vacancies [2]. In addition, the Brazilian prison system originally acquired for men was later adapted for women[3]. About 75% of the prisons are male, 18% are mixed, 7% are female and others have a wing adapted for women in a male facility, and only 14.2% of the units have a space reserved for pregnant and lactating women [2]. To face the problems of increasing female imprisonment, the National Policy for the Care of Women Deprived of Liberty and Released from the Prison System (PNAMPE) was created in order to improve their living and health conditions [4].

For Primary Health Care (PHC) professionals, caring for the prison population is challenging, as health care in this scenario differs from other contexts due to its specificities, such as gender inequalities that shape unique illness processes in the deprivation of freedom [5-6]. Among these specificities, there is an urgent need for the female health care system in the prison system to go beyond the traditional biologicist, medicalizing and fragmentary approach to health actions, through the incorporation of perspectives such as humanization, integrality, longitudinality of care in different life cycles and gender transversality[4].

It is noteworthy that the health care of women deprived of liberty, anchored in such perspectives, favors the expansion of this focus in the understanding of different vulnerabilities and denotes challenges to the coordination of intersectoral and interprofessional actions to meet their demands that tend to be invisible, both by the State and by the health services. In view of the panorama of female imprisonment as a problem for the field of collective health, the question of this study is listed: “What are the notions of health, illness and assistance from the perspective of women deprived of liberty?”

The study is justified in view of the demands to problematize the notions of health, illness and care for women deprived of liberty and to present elements that will contribute to the planning and implementation of interventions regarding the promotion of their health in a prison unit. For health care for women deprived of liberty, converging with the unique demands of this population, it is necessary to know the notions of health and illness from their perspective. This manuscript aims to understand the notions of health, illness and assistance from the perspective of women deprived of liberty.

METHODS

Case study [7], with a qualitative approach, whose unit of analysis is a State prison located in the south of the country. During the research period, 241 people deprived of liberty

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were sheltered, distributed among the closed, semi-open and open systems, and 28 of these were female [8]. The prison unit has ten cells designed to house 48 detainees in a closed system, of which nine are for men, with about 22 detainees in each, and one cell was adapted to house women in a closed system, and was with 18 inmates at the time. On site, there is a building with capacity for 148 people from the semi-open and open systems, distributed in seven rooms, 81 men and 10 women [8].

The inclusion criteria were: being incarcerated in a closed system for at least three months and having the cognitive conditions to answer the interview. Those deprived of liberty in a semi-open or open system were excluded. Of the 18 women deprived of liberty in a closed system invited for the study, 11 showed interest and accepted the invitation. Data were produced from July to October 2017, through semi-structured interviews, non-participant observation recorded in a field diary and document analysis.

In the prison unit, the social worker was the professional reference for the feasibility of the research, so it was agreed that two weekly interviews would be scheduled in advance, in a room made available by the institution. Despite prior telephone contact on the scheduled date of the interviews to certify their feasibility, the interviews were canceled three times due to the lack of a professional to escort the participants and unforeseen events in the dynamics of the prison unit.

The interviews were recorded on digital media and lasted about thirty minutes each. Its script contained sociodemographic information, questions about health, illness processes in deprivation of liberty, health needs and self-care practices in the prison environment. The transcripts of the interviews were returned to the participants for validation of their testimonies.

Another data production strategy was non-participant observation, carried out weekly after the interviews. At these times, one of the authors circulated around the prison unit, accompanied by a member of the team to get to know the physical structure, routine and daily life of the people who were there. This process lasted four months, with a total of 20 hours of observation recorded in a field diary, whose notes were identified by the letters NDC, referring to the field diary note.

The data produced were submitted to thematic analysis, operationalized by the steps: pre-analysis; exploration of the material; treatment of the obtained results; and interpretation. In the pre-analysis, the recorded interviews were transcribed, the material was selected, systematized and re-read for an overview of the data produced in order to meet the validation criteria for emerging themes such as exhaustiveness, representativeness, homogeneity and pertinence. Soon, these data were classified, categorized and interpreted [9]. The writing of the article followed the COREQ guideline (Consolidated Criteria for Reporting Qualitative Research).

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The research was approved by the Research Ethics Committee, under opinion nº 2,121,735, in accordance with Resolution nº 466/2012 of the National Health Council, and all participants signed the Informed Consent Form in two copies.

To preserve the identity of the participants, their speeches were identified by the letter 'M' for women, followed by Arabic numbers from 1 to 11. There was also an analysis of institutional documents from the prison unit and specific legislation.

RESULTS

The study consisted of 11 women deprived of liberty in a closed system, the majority declared themselves white, young, single, with few years of study and low professional qualification before prison. All were arrested for drug trafficking, of which (4) were repeat offenders, and the length of imprisonment ranged from four months to three years. Sociodemographic characteristics can be seen in Chart 1.

Chart 1 - Sociodemographic characteristics of women deprived of liberty. Palm tree of Missions, 2022.

Variables	N
Race/Ethnicity	
white	10
black	1
Age	
19 to 29 yo	5
30 to 40 yo	4
Above 50 yo	2
Marital status	
Single	5
Married	2
Stable union	3
Widow	1
Religion	
Christian	6
Catholic	5
Scholarship	
Full Elementary	7
Paro of High School	3
Full High School	1
Employment before prision	
Housemaid	8
Baby sitter	1
Unemployed	2

Source: Research data, 2022.

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Regarding sexual and reproductive health, the number of pregnancies ranged from one to eight, and the highest number of deliveries was six, and three participants had more than one abortion. Since the deprivation of liberty, none of them has received an intimate view. Table 2 presents information on the participants' sexual and reproductive health.

Table 2 - Sexual and reproductive health of women deprived of liberty. Palm tree of Missions, 2022.

Variables	**N**
Preservative use	0
Does not do contraception	5
Injectable contraceptive use	3
Use of oral hormonal contraceptive	1
Menopause	2
Rapid for tests HIV, Hepatitis B and C and syphilis	11
Pap test	9
Did not do Pap test	2
Mammography test	3
Did not do mammography test	3
Out of age range for mammography screening	5

Source: Research data, 2022.

WOMEN DEPRIVED OF LIBERTY: HEALTH, ILLNESS AND ASSISTANCE

The statements of the participants in this study reveal that having good health conditions is an essential factor in life, inherent to the needs of human beings. It is also identified that the notion of absence of diseases and limiting physical symptoms associated with the non-use of drugs is attributed to health.

> I think that's everything in life. No pain or illness. People in pain are not easy! (M4)

> It's not needing medication. It is having normal health. (M5)

> Health is everything. Staying in this place the way I'm living is horrible! So, being healthy for me is not having pain. If you don't feel pain, time goes by and we don't even see it. (M7)

> That's all, it depends on being well, without illness, without pain. Who has health has everything! (M8)

Still on health concepts, the women's narratives showed care for a healthy life, especially in relation to food. In this regard, there was a unanimous complaint about the poor quality of food provided in the prison unit and the need for a balanced diet. The problem of inadequate food was recurrent, at various times, during visits to the prison unit, it was observed that the participants complained about the poor quality of the food received, when they showed

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food brought by family members, such as fruits and cookies. (NDC)

> Have a healthy life, good food. Food would have to be different, here it is weak, it is food that has nosauce, no flavor. (M3)

> The food is not good, when beets don't come, chayote, fried egg or sausage with rice and beans. On the weekend it's better, there's sausage, mayonnaise and chicken. They even fight to get more meat. (M1)

> Being healthy is taking care of yourself, having a good diet, but the food here is bad, it's even difficult to eat, it harms our health. (M6)

The testimonies below reinforce this dissatisfaction, especially for disregarding specific nutritional demands during the gestational period.

> The food here is terrible, my colleague and I are pregnant, we need to eat fruits, vegetables, but what comes is undercooked beans, rice and beetroot, sometimes there is boiled egg or sausage, meat, just once in a while, more on the Sunday. (M9)

> We don't have healthy food, like the food they bring from home on the visit, the rest of the days, I spend only with junk food. (M5)

Among the aspects that weaken women's health, the relationship between the environment and health is highlighted, since, as they are in a prison unit, there are precarious conditions in the structure, such as overcrowding and lack of privacy.

> The cell is small, it has 18 women in 8 beds, many sleep on the floor. (M1)

> The environment has to be better, because it interferes a lot with our health. (M3)

> We have to take care of ourselves, not walk barefoot so as not to have a bladder problem, the situation is embarrassing. Those who sleep on the floor have to be well wrapped up, because it gets wet in here. (M2)

Other obstacles cited by women deprived of liberty are related to small cell confinement and passive smoking. The testimonies show that confinement in a small, humid and unventilated cell, where most people sleep on mattresses on the floor due to the lack of beds, was considered a sickening environment.

> Here, the place contributes to getting sick, it's humid, without ventilation, most colleagues smoke in the cell, so the place makes us sick. (M2)

> The place, you sleep badly, not everyone has a bed, there's no way not to get sick. (M3)

> There are a lot of cigarettes, the place is small for many people, so it ends up aggravating those who already have the disease, so everything contributes to getting sick. (M11)

There was a consensus that inadequate care for basic needs such as sleep and rest are urgent demands that need to be met, as well as an increase in the number of cells, an adequate number of beds and separation between smokers

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and non-smokers. These demands, according to the interviewees, have not yet been heard and accepted.

> The sink pipe is broken, everything gets wet, we always ask to fix it, but they don't listen to us. (M1)

> There could be more cells, the place is small, humid, I sleep on the floor, I have a lot of back pain, I don't sleep well, this is bad for my health, the diet could be improved. (M6)

> In the other prison, there's a cell just for smokers, but if there's no place even to sleep, who's to say to those who don't smoke. If one more comes, sleep under the sink, on the wet floor. (M9)

> We have many needs, but at the moment, having another cell is urgent. This could be improved, but there is no point in asking, complaining, they never solve it. (M8)

The statements of the deponents reveal that the collective interaction in the cell can lead to illness, especially related to aspects of psychic suffering, enhanced by the overcrowding of this space.

> Sometimes, we get stressed with each other, there are a lot of women in this little cubicle, for one to pass, another has to turn around. (M3)

> There are a lot of depressed people in the cell, there's a lot of gossip, you see one beating the other, they fighting each other, it's a shock, a stress. (M7)

> Don't get tense, nervous, be okay with everyone, otherwise you'll go crazy, it's tense here! (M10)

The findings also point to the presence of sadness, anguish and concerns with the children related to lack of communication. The affective abandonment of the partner, the longing for the children and other family members and the regret for the committed acts were elements that negatively affected health, generated stress, anxiety and depressive symptoms that collaborated, to some extent, to manifestations such as insomnia, headache, high blood pressure and asthma attacks.

> Most are due to the nervous state, we think about the children, the grandchildren out there, it's not easy to go without seeing the children. In the cell, we pass straight by with a headache, the pressure rises due to nervousness. My asthma also gets worse if I'm nervous. (M4)

> Your life changes, it's a lot of loneliness, shame, regret, I separated when I came here, he didn't want to know about me anymore. The family visits little, it's not good for the children here, it's sad, it's hard for everyone. Here we pay for our mistakes, out there they suffer for us. (M6)

> Look, it's hard to say, because then comes the longing for the son, the mother, the regret of having done something wrong, then people start to get sick. (M7)

> The longing grows, I have a teenage son, I'm afraid I'm doing something wrong. If I think, it gets on my nerves, I lose sleep, the less I put in my head, the better. (M11)

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Of the eleven participants, seven used psychotropic medication and two others reported discontinuing this drug because they were pregnant.

> Since I came here, I take medication for my nerves, most of the time I'm high on drugs, it's hard to stay here. (M5)

> I take medicine for nerves, these antidepressants, here almost everyone takes it. (M7)

The use of psychotropic drugs constitutes, in the perspective of these women, a health maintenance strategy due to the fact that the prison environment generates psychic suffering and, consequently, produces processes of illness. In the same direction, other drugs are also used in physical problems such as hypertension, heart and respiratory problems, diabetes, rheumatoid arthritis, inflammatory reactions and muscle pain.

> I take many types of medication, I have rheumatoid arthritis, now I take heart medicine, muscle relaxant for back and body pain, these types for inflammation, because sleeping on the floor hurts. (M3)

> I take good care of myself, I have a blood pressure device, a thermometer, I take medicine for blood pressure, heart, diabetes, cholesterol and an inhaler for asthma. (M4)

> Difficulties were pointed out regarding the availability of medication in health services and, in these cases, it is up to the family to buy them, which is not always possible due to their limited socioeconomic conditions.
> When I need medicine, my family buys it and brings it on visiting days. (M4)

> I had to take medicine for blood pressure, as they didn't have it at the health center, I had to buy it, but there are people here who don't have this condition. (M5)

> It could improve the issue of having more medicines here, like the ones we need to be free. We made a mistake, we're here paying, but many don't have money to buy when there's a shortage at the post. (M7)

> As for health care received since deprivation of liberty, medical, dental and nursing care were the most cited. These were considered good, resolute and welcoming, as they met their health needs with respect for their singularities.
> When I got sick, they took me to the hospital, I was well attended, respected. (M3)

> If I have nervous breakdowns, anxiety and shortness of breath, they take me to the center or hospital. (M4)

> I told the dentist that I always have a headache, he saw that my blood pressure was high and asked the doctor to see me, he cared, he was interested, he was very human with me. (M5)

> Now, at the end of the pregnancy, they take me to the doctor and nurse every 15 days. (M9)

The main health services accessed by the participants were Family Health Units, hospital and Testing and Counseling Center (CTA) for sexually transmitted infections (STIs) and

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hepatitis. This search was motivated by falls, emotional issues, chronic non-communicable diseases and sexual and reproductive health.

> When I fell, I hurt my mouth, I had to go to the dentist and have a bandage done at the clinic. (M1)

> I go to the clinic, I have a problem with nerves, a headache and high blood pressure. I had never done preventive, so I did it and discovered syphilis, treated it and was cured. (M2)

> If I have pain, I ask for medicine and they give it right here. If it's a bigger problem, they take me to the health center or the hospital. I also went to the CTA, I did those tests, there was syphilis and I treated it. (M6)

Some participants avoid going to the health service, seeking care only when essential, as they are taken handcuffed and escorted. One pregnant woman reported that in prenatal consultations, the handcuffs are removed if the procedures require it, which causes her embarrassment and shame due to social prejudice.

> I take care not to get sick, to avoid consultations, I'm ashamed to go out in handcuffs. (M4)

> No one pretends to be sick just to get out in handcuffs, go through the embarrassment just because he looks good, that's what he really needs. As I'm pregnant, every month I go through this, it's embarrassing. You feel people's prejudice, they look at each other, comment. (M9)

> Despite the participants' easy access to health services when necessary, there are difficulties in their accessibility due to logistical problems at the prison unit, which depends on transportation and escort by prison officers. As these are not always available, appointments sometimes need to be rescheduled.Às vezes, marcam a consulta e no dia não tem escolta, daí ligam lá e desmarcam. (M9)

> It's more the transport, sometimes the car is broken, or he's traveling with other prisoners, or he doesn't have an escort. But, if the case is serious, they call Samu. (M11)

The assistance provided in the health services was considered good and resolute in meeting the unique health demands presented by the women, with easy access, despite barriers in accessibility due to the logistics of the prison system itself. However, the precarious conditions of the ambience of the prison unit strongly affected the fulfillment of these women's health needs in the physical, psycho-emotional and social dimensions, as well as the restriction of possibilities for the construction of comprehensive self-care practices.

DISCUSSION

In Brazil, the socio-demographic profile of women deprived of liberty is mostly composed of young, brown and black, of reproductive age, single, with children, low education and little professional qualification exercised before imprisonment for involvement in drug trafficking [2-3.10-12]. A study on the reality of imprisoned women in Colombia shows a similar profile [13] and research in the United States points to a predominance of black women

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from lower socioeconomic strata [14]. In this study, the divergent element of this profile was in relation to the color/race item in which only one participant declared herself to be black.

In deprivation of liberty, most participants received sexual and reproductive health care for screening for STIs, cervical and breast cancer. This covers the pregnancy-puerperal period, reproductive planning, prevention and treatment of STIs and screening for cervical and breast cancers [12,15]. A study with women arrested in Mato Grosso found a seroprevalence of syphilis of 15.69% and a rate of 9.8% of active infection undergoing treatment, and the practice of unprotected sexual intercourse was also highlighted [16]. In Colombia, sexual and reproductive health problems and STIs are prevalent in the female prison population [13].

The notions of health of women deprived of liberty were perceived as vital phenomena, centered on organic functions of the psycho-emotional sphere, based on the biomedical model. Research in a women's jail in Mato Grosso highlighted health concepts that also dealt with reduced notions (biologicist and curative practices) and broader ones, encompassing the perception of health linked to freedom and the possibility of carrying out work activities [17].

The health conditions of women deprived of liberty are precarious and the provision of care is deficient, which are sheltered in contexts that demean citizenship rights and the fulfillment of basic needs for a dignified and healthy life [10]. This complex reality of the prison system, in addition to perpetuating health inequalities, is also crossed by vulnerabilities, with negative repercussions on the lives and health of these women [8,11,17-18].

The illness process of women deprived of liberty was affected by factors such as precarious conditions related to overcrowding in cells and accommodation, poor quality food, idleness and lack of leisure, hostile environment and conflictual coexistence, abusive consumption of tobacco and other drugs and barriers to health accessibility [5-6,10-11]. This panorama of the health of women prisoners in the country is consistent with the scenario of this case study.

Failure to meet basic needs for sleep and rest, essential for healthy living, identified in this study, was also identified as a condition for the process of falling ill in this population in other studies [10-12,17]. Significant changes in sleep patterns were associated with worse quality of life scores in this population [15].

The case studied portrays the precarious infrastructure of the Brazilian prison system, with a shortage of vacancies and insufficient beds and mattresses to house a greater number of women than its capacity. In this way, processes of depersonalization are established and institutional violence is perpetuated, in a dehumanized and dehumanizing dynamic, which reinforce stigmas and social exclusion, characterizing themselves as unhealthy places of torture and suffering [3]. Similarly, in Colombia, the prison situation is also crossed by organizational problems and precarious

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infrastructure of prison institutions [13]. A Peruvian study in a female penitentiary in Chorrillos indicated that precarious conditions do not favor the provision of minimum health services, with repercussions on the physical and mental health of this population [19].

Another basic need is the right to quality food, which presupposes the guarantee of food security. A study carried out in the female penitentiary system in Paraíba revealed a scenario of scarcity, in which the poor quality of food (monotonous and without variability), associated with malnutrition, violates the Constitution and becomes an instrument of penalty [20]. A similar reality was identified in research on the attitude and eating habits of women in penitentiaries in the south of the country, in which food was also of low quality, monotonous eating pattern and little nutritional variety [21]. These facts are in contrast to the PNAMPE, which ensures the right to adequate food in the prison environment, considering the nutritional specificities of each woman (young, elderly, pregnant, infant) and the elaboration of a menu by a nutritionist [4,6].

For the interviewees, the main health problems acquired or aggravated by deprivation of liberty were high blood pressure, respiratory problems, pain complaints, depression and anxiety. In a mixed prison in Ceará, cardiovascular and respiratory diseases and pain complaints emerged or worsened after imprisonment, and may be manifestations of the failure to meet the biological and psychosocial needs of those inmates [10]. In a penitentiary in the State of Rio de Janeiro, female exposure to several health risk factors in that environment predisposed to comorbidities with prevalence of hypertension and diabetes [11]. In Recife, the main problems were: musculoskeletal (53.0%), respiratory (25.4%), depression (20.6%), arterial hypertension (19.2%) and diabetes (4.5%) [15]. Other studies also show that incarceration potentiates physical, sexual and reproductive health and other psycho-emotional problems [5-6,12,18].

In the prison environment, there is close, contiguous and uninterrupted contact with people with different personalities, life histories and diverse criminal backgrounds. This condition sometimes makes daily living difficult and stressful due to tense and conflicting interpersonal relationships [3,15,17]. Research in police stations in Curitiba identified that psychic symptoms were perceived by the detainees as a disease and did not receive care. These highlighted that mutual support acted as a health protector. Possibly, this is why good relationships and support were recognized as protectors of mental health [6].

The removal of children makes it more difficult to bear incarceration, which forces family reorganization, destabilizes and weakens bonds and interrupts affective bonds. It still generates loneliness, suffering, sadness, revolt, helplessness, anxiety, insecurity regarding the marital situation and abandonment, especially of the partners with whom they lived before the fulfillment of the reclusion. Such elements are

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stressors that contribute to compromising the mental health of this population [17-18].

The dimensions of the psycho-emotional health of the participants and their complaints of psychic suffering, depression and anxiety tend to be made invisible because they do not demand assistance from those who experience them, from health professionals, from the prison unit and the State that protects them. To the detriment of the non-recognition of demands of this nature, which complicate the process of imprisonment, medicalization seems to have been the resource adopted by the participants so that (re)existing in the prison unit was bearable. In deprivation of liberty, due to psychic suffering and psycho-emotional problems, the use of psychotropic medications is common in this scenario. Associated with this is the lack of actions to promote mental health, which weakens comprehensive health care [6,18]. In the southern region, depressive symptoms, anxiety disorders and insomnia were recognized by prison Primary Care teams as the main health problems among inmates [5]. Research on women prisoners in Colombia points to a high prevalence of different mental disorders in this population [13].

In the context studied, health care for women deprived of liberty is essentially guided by drug therapy (antihypertensives, analgesics, muscle relaxants and psychotropics), in a dynamic of medicalization of human phenomena (pain, anguish, loneliness, longing, suffering, depression and anxiety), which is a coping strategy for the reality they experience. This corroborates what the literature calls the 'phenomenon of medicalization of life in the prison environment', in which the use of psychotropic drugs is constituted as a therapeutic resource for self-preservation and survival in the face of precariousness, negligence, omissions, violations (institutional, human and citizenship), State violence and inadequate care for health needs in prison [5-6,18].

The recurrent lack of medication in the prison environment was another evidenced need, which should be made available by the APS. In these situations, these are usually paid for and brought by family members or friends in the visitation and, in the absence of financial conditions, such demand is usually neglected by the State [6,10]. A study on access and rational use of medicines in the prison system of Paraíba points out that, when the penitentiary does not provide these medicines, treatment is usually interrupted due to the family's financial difficulties for the acquisition, which can compromise the health of this population [22].

It is noticed that, despite the fact that health actions have a curative nature, and also the absence of promotional actions that favor women's health care, health services have met the most immediate health demands of the inmates. It should also be noted that such problems are not specific to the case under analysis, but are consistent with demands not faced in the country, whose bottlenecks impose the challenge of meeting the current national and international policies for the shelter of this population on the Brazilian prison system [5-6].

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In the scenario studied, although access to health is guaranteed, there are structural, logistical and political-managerial obstacles in the prison unit (absence of a prison health unit, lack of human resources for escorts and vehicles for transport) that affect the access to health for women deprived of liberty. Still, the fact that they delay the search for health care due to shame, humiliation, embarrassment, prejudice and social stigma configures a dynamic that both produces and enhances processes of illness. In addition to the abjection and social exclusion of these women due to deprivation of liberty, gender vulnerabilities also affect, since entering criminality and criminal conduct violates and transgresses the normative social ideals of roles that assign them attributes such as the weaker sex, good mothers and caregivers of family [3,5-6]. As a limitation of the study, it is pointed out the fact that it was carried out with women deprived of liberty from the closed system of only one prison unit and, despite similarities with other studies, these results do not allow generalizations. However, beyond the space of micro-management (prison unit), the case under analysis makes visible aspects of the macro prison system.

FINAL CONSIDERATIONS

The notions of health of women deprived of liberty are consistent with negative conceptions limited to organic functions, of the psycho-emotional sphere and absence of diseases (anchored in the biomedical model). This approach results from inadequate care for basic needs, which complicates and makes imprisonment more difficult, as well as (re)existing in this environment.

Considering that health happens in the course of life, and that the deprivation of liberty negatively interfered with it, there is an obstacle to the promotion of health and well-being, with the potential to produce illness processes. In this perspective, it is highlighted that their health needs required improvements in the structural conditions of the prison unit and an increase in the number of female cells. Furthermore, the participants' health care focused on the medicalization of everyday life in the prison environment due to psycho-emotional problems, which demands special attention to their mental health.

The deponents praise the need for rearticulation and expansion of offers in health care, when in deprivation of liberty, through intersectoral and interprofessional actions convergent to the promotion of health and citizenship. These must have gender transversality as a normative horizon, the humanization of comprehensive and longitudinal care and the production of more dialogical, affective and effective spaces. In addition, the construction and strengthening of bonds, listening to invisible health needs and the caring encounter between subjectivities (women deprived of liberty, health professionals, staff/management of the prison unit) and the State that protects them, are elements that collaborate in this assistance.

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This study contributes to the field of collective health, public policy management and interprofessional action, as well as the production of knowledge for professional training. It also makes it possible to understand the notions of health, illness and health care for women deprived of liberty and the elements involved in the processes of becoming ill in the prison environment.

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