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DIFFICULTIES OF WOMEN DEPRIVED OF LIBERTY IN ACCESSING HEALTH SERVICES

Dificuldades das mulheres privadas de liberdade no acesso aos serviços de saúde

Dificultades de mujeres privadas de libertad para el acceso a los servicios de salud

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ABSTRACT

Objective: To understand how the female inmates of a public jail are provided with access to health services. **Methods:** This is a descriptive and exploratory research, with a qualitative approach, developed in the female public jail of a municipality in the northern region of Mato Grosso, Brazil, with 15 women deprived of their liberty. Data collection was carried out in October 2016, through a semi-structured interview, when the statements were recorded and later transcribed for content analysis in the Thematic Analysis modality. **Results:** Discontentment with the services provided was evidenced, mainly due to the absence of human and material resources necessary for health care in incarceration. Referral to municipal services is only performed in urgent/emergency situations, being carried out with use of an escort, which is often limited due to the small contingent of available professionals. **Conclusion:** The difficulty in access expresses the iniquities to which this population is exposed, limiting the actions of promotion and prevention, making the access restricted to treating diseases and injuries in a severe and acute stage, in which the attention is exclusively directed to the healthcare assistance.

Descriptors: Health Services Accessibility; Women; Prison; Social Determinants of Health.

RESUMO

***Objetivo**: Conhecer como se dá o acesso aos serviços de saúde pelas reeducandas de uma cadeia pública. **Métodos**: Trata-se de pesquisa descritiva e exploratória, com abordagem qualitativa, desenvolvida na cadeia pública feminina de um município da região Médio-norte de Mato Grosso, Brasil, junto a 15 mulheres privadas de liberdade. A coleta de dados ocorreu no mês de outubro de 2016, através de entrevista semiestruturada em que as falas foram gravadas e, posteriormente, transcritas para análise de conteúdo na modalidade Análise Temática. **Resultados**: O descontentamento com os serviços oferecidos foi evidenciado, devido, principalmente, a ausência dos recursos humanos e materiais necessários para o atendimento em saúde no cárcere. O encaminhamento para serviços municipais é realizado apenas em situações de urgência/emergência, sendo executado através de escolta que, muitas vezes, é limitada em decorrência do baixo contingente de profissionais disponíveis. **Conclusão**: A dificuldade no acesso expressa as iniquidades a que essa população está exposta, limitando as*

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ações de promoção e prevenção, tornando o acesso restrito ao atendimento de doenças e agravos em fase grave e aguda, em que a atenção é voltada exclusivamente para assistência.

Descritores: *Acesso aos Serviços de Saúde; Mulheres; Prisões; Determinantes Sociais da Saúde.*

RESUMEN

Objetivo*: Conocer cómo se da el acceso a los servicios de salud por las mujeres reeducadas de una cárcel pública.* ***Métodos****: Se trata de una investigación descriptiva y exploratoria de abordaje cualitativo desarrollada en una cárcel pública femenina de un municipio de la región Medio-norte de Mato Grosso, Brasil, con 15 mujeres con privación de libertad. La recogida de los datos se dio en octubre de 2016 con una entrevista semiestructurada en la cual las hablas fueron grabadas y, a posteriori, trascritas para el análisis de contenido en la modalidad Análisis Temática.* ***Resultados****: Ha sido evidenciado el descontento con los servicios ofrecidos, en especial, con la ausencia de los recursos humanos y materiales necesarios para la atención en salud en la cárcel. El seguimiento para los servicios municipales se da solamente en situaciones de urgencia/emergencia a través de escolta la cual muchas veces es limitada por el bajo contingente de profesionales disponibles.* ***Conclusión****: La dificultad del acceso expresa las iniquidades a las cuales esa población se expone limitando las acciones de promoción y prevención convirtiendo el acceso restricto a la atención de enfermedades y agravio en la fase grave y aguda en la cual la atención se vuelve con exclusividad para la asistencia.*

Descriptores: *Accesibilidad a los Servicios de Salud; Mujeres; Prisiones; Determinantes Sociales de la Salud.*

INTRODUCTION

The modes of social organization of production, integrated by multiple factors, such as housing, food, education, work, income, environment and access to goods and services, consolidated at the VIII National Health Conference, held in 1986, placed health in Brazil under the responsibility of the government; which should provide dignified living conditions and universal and equitable access to actions and services aimed at promotion, prevention and recovery of health at all levels of attention[1].

Accordingly, the Brazilian Criminal Enforcement Law (*Lei de Execução Penal - LEP*), a pioneer in ensuring health rights in the prison system, establishes that the individual in rehabilitation, convicted inmate or on temporary arrest should be provided with health care, with a view to guaranteeing promotion and recovery within the prison system, or be carried out, under authorization from the penitentiary warden, in other facilities, in case this system is not capable of performing it[2].

When investigated, the organization of health care in the prison system has been pointed out[2-4] as a bottleneck for the capacity to provide support for the life of the inmates in rehabilitation. In this context, a direct relationship is established between the structural conditions of the penitentiary and the illness, whether physical or mental[4].

The prison units have not been able, in their organization, to maintain dignified conditions for attention to the quality of life and health during the inmate rehabilitation[5], and the main challenges include the availability of professionals and technological resources, the undervaluation of the inmate's signs and symptoms, services lacking adaptation, difficulty in access due to the prioritization of safety in the system to the detriment of health, and health professionals' fear to enter this space[2].

As valuation of the rights of the inmates, enforced in the provisions of sentences or court decision, the space of the prison system should provide harmonious conditions of social integration that permeate the various areas of religious, social, legal, material and educational support. Specifically in the health field, the units need to provide a service network structure in order to enable access to health and conditions for resocialization[6].

According to the National Survey of Penitentiary Information (*Levantamento Nacional de Informações Penitenciárias - INFOPEN*)[7], correctional facilities by gender are mostly intended for the male population, with 74% of the prison units designed for men and only 7% for the female public, whereas the other 17% are considered mixed, which means that they can present specific wards/cells for incarceration of women inside a formerly men's facility. According to the context evidenced, there was a large-scale increase in crime, with regard to women. To the point that, in 2000, there were 5,601 women incarcerated in the correctional system, whereas, by the year 2014, that number was around 37,380 female prisoners.

The majority of women in the Brazilian prison system are represented by young people, who are often mothers, in the role of provision of resources for the family, with low level of education and economically low culture. A large number of these women have some connection with drug trafficking, and many enter into this activity through friendships and, in other cases, their very partners are the ones who prompt them to do so[7].

Incarcerated women, when pregnant, need the existence of adequate cells or dorms for pregnant women in mixed or female units, though this is not always seen. With the large increase in the female prison population, it becomes necessary to analyze wheter the infrastructure of the Brazilian prison units has experienced the same growth, since it is well known that the prison system infrastructure is precarious, overcrowded and lacks human conditions as for ventilation, lighting, hygiene, etc., that is, despite such increase in the prison population, the places that house it have remained the same[7].

It should be stressed that the vulnerabilities associated with these women are intensified, as imprisonment is, in most cases, related to affective bonds and the search for reduction of the social inequities they experience in daily life; incarceration, however, results in distancing from their children, abandonment of their partners and relatives, culminating in greater social exclusion after the process of resocialization[8].

Health in the prison system used to be restricted to episodic actions, and such characteristic was only modified from the LEP and the Brazilian Constitution of 1988, by means of the State's accountability, with the guarantee of the universal right to health, including citizens deprived of their liberty. A greater visibility of this population has been observed since the enactment of the Interministerial (Health and Justice) Ordinances no. 668/2002 and no. 1.777/2003, which have subsidized the deployment of the National Health Plan in the Penitentiary System (*Plano Nacional de Saúde no Sistema Penitenciário - PNSSP*)[9].

In force since 2002 and seen as an advancement in Brazil, the PNSSP has made explicit the guidelines for a specific health policy for persons deprived of liberty. Such policy establishes that access to health services and actions must reduce the health issues and injuries that may arise from the conditions of confinement, reducing the health inequities to which these populations are exposed[2].

There is, however, a paradox presented between the Brazilian legislation and reality. There is a separation of the constitutional right to health from that experienced in the daily life of prison services. Universality, equity and comprehensiveness are jeopardized by restricting care to a minimum and not guaranteeing a network of attention capable of looking at this population as a part belonging to society[3].

The right of the penitentiary population to health care and services is explicit in Criminal Enforcement Law no. 7.210, Federal Constitution of 1988, Law no. 8.080, and Law no. 8.142. Nevertheless, for this to become effective, it entails the availability, acceptability, capacity of payment and information, which culminates in the need for intersectoral and transversal actions of the government, as well as social and economic policies, enabling a better distribution of income and strengthening of citizenship[10].

A study based on morbidity statistics in the state of São Paulo showed that the most prevalent health issues among the penitentiary population are allergies, respiratory, vascular and musculoskeletal conditions, depression, hypertension, and urinary problems[11]. In the same study, women self-rated their health negatively.

Discussing the way vulnerable populations access the health services, and the daily difficulties and challenges experienced, especially by women deprived of their liberty, is understood as essential to elicit reflections on new strategies that can reduce these inequities and promote health. In this sense, it is of fundamental importance to approach this issue in the field of community health, since the reality described here may support new directions for the restructuring of public policies and implementation of effective actions for this scenario.

That being so, the question is: how do women in a public prison system access the health service? Therefore, in order to respond to this questioning, we sought to understand the way the access to health services by female inmates of a public jail unfolds.

METHODS

This is a descriptive and exploratory research[12] with a qualitative approach. Qualitative research is one in which the researcher aims at a better understanding of the human behavior and experience, and seeks to understand the process by which people construct meanings and describe what such meanings are[12].

The study was carried out in a female public jail in a municipality in the midnorthern region of the state of Mato Grosso, Brazil. This unit, opened in 1978, initially housed male inmates. Subsequently, it housed both sexes, until 2009, when the Male Detention Center was inaugurated, and men were then transferred. Currently, it holds only women, coming from several different municipalities of the state and surrounding states, with a capacity for 58 inmates, distributed in eight cells. The professional team consists of 21 correctional officers[13].

The detention center under study houses 57 women deprived of their liberty, which represents the total amount of inmates. The selection of study participants followed inclusion and exclusion criteria. As inclusion criteria: inmates aged over 18, who agreed to participate in the study and were able to respond to the interview. As exclusion criteria: inmates with length of stay under 30 days in the detention center. The sample size was defined by data saturation[14] and, thus, 15 participants formed the final sample of this study.

Data collection was carried out in October 2016, after the women became aware of the objectives of the study and signed the Informed Consent Form. It occurred by means of an interview guided by a semi-structured interview script, comprising closed questions regarding identification data (age, schooling, marital status, income, family aspects, profession) and open questions about the women's perception of the access to health services. The interviews were conducted individually, in a private room, with an average length of 30 minutes.

Data was analyzed using the content analysis technique[15], which is the set of communication analysis techniques and uses systematic procedures and objectives to describe the content of the messages. This technique is composed of three stages:

pre-analysis, exploration of the material, and treatment and interpretation of the results. The pre-analysis consists in organizing the material to be analyzed in order to systematize the initial ideas. The exploration of the material consists in definition of categories and identification of the units of record and context in the speeches of the participants. The treatment and interpretation of the results is the step that consists in highlighting the information for analysis, culminating in inferential interpretations[15]. Subsequently, the empirical material produced in the interviews generated three thematic categories: "Only if pain appears I'm allowed access", "Access to health care" and "Types of care offered". The categories were carefully presented and discussed according to the participants' reports and relevant literature.

The present study was approved by the Research Ethics Committee of Mato Grosso State University (UNEMAT), under Approval no. 1.457.621.

To maintain anonymity, the women interviewed were coded using an alphanumeric method, so that the letter "W" indicates "woman" and the numerical element that accompanies the group expresses the order of invitation to participate in the study.

RESULTS AND DISCUSSION

In order to broaden the understanding about the identification data of the interviewees, there was initially a brief characterization of this group. After that, the categories that emerged from the study were discussed considering the literature.

Data on the identification of the interviewees

The participants of the study were aged between 18 and 31 years, the majority reported themselves as *pardas* (mixed ethnicity), single, with up to three children and level of education not beyond middle school, similar to other national studies[16-19].

Prior to incarceration, the largest contingent of inmates were in the role of "housewife/ homekeeper" and worked as a salesperson, followed by functions related to low qualification. In addition, the professions reported by the inmates are related to low-paying jobs[20].

Only if pain appears I'm allowed access

Living conditions in prison are strongly present in the interviewees' statements. This category, "only if pain appears I'm allowed access", refers to a situation in which the access to health is seen as a privilege of those outside the walls, recognizing that human and material resources in prison units, intended for the health issues, are scarce.

The reports point out fragility in promoting health and disregard of the scenario of access to health care. According to a noticeable statement, health is beyond the prison walls, and it takes the verification of an ill health for one to be allowed access to health services:

> *"Health for me means having medicines when you are in pain; is having access to professionals such as a physician, SAMU (Emergency Medical Service); it is being attended to when I need it; being able to go wherever necessary in order to be attended to, and not being at the mercy of the prison." (W5)*
>
> *"There is no doctor! When necessary, we are escorted to see the doctor." (W7)*

Such expressions refer to a parallel between health, freedom and access. For the inmates, health is associated with freedom and access to health services outside the prison, where they seek to be assisted to, according to the needs presented.

Once sentenced to confinement in prison, the woman will be subject to the "normalization of bodies"[21]. As she submerges into prison, she begins to submit to a set of rules, orders and restrictive routines, formally determined, which manage the institutional order in prisons. Distancing from the family, children and friends, losing privacy, personal objects and documents, among others, mark the disruption with the world left outside the prison walls. It is the mortification of the self[21].

The deprivations comprised in the prison sphere, whether restrictive of the right to come and go, social, cultural, personal, emotional and/or health-related rights, make life in prison a conflict and a moment of crisis from an existential point of view[22].

Such deprivations have a direct impact on the health of these women, since there are difficulties in the daily life of the correctional facility that interfere with the physical health status of the inmates. From the difficulty related to nutrition, smoking, sedentary lifestyle, lack of weight control, idleness and restrictions in guided physical activities, up to the daily sun exposure[23].

Furthermore, incarcerated women are also affected by more health problems than the female population in general, because of the living conditions prior to admission to prison, which contribute to mental health problems, aggravated by the poor conditions of access to health care[24], in addition to the disruption with the world left outside the prison walls[21].

In a study carried out in the state of Santa Catarina, Brazil[25], of the 17 prison units studied, only one did not provide medical care. The other ones had their own health teams that, although incomplete, met some needs of the demand, and others also had the support of volunteers. However, the study pointed out that public prisons and correctional facilities that are not officially designed as prisons are not provided with that service.

According to the PNSSP, penitentiaries with more than 100 inmates should be provided with a permanent multiprofessional team, which should be composed of a physician, nurse, dental surgeon, social worker, psychologist, nursing assistant and dental assistants, 20 hours per week. In units housing less than 100 inmates, professionals of the healthcare network must be designated to perform weekly care[26].

According to professionals working in the area, the main difficulties for implementing the PNSSP are the lack of professionals to compose the health teams, or temporary employment, and the municipalities' resistance to referring health units to care for the inmates. Moreover, there is the need for ambulances and escort, thus constituting challenges in the scope of comprehensiveness in health[27].

Access to health care

In the reports of this category, it is observed the frequent reference to the nursing professional as a mediator, which enables the listening and assists in guaranteeing the access to health services. Nevertheless, this professional is regarded as an intercessor and, at the same time, seems to be unable to fully meet the demand.

The participants of the present study point out that the scarcity of human resources, the size and diversity of problems inherent to their condition of being a woman (sexual and reproductive aspects) permeate the provision of care activities offered in this facility, since the actions that the nurse can implement in the different dimensions of care cannot, by themselves, overcome the weaknesses of these women's prison context, so that intersectoral and multiprofessional actions are necessary, as the women affirm in their statements:

> *"[...] it is transmitted to the nurse who comes by on one day of the week and she consults us." (W13)*
>
> *"I go to the warden, but we cannot always make it. The nurse attends to us, sends the prescription for prescription drugs." (W14)*
>
> *"We have campaigns (vaccination, vermifuges), screenings, but there is no doctor." (W11)*
>
> *"The nurse comes by once a week, does some things, whatever she can, doesn't she? But it does not solve our problem. The pain continues, the medicine does not; the screening I need is never available to be scheduled... Very sad. She tries, but she will not have the cancer removed from my breast without help." (W15)*
>
> *"I feel a lot of pain in my belly. When I go to the doctor, he gives me some medicine; when it's over (the medicine), the pain comes back... There's no gynecological screening for cervical cancer here because it looks like the lab is not carrying out the tests. I'm still in pain, with menstruation that keeps bleeding almost throughout the whole month and it's never solved." (W8)*

In the context of these statements, one can see these women's need to access health care actions, both in primary care within prisons and in medium- and high-complexity referral services, as a safeguard to meet the individual needs of each one.

It is noted that the one who is mainly responsible for the health care provided to the inmates is the nursing professional but, because of the work overload and the absence of a minimum team, this professional has not been able to work on promotion and prevention. They point out, in the organizational aspect of the system, an operational fragility for conducting the basic human dignity, which is the right to health and, at the same time, an occupational risk of work for this professional[19].

Lacking a physician to compose the multiprofessional team corroborates the pressure exerted on the nurses with regard to the exercise of attributions that are not suitable for them[26].

The LEP advocates screenings, care and medical treatment provided free of charge to individuals who find themselves in any form of deprivation of liberty, from the moment they are admitted into the penitentiaries and throughout the period of detention, whenever necessary. Despite that, it has been seen that these recommendations have not been ensured, which culminates in rendering this public on the margins with regard to the guidelines of the Unified Health System (*Sistema Único de Saúde - SUS*)[2].

In view of these findings, one is directed to the reflection that the proper monitoring of the health conditions of the population deprived of freedom in Brazil is an important health conditioning factor, living up to the negligence verified in the State policies[23].

The interviewees reported how the flow to the Emergency Care Unit unfolds. Most of the time, it starts with the request for help from the corrections officer due to its greater proximity to the inmates. Subsequently, the health needs are transmitted to the warden, where the cases are evaluated according to the demand and availability of the service, so that the inmate can be accompanied by a police escort to the Emergency Care Unit. The interviewees' statements describe this situation:

> *"Talk to the correctional officers, they talk to the warden, she passes it on to a nurse [...]." (W13)*
>
> *"[...] Everything is told to the corrections officer. They make sure it is necessary and then one can go (to the doctor)." (W9)*
>
> *"Talk to the jailers, but not always do they have professionals, escorts available to take you for a medical appointment... Sometimes, they have to choose, from those in need, which one you will be attended to." (W4)*

According to the reports, the pertinence of the need for health care is evaluated by the correctional officers and the warden,

which can aggravate health conditions, since a judgment is made based on subjectivity and it is not described in the attributions and technical competencies. That occurs because the decision to access the services, for the most part, is permeated by the evaluation at the level of common sense of professionals outside the scope of health, since these are not available on the facility.

It is the responsibility of the health professional to plan, organize, manage and develop health care actions within the prison environment, including screening and classification of health risk. The health risk assessment is usually performed by nurses and includes an investigative checklist oriented to the signs and symptoms[27].

What is perceived is that, in this unit under evaluation, the correctional officers end up being important mediators for the access to health services and in the identification of priorities. A study points that such action has been a result of the permanent contact between the correctional officer and the prisoners, since the former is the one who takes them out of the cell, accompanies and brings them back after medical appointments and eventual hospital stays[28].

The prisoner escort service is the same for all types of demands that are asked for inmate removal. Thus, there is a preference for meeting needs related to the judiciary, such as audiences, for example, to the detriment of transport due to health care, which leads to postponement of care, constituting a risk factor for morbidities[28].

Types of care offered

Regarding this category, which focuses on the types of care offered to the inmates participating in the current study, a reductionism in the conception of primary care is highlighted, transforming it into a prompt care for dispensation of medications, mainly analgesics, administration of injectable contraceptives, specimen collection for laboratory tests prescribed by health care services and provision of guidance on health education.

In such reductionism of the primordial strategies of the concept of primary attention, there is a clear distancing from prevention and monitoring actions, as highlighted by the interviewees:

> *"Talking to the jailer, one sometimes gets some medicine. Not a medical appointment." (W11)*
>
> *"[...] The nurse comes by and dispenses medicines for them (correctional officers) to deliver to us." (W10)*
>
> *"[...] They only give injection to avoid pregnancy. There is no medicine and, sometimes, we are not even taken to the hospital." (W6)*
>
> *"When I was at home, I used to visit the health unit, to do screening for gynecological cancer, to get vaccinated and, when I was sick, even if it took me some time, I managed to get an appointment with the nurse, the doctor, or even received help from the health worker. You do not have any of that here unless you're really ill, then you go to the hospital, take some medicine, and comes back here." (W2)*

In the reports, there are complaints related to the lack of comprehensive care that goes through a medical history and assessment recorded in consultations. Moreover, of the few records, there are reports of failures, especially because there is no continuity in care.

There are records showing that, in the penitentiary system, there is circulation of respiratory diseases, tuberculosis, Acquired Immunodeficiency Syndrome (AIDS), aggravation and onset of mental problems, cancer, leprosy and other health conditions that are neglected by the absence of monitoring of the medical appointments and the low number of human resources in health appropriate to a multiprofessional team[29].

As for the dispensing of medicines, it is common not to find a qualified health professional in penitentiaries. In such cases, the correctional officer becomes responsible for dispensing medicines to the inmates[22] (or the inmate herself keeps the medication in its possession). This fact is explained in the report made by M11, who says that, by talking to the corrections officer, and in case the medicine is available, it is dispensed.

Resolution 04 of July 18, 2014, of the National Council of Criminal and Penitentiary Policy (*Conselho Nacional de Política Criminal e Penitenciária - CNPCP*), stipulates the National List of Essential Medicines (*Relação Nacional de Medicamentos Essenciais - RENAME*) as the reference base for use of medicines by the penitentiary system of each state. The acquisition of these drugs should be carried out following the standardization of treatment for prevalent diseases, according to the Clinical Protocols and Therapeutic Guidelines established by SUS[30].

In addition to the pharmaceutical attention for acquisition and dispensing of medicines, other professionals are involved, including the nurse, who is qualified for the prescription of medicines used in public health services programs, as stated by Law no. 7.498/86[31].

In addition to mistaken attributions in the dispensing of medicines during this process of searching for health services and in the actual care that is provided, there is a lack of communication between those who need care and the one who evaluates the need. The mismatch between the need and the fulfillment of health demands exposes the fragilities faced by these women, as indicated in the following statements:

"[...] Previously, the doctor who attended to us did not provide adequate care, (there was) little communication and a sense of inhumane." (W12)

"[...] The test results arrive and there is no doctor, I am just left into the cell. I have a bad illness [...] They have found the problems and they have disappeared, and I am here, knowing that I am sick but receiving no treatment because there is never an opportunity for it... That's the way it is, here in prison." (W1)

"It's complicated. We sometimes ask for a medical appointment, but we do not always get it. I was having a miscarriage and yet I barely got a consultation. The doctor prescribed some medicine and I did not manage to receive it. I was only sent to the emergency room when I started bleeding. Then, almost dying, did they attended to me, they removed the baby, and I came back here. I still feel a lot of pain in my belly." (W14)

The above-cited reports demonstrate that, besides the lack of access to basic health services, medical attention is often discontinuous and does not work from the perspective of referral and counter-referral.

Referral and counter-referral processes are management systems brought by SUS for its consolidation. They are part of the competence of each component of the health care network (primary, secondary and tertiary) and are organized by criteria, flows and mechanisms of agreement of operation in order to ensure comprehensive attention to the users. For the promotion of this care to be effective, it is necessary that the levels of attention be interconnected, putting the referral and counter-referral processes into practice[32,33].

It is necessary, even more so in this space of coexistence, that users and health professionals establish a dialogue, a form of interaction that is not related only to the search for diagnosis for the conditions presented. As specified by the PNSSP[8], primary health care actions and services will be organized in the prison units and carried out by interdisciplinary health teams, and access to other levels of health care will be agreed and defined in the context of each state.

This conception, based on the establishment of dialogue, unfolds from the biomedical model to that of health surveillance, capable of searching in the origins the meanings and implications of experiences in health, disease and care[31].

The construction of specific policies for the most vulnerable groups emphasizes that the constitutional right to health actions needs ratification to be fulfilled, once the guarantees of access to these services are not met[2].

Among the limitations of the current study, we highlight the selection of only one municipality and the use of only one modality of correctional facility. Moreover, the poor bond between the researcher and the study participants may have limited a greater expressiveness in the narratives. However, the wealth of knowledge produced by this research, giving visibility to the life histories of women deprived of their liberty, points out important vestiges for foundation of proposals of actions in this scenario.

This study reflects the distancing that still exists between society and vulnerable and/or marginalized subjects. These people, for several reasons, abandon lifestyles that are considered ideal and healthy for the full development of the human being and expose themselves to situations of risk, either due to their own individual vulnerability or in consequence of their actions. Nevertheless, the circumstances of the personal life that led these people to incarceration cannot nullify the opportunity of exercising citizenship and defending human dignity.

Thus, in order to achieve measures that guarantee a better condition of equality and respect for the singularities of these women, there is a need to mobilize managers and professionals, especially by means of those who experience and know this context. With this improvement, aiming at the resocialization and the rescue of these women's integrity in order to emancipate them. To this end, the process of deprivation of liberty can be prolonged and require efforts from the individuals and team working in the facility, so as to favor a more humane and wholesome environment.

In this sense, in line with the PNSSP, health promotion activities should be implemented, providing educational information and guidance regarding care, which enable the learning of the body, corporality and the relationship between women and this risky environment. Also, thinking about resocialization requires the creation or maintenance of projects that promote the quality of life in this space, not restricted to the power of authority and rigid discipline normally disseminated, but rather that this learning can be meaningful and welcomed as a resource for perseverance and for obtaining a new future after freedom.

FINAL CONSIDERATIONS

In the present study it was possible to identify, from the reports, the precariousness of access to health services and the scarcety of human and material resources in the penitentiary, which leads to the assertion that basic health rights are not guaranteed to their completeness.

The lack of care provided by physicians and other health professionals are exposed in the inmates' reports, and the nursing professional stands as the most cited one. The high demand, the difficult accessibility between professionals and prisoners, the lack of referral and counter-referral services, the scarce human resources in health, among other aspects, render the comprehensive health care compromised.

It is hoped that the results of this research can support interventions in the correctional system, so that the inmates can be covered as advocated by the pertinent legislation and receive the necessary health care for the maintenance of well-being and to serve their sentence with higher quality of life, which will contribute to their subsequent (re) insertion into society.

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CONFLICT OF INTERESTS

The authors declare that there is no conflict of interest.

CONTRIBUTIONS

All authors participated in the elaboration and outlining of the study; collection, analysis and interpretation of data; writing and/or revision of the manuscript.

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