ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL

Access to Health Services: what the women deprived of their liberty say?

Acesso aos Serviços de Saúde: o que dizem as mulheres privadas de liberdade?

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Abstract

The aim is to analyze how incarcerated women perceive access to health services. This descriptive, exploratory and qualitative study was carried out with 40 women in a female prison in the state of Rio de Janeiro, Brazil. It was used in data collection, semi-structured interview, and subsequent transcription in the integrated. The interviews were submitted to content analysis in the thematic modality. Before and during incarceration, women reported difficulties in accessing health services. However, they appear contradictory, inferring the possibility of, after entering the penal system, these women were able to access some health services never visited before the confinement period. It concludes that to ensure the applicability of the current policy, there is a need for comprehensive health care strategies for these women, which ensure access to health services in a broader perspective of promotion, prevention, treatment and rehabilitation, before, during and after imprisonment.

Keywords: Access to Health Services; Integral Health Assistance; Women; Prisons.

Resumo

Objetiva-se analisar como as mulheres encarceradas percebem o acesso aos serviços de saúde. Estudo descritivo, exploratório e qualitativo realizado com quarenta mulheres em um presídio feminino do Estado do Rio de Janeiro, Brasil. Foi utilizada na coleta de dados, a entrevista semiestruturada, e posterior transcrição na integra. As entrevistas foram submetidas à análise de conteúdo na modalidade temática. Antes e durante o encarceramento, as mulheres referiram dificuldades para acessar os serviços de saúde. Entretanto, surgem falas de modo contraditório, inferindo a possibilidade de, após a entrada no sistema penal, essas mulheres conseguem acessar alguns serviços de saúde jamais visitados antes do período de confinamento. Conclui-se que para garantir a aplicabilidade da política vigente, existe a necessidade de estratégias de atenção integral à saúde dessas mulheres, que assegurem o acesso aos serviços de saúde numa perspectiva ampliada de promoção, prevenção, tratamento e reabilitação, antes, durante e depois da prisão.

Palavras-chave: Acesso aos Serviços de Saúde; Assistência Integral à Saúde; Mulheres; Prisões.

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Introduction

Public Health Policy, focused on the penitentiary system, was established in 1984 in the Implementing Act Criminal[1], in which the services physician, pharmacist and dental practitioner were provided for persons deprived of liberty. In 1988, with the Federal Constitution, art. 196, health was ensured as a right of all and the duty of the State[2]. Thus, guaranteed by means of public policies, the decentralization of health services, integral care with priority for preventive activities and community participation in health actions. The complexity of the broader concept of health, in view of aspects related to food, education, work, environment, leisure and etc., should support the operationalization of care and preventive actions, in a perspective related to the guarantee of equity and universality of access to the services of health[3].

However, when talking about access to health, it is necessary to reflect that accessing the health system goes beyond the user's entrance to the services. Access, to be fully guaranteed, it should be carried in consideration issues that go in addition to consultations individuals. That is, the demands should be met in a comprehensive manner, ensuring continuity of attention to the health[4]. Access to health, from a perspective of fairness, should refer to intersectoral actions of the public health policies geared towards education, housing, better income distribution and the strengthening of the health and citizenship[5].

Thus, it can be observed the existence of countless factors that interfere in the guarantee of this process: population income, knowledge and user confidence in the health system, predisposition of people to use the health service, available means and time to access the actions and activities of the service; source of information and organization of the health institution, time/delay of care, lack of human resources, difficulty in pursuing health care and differentiated health needs. Such situations contribute to (dis) qualify or make (des) equal the population's access to health[4-5].

Effective health access with equity and universality is still a great challenge, because the concept can change according to the needs, demands and uses of the health services of each territory and/or population group[6]. Thus, it is necessary to impact on health services, involving new conducts and perspectives of public policies directed to women deprived of freedom[7].

According to the understanding and needs of people using the Unified Health System (SUS), access to services (or lack thereof) can mirror a process of characteristic inequalities of certain vulnerable groups in society[8].

Therefore, access to the health service encompasses a multidimensional understanding related to public policies beyond the specific health-related, must realize the existence of resolutive services that meet the range of health complexity, respecting the needs of the population[9].

Thus, in relation to the penitentiary system, since the decade of 90, a process of adequacy was necessary in relation to the SUS to ensure and broaden the right to health of persons deprived of liberty. Such changes were observed from 2002 onwards, when a breakthrough in legislation was perceived through the National Health Plan of the Penitentiary System (PNSSP), whose purpose focuses on the organization of criminal health based on the principles of the SUS[10-11].

In 2014, there was a new change in the health policy of the penal system and the National Policy of Integral Care to the Health of People Deprived of Freedom in the Prison System (PNAISP) was instituted. The general objective of this policy is to ensure, to people deprived of liberty, access to integral care in the SUS, respecting the precepts of human rights and citizenship[12].

With the objective of expanding the rights to health of the female population deprived of freedom, also in 2014, the current National Policy of Attention to Women in the Situation of Deprivation of Liberty and Egresses of the Prison System was instituted - PNAMPE[13]. This policy has came to reformulate the practices of the Brazilian prison system in relation to women's rights, promoting, developing and encouraging integrated and intersectoral actions aimed at complementing and access to fundamental rights foreseen In the Federal Constitution and the Penal Enforcement Act[13].

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PNAMPE guarantees, To the woman deprived of liberty, access to health and, In line with the National Policy for Integral Attention to Women's Health (PNAISP), assistance to education, legal and religious assistance, access to labor activity, compatibility of daily hours of work and study, in addition to the compatibility of labor activity with the condition of pregnant woman and mother, assured the remuneration, the remission and maternity leave[13]. Thus, the study has the purpose of answering the following question: How is the access of women in the prison system configured?

Thus, the study aimed to analyze how incarcerated women perceive access to health services.

Method

This was a descriptive, exploratory study with a qualitative approach, conducted in the period from October 2014 to January 2015 in a female penitentiary located in Western side of the State of Rio de Janeiro, Brazil.

Through individual semi-structured interviews, 40 women deprived of liberty, who were identified from an official nominal list of the institution that totaling 358 women, participated in the study.

The inclusion of the interviewees occurred through the following criteria: women who had records numbering during the period of data collection and who did the follow-up/consultation/attendance. While the exclusion criteria established were: physical and psychic difficulties, eventual prohibition of penitentiary agents on duty, transfer to another unit of the prison system and exit of the system for reasons of freedom during the information gathering process.

The researched penitentiary is exclusive for women. It was inaugurated in 1942, being the first female prison of the state inserted in a prison complex that encompasses 27 units under the management of the Penitentiary Administration Secretariat of the State of Rio de Janeiro. In this penitentiary there is: one health outpatient clinic, one State School of regular education that contemplates from literacy to high school, several workshops with professionalizing courses, and there is also paid work for some prisoners, called Cleaning. For every three days worked, one day is deducted from her penalty. The prison unit also offers religious encounters of various beliefs. Attached to the institution studied, there is the Maternal Infant Unit (UMI), where women are in the postpartum period with their newborn children, until the age of six months.

The interviews were conducted at the Penitentiary Outpatient Clinic, whose physical space has offices, procedure room, small warehouse, toilets for professionals and users, and a corridor with a stretcher. Patients who are attended at this outpatient clinic have a health record that is filed in an exclusive locker for this service. It is worth remembering that this outpatient clinic is only open when a health professional is working in the prison unit.

The interviews took place in one of the clinics of this outpatient clinic. To start each meeting, the researcher presented the objective of the study and total guarantee of anonymity to participants. It is important to emphasize that in order to be allowed the research in the prison system, the Secretariat of Penitentiary Administration of the State of Rio de Janeiro demanded the fulfillment of some questions for data collection, such as: the researcher's entry into prison could only occur after the daily conference of prisoners; the departure of the researcher from the institution would have to be held 1 hour before the conference held at the end of the day; the recordings of audio and filming, photographs and the reproduction of any document, as well as the signatures of the Free and Informed Consent Term (TCLE) and/or any form of nominal identification of persons deprived of liberty have been prohibited.

The participation of women occurred after invitation and accepted to integrate the research. It is worth noting that the state was the legal guardian for the participation of prisoners in activities involving research. In this case, with the prerogative of maintaining the privacy of incarcerated women, the prison institution demanded anonymity, authorizing them to participate voluntarily, but prohibiting any type of record that could identify these women out of prison.

Thus, the participants were instructed as to the aforementioned requirements and when they agreed to participate in the research, the

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researcher was transcribing the testimonies, providing timely reading of the transcripts so that the interviewees could hear and demonstrate (dis) agreement. With the assurance of secrecy and anonymity, the statements were identified by alphanumeric codes from "M1" to "M40", observing the sequence of interviews.

The research was approved by the Ethics and Research Committee of Fluminense Federal University (CEP/UFF), under Protocol No. 696.795/2014 and authorized by the Secretariat of Penitentiary Administration of Rio de Janeiro, by the process E-2108753/2014, attending à Resolution No. 466/2012 of the National Health Council (CNS), that it has on research with human beings.

To analyze the results, were opted for content analysis in the thematic modality[14], aiming to obtain information that would express approximation with the reality given by the interviewees.

Results

From the women's statements and after reading the testimonies, it was possible to identify, in relation to access to health, two thematic categories: 1) Women's access to health services before prison; 2) Women's access to health services during incarceration.

Women's access to health services before prison

Before the incarceration period, it can be observed that the reports of women indicate that the demand for health services occurs in sporadic situations from the episodes of disease or a certain complaint. See the speech of a participant when signaling that her going to the health service occurred:

> *"When had a problem"* (M25).

Or observe another woman's testimony, highlighting that she only sought health care when her conditions were precarious:

> *"Only in precarious cases was I looked for care"* (M8).

It was still possible to identify the existence of women who even having reports of previous morbidities, as hypertension and diabetes, they did not have the habit of accessing health services from a health monitoring perspective, in a neglected way to their physical, psychological and emotional health conditions, as can be exemplified from the report:

> *"I never went to the health service in freedom, didn't seek care, had no such habit"* (M37).

This negative regarding access to health services (or lack thereof) can be perceived even by means of information demonstrated from responses directed a not conducting specific questions or a particular procedure, such as the preventive examination of cervical cancer. Thus, the testimonies that follow demonstrate that even for the realization of a particular procedure these interviewees could not access the health services that meet their needs.

> *"I never did a gynecological exam, because I couldn't perform"* (M16).

> *"I never did a preventive when I was free, it was hard to schedule, it was hard to get the doctor"* (M21).

These statements show that women have stumbled upon setbacks to effectuate access to health services when in freedom, which may be inferred by the precarious quantitative of professionals, due to the delay related to the marking of procedures or consultations, or even by the economic difficulty that indirectly dialogues with the possible difficulty of locomotion to the institution. Therefore, it reinforces the idea that even having knowledge of the need to access individualized actions, in an emergency-care aspect or even with curative bias, these women undergo difficulties to ensure integral health care.

Women's access to health services during incarceration

In the prison institution studied, women fulfill feather in closed system, so they do not have free access to health services outside the penitentiary complex.

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Women's health care during the incarceration period is performed, most of the time, in the ambulatory of the prison unit. The actions taken are far from integral care as advocated by the current policy. Therefore, the access to the outpatient clinic of individual care occurs, or from their own requests through notes that are forwarded to health professionals, or when safety requests specific assistance for some incarcerated woman. It is interesting to point out that this last situation happens only when women present some health problem that is interfering in the daily life of the penitentiary. From the question "Do you use the health service of this penitentiary? ", testimonies can be observed that signal processes of difficulties experienced by resistances, tensions or by structural interferences.

> *"No, I hardly come here (prison ambulatory), when I send a note they don't call me"* (M1).
>
> *"No, I can't"* (M17).
>
> *"Here is bad water (ambulatory prison), this day, I was full of bruises and nobody called me"* (M20).

Such resistances may originate from both the safety professionals and the interviewees themselves. See example from the following statement:

> *"I take medicine so I don't have to go to the health service. I'm afraid of the SOE (Special Operations Service), I'm clumsy, everything that brings me trouble I avoid"* (M13).
>
> *"Yes, but it's hard. This outpatient clinic is useless, I need a gynecologist, but there isn't"* (M12).
>
> *"Yes, several times. Because of the controlled medications"* (M2).

Regarding the need for women to be referenced by the professionals of the penal system for some service outside the prison outpatient clinic, requests for authorization to the direction and realization of appointments in the Health Coordination of the Penitentiary System in Rio de Janeiro, Brazil. It is important to highlight that, the transport of persons deprived of liberty for health care in the public network is carried out by the Special Operations Service (SOE). When there is a need for hospital services/hospitalizations, women are also transferred with escort, from SEAP-RJ ambulance to network institutions outside the penitentiary complex. In the case of the need for urgency/emergency services, women are referred to the Emergency Service Unit (UPA) located in the SEAP-RJ penitentiary complex and, if necessary, are routed to the public network.

Thus, as seen in the statements above, the health service of the penitentiary studied is still characterized by individualized attention, curativistic or performed by free demand; and passed through difficulties related to access to health-related activities.

However, even if it is permeable by difficulties and that in some measure is still disqualified by some interviewees, it can be observed that some women acknowledge that they have the right of access to health guaranteed by law and, moreover, provoke situations to be effectuated. The interviewees demonstrated recognition of their rights and this question can be expressed in the following statements:

> *"I'm stuck, but my citizenship and health rights have to stay. I'm already paying for what I owe, I need to get out of here alive and healthy"* (M2).
>
> *"I did a gynecological consultation, went to the dentist, psychologist and the social worker, all by judicial request"* (M18).
>
> *"We pay what we owe for justice, but for society the chain is eternal, our rights are not guaranteed, health is a right of all"* (M15).

Even if they were contradictory, the testimonies above present viability to highlight that access to health services during incarceration may be permeated by restrictions, but to some extent, effective.

Discussion

The interviewees' understanding of health issues still if is related to the absence of disease, and there is no perception that health services

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should develop actions related to health promotion. Thus, it can be observed from the empirical field, speeches related to the lack of demand for health services and the banalization of the necessity of conducting examinations with a view to the prevention of diseases.

As health needs are distributed unevenly among people from different social classes and are more evident in lower income classes, generally, incarcerated women, that come from these socially marginalized groups, experiencing difficult or deficient access to health services[15].

With this study, it can be observed that both access to health services before incarceration and after it, is still focused on individual treatment and distanced from aspects of health promotion, prevention and recovery, as determines the specific public health policy for women deprived of freedom[13-16].

From the interviews conducted with incarcerated women, the presence of difficulties in accessing health services (both before and after imprisonment) was found to be similar to the information shared in a study[6], that presents the difficulties of access from the structural dimensions (financing and coverage), relational (understanding of the health-disease process) and operational (organization of services). That is, the participants of this study, especially regarding the period in which they were before the arrest, faced difficulties in covering and scheduling services. This does not rule out the possibility of experiencing temporal lapses on the part of these women, slowing the demand for health services.

Thus, the difficulties of access to health were evident both for the woman who was outside the prison system and for the incarcerated woman[17], contradicting what they advocate Public Health Policies in relation to the guidelines and principles governing the SUS[13]. See the existence of women who need a judicial mandate to achieve access to the health service.

However, regarding the period of incarceration in the prison system, even in the face of health services that present restrictions to provide the necessary and adequate care to women deprived of liberty (quantitative deficit of equipment resources, medications and physical space), it can be observed in a restricted, contradictory way and without possibility of generalizations, which, to some extent, there are actions that enable access to health services[18-19].

In agreement that the right to access to health is one of the prerogatives of the Brazilian Constitution that must be guaranteed through public health policies, including those related to the country's prison system, it is understood that this right should not be neglected, especially for the incarcerated female population. Therefore, there is a need to emphasize that this population continues with the understanding related to the concept of health as absence of diseases, besides presenting specificities related to the genus, is in situations of vulnerabilities that negatively interfere with health conditions.

Considering that the prison system still favors the occurrence of health problems, functional weaknesses and restrictions of activities[21], the guarantee of the right to access to the health of women deprived of liberty should be encouraged with a view to the need to preserve health conditions and ensure comprehensive health care. That is, the prison system should have a focus beyond its curative dimension, addressing care with a view to actions of promotion, prevention of diseases, disease treatment, health recovery and improvement of quality of life. Because when this right is denied within prisons, it becomes a problem for every society[22].

Even in the face of the contributions, it is worth to present some limitations related to this study: bureaucracy established by the prison system to effect the authorization for the start of the research; time limitation provided by the institution for the collection of information; prohibition of the use of audio recordings and filming, photographs and the reproduction of any document within the prison; limitation of the daily quantitative of interviews; monitoring of women by a security agent at the entrance and exit of the interview.

Conclusion

Analyzing the (non) guarantee of access to health services before and during the incarceration period contributes to observe how the process of (dis) qualification of activities in these institutions has been. It is of paramount importance, considering that the care given to the incarcerated

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woman should contemplate the real needs and demands with a view to consolidating a comprehensive care to the health of this population. In addition to the need to reorient or implement the dynamics of some activities related to health services in general.

The speeches of the women arrested make it clear that this population finds difficulties in accessing health services inside and outside the prison, demonstrating that If are in the process of exclusion, even before the imprisonment. However, it is worth noting that, in some measure during the arrest, they start to access services that before incarceration could not and even did not validate their importance. Even so, especially the prison units, should provide incarcerated women with the continuity of access beyond their entry into the system for individual consultations. In other words, they should also ensure the accomplishment of examinations, completion of treatments and integral follow-up of chronic-degenerative morbidities.

Even though a punctual realization of health-related activities has been highlighted, it is interesting to share that these actions should be part of an enlarged context in view of the complexity and vulnerability that involves the life of women during the prison.

In general, it is essential that health services, both within and outside the penitentiary system, promote healthier environments, resolutive actions and facilitate women's access to integral care in the various stages of life.

References

1. Ministry of Justice (BR). Law No. 7,210, of July 11, 1984, has the Brazilian penal Enforcement law. Brasilia: Ministry of Justice; 1984.

2. Moraes A. Constitution of the Federative Republic of Brazil of 05 October 1988. 43. ed. São Paulo: Editora Atlas; 2017.

3. Carvalho G. Public Health in Brazil. Estud. Av. 2013; 27(78): 7-26.

4. Campos RTO, Ferrer AL, Gama CAP, Campos GWS, Trapé TL, Dantas DV. Evaluation of the quality of access in primary care of a large Brazilian city from the perspective of users. Saúde Debate. 2014; 38 (esp): 252-64.

5. Sanchez RM, Ciconelli RM. Concepts of access to health. Rev Panam Salud Publica. 2012; 31(3): 260-8.

6. Viegas APB, Carmo RF, Luz ZMP. Factors influencing access to health services in the vision of professionals and users of a basic reference unit. Saúde Soc. 2015; 24(1):100-12.

7. Stopa SR, Malta DC, Monteiro CN, Szwarcwald CL, Goldbaum M. & Cesar CLG. Use of and access to health services in Brazil, 2013 National Health Survey. Rev. Saúde Pública. 2017; 51(suppl. 1):1S-10S.

8. Silva JO, Valente GSC. The collective health nurse in the treatment and monitoring of the seropositive elderly. Rev Enferm Atual. 2017; 20(82): 19-26.

9. Assis MMA, Jesus WLAD. Access to health services: approaches, concepts, policies and analysis model. Ciênc. Saúde Coletiva. 2012; 17(11):2865-75.

10. Ministry of Justice (BR). Interministerial Ordinance No. 1,777 of September 9, 2003. It has on the National Health Plan of the penitentiary system. Brasilia: Ministry of Justice; 2003.

11. Lermen HS, Gil BL, Cúnico SD, Jesus LO. Health in prison: analysis of social health policies directed to the Brazilian prison population. Physis. 2015; 25(3): 905-24.

12. Ministry of Justice (BR). Interministerial Ordinance No. 1, January 2, 2014.

Establishes the national policy of Integral health care for people deprived of liberty in the prison system. Ministry of Justice; 2014.

13. Ministry of Health (BR). Interministerial Ordinance No. 210 of January 16, 2014. Establishes the national policy of attention to women in situations of deprivation of liberty and graduates of the prison system. Ministry of Health; 2014.

14. Bardin, L. Content analysis. São Paulo: Edições 70; 2011.

15. Nicolau AIO, Pinheiro AKB. Socio-demographic and sexual constraints of knowledge, attitude and practice of the use of condoms. Texto & Contexto Enferm. 2012; 21(3):581-90.

16. Fertonani HP, Pires DEP, Biff D, Scherer MDA. Health Care Model: Concepts and challenges for Brazilian primary care. Cência & Saúde Coletiva. 2015; 20(6):1869-78.

17. Miltão LP, Kruno RB. Living the gestation within a prison system. Saúde (Santa Maria). 2014; 40(1):75-84.

18. Barbosa ML, Celino SDM, Oliveira LV, Pedraza DF, Costa GMC. Primary health care of inmates in the penitentiary system: subsidies for the performance of nursing. Esc. Anna Nery. 2014; 18(4):586-92.

19. Almeida PRC, Soares RSC, Coura AS, Cavalcanti AL, Dutra MOM, Lima TMA. Health condition of women deprived of liberty: an integrative review. Rev. Bras. Ciênc. Saúde. 2015; 19(1):73-80.

20. Silva M. Saúde Penitentiary in Brazil: Plan and policy. Brasília: Verbena; 2015.

21. Bergh BJVD, Gatherer A, Fraser, A, Moller, L. Imprisonment and women's health: concerns about gender sensitivity, human rights and public health. Bulletin of the World Health Organization. 2011; 89(9):689-94.

22. Damas FB. Health care and conditions in the prisons of Santa Catarina, Brazil. Rev. Saúde Públ. Santa Cat. 2012; 5(3):6-22.