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RESEARCH

WOMEN IN DEPRIVATION OF LIBERTY: NARRATIVES OF OBSTETRIC UN(ASSISTANCE)

MULHERES EM PRIVAÇÃO DE LIBERDADE: NARRATIVAS DE DES(ASSISTÊNCIA) OBSTÉTRICA

MUJERES PRIVADAS DE LIBERTAD: NARRATIVAS DE (FALTA DE) ATENCIÓN OBSTETRICA

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ABSTRACT

Objective: to reveal narratives of women deprived of their liberty about the obstetric care offered during the experience of the pregnancy-puerperal cycle. ***Method:*** exploratory, qualitative study, based on oral history. Data collection was carried out in a female prison institution in a state in the Northeast, with six women who were experiencing some period of the pregnancy-puerperal cycle. The interviews were carried out by a cohort and analyzed using the content analysis technique. ***Results:*** fragility of health care prevailed in the speeches in all phases of the pregnancy-puerperal cycle, involving un(assistance) prenatal care, unperceived experience of violence obstetric, feelings of abandonment duringdelivery and lack of an adequate environment for newborns within the correctional facility. ***Conclusion:*** the characteristics evaluated contribute to foster new reflections on the standard of care for women deprived of their liberty and their children and emphasize the need for political and administrative reorganization of the prison system within the scope of SUS.

Keywords: Prisons; Pregnancy; Postpartum Period; Obstetric Nursing; Violence Against Women.

RESUMO

Objetivo: *revelar narrativas de mulheres privadas de liberdade acerca da assistência obstétrica ofertada durante a vivência do ciclo gravídico-puerperal.* ***Método:*** *estudo exploratório, qualitativo, fundamentado na história oral. A coleta de dados foi realizada em uma instituição prisional feminina de um estado do Nordeste, com seis mulheres que estavam vivenciando algum período do ciclo gravídico-puerperal. As entrevistas foram elaboradas por coorte e analisadas pela técnica de análise de conteúdo* **Resultados:** *prevaleceu nos discursos a fragilidade de atenção à saúde em todas as fases do ciclo gravídico-puerperal, envolvendo des(assistência) no pré-natal, vivência não percebida de violência obstétrica, sentimentos de abandono no parto e falta de ambiente adequado para os recém-nascidos dentro da instituição correcional.* ***Conclusão:*** *as características avaliadas contribuem para fomentar novas reflexões acerca do padrão de atendimento às mulheres privadas de liberdade e seus filhos e acentuam a necessidade de reorganização político-administrativa do sistema penitenciário no âmbito do SUS.*

Palavras-chave: *Prisões; Gravidez; Período Pós-Parto; Enfermagem Obstétrica; Violência contra a Mulher.*

RESUMEN

Objetivo: *revelar narrativas de mujeres privadas de libertad sobre la atención obstétrica en el embarazo, parto y puerperio.* ***Método:*** *estudio exploratorio, cualitativo, basado en la historia oral. La recogida de datos se realizó en una cárcelfemenina de un estado del noreste, con seis mujeres que atravesaban alguna etapa del ciclo embarazo - puerperio. Las entrevistasse elaboraron por*

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una cohorte y analizaron por su contenido. ***Resultados:*** *en los discuros predominó la insistencia en la fragilidad de la atención a la salud en todas las etapas del ciclo embarazo - puerperio, incluyendo atención (falta de atención) prenatal, vivencia no percibida de violencia obstétrica, sentimientos de abandono en el parto y falta de un ambiente adecuado para los recién nacidos dentro dela institución penitenciaria.* ***Conclusión:*** *las características evaluadas contribuyen a propiciar nuevas reflexiones sobre los servicios médicos alas mujeres privadas de libertad y asus hijos y enfatizan la necesidad de la reorganización política y administrativa del sistema penitenciario en el ámbito del Sistema Único de Salud (SUS).*

Palabras clave: *Prisiones; Embarazo; Periodo Posparto; Enfermería Obstétrica; Violencia contra la Mujer.*

INTRODUCTION

Recent data from the 12th edition of the World List of Prison Population show that Brazil is ranked 3rd in the world ranking of the largest penitentiary populations, with 690,000 prisoners in total, with approximately 45,000 of these women.[1] Although the number of women in situations of deprivation of freedom is lower than that of men, between the years 2000 and 2014 its increase occurred more significantly, revealing a 567% growth against an increase of 220% in the male population.[2]

Despite the fact that the incarceration of women is on an upward curve, the growth of female prisons does not keep up with this rhythm, culminating in a large number of institutions that do not have an adequate structure to accommodate the specificities of women, since most institutions were planned to serve the male prison population, undergoing only an adaptation process to house women.[3]

It is also observed that the increase in the number of women deprived of their liberty generated an increase in the percentage of those experiencing some of the phases of the pregnancy-puerperal period. This growth sparked discussions about the adaptation needs (physical and assistance) that prison institutions needed to achieve to ensure good assistance to the binomial in an environment of so many vulnerabilities.[4,5]

In an attempt to minimize existing problems, important changes were made to the Penal Execution Law (PEL) based on the sanction of Federal Law 11.942/2009, guaranteeing, for example, the right to care during the pregnancy-puerperal period, as well as assistance postnatal care to the mother and her child.[6] The National Penitentiary Department also developed and implemented the National Policy for Attention to Women Deprived of Liberty and Prisoners (*PNAMPE*), contributing to guarantee the rights of women and legitimize the discussion of gender focus.[7]

Even with the existence of these legal provisions, women in deprivation of liberty continue to live in prisons with numerous problems, especially with regard to the right to health care.[8] The situation is even more serious in the cases of pregnant women in prison, given that the pregnancy condition makes them more sensitive and vulnerable to developing health problems and experiencing episodes of violence.[9]

Among the types of violence, during the pregnancy-puerperal cycle, attention is drawn to obstetric violence, defined as any disrespectful and dehumanized attitude, in addition to negligence and mistreatment against the parturient and/or newborn that may cause harm and/or psychological and physical suffering, which can pass through all levels of assistance (low, medium and high complexity).[10,11]

Violence against pregnant women has a prevalence between 1.2% and 66%, depending on the different forms of aggression.[12] In incarcerated pregnant women, this comparison is limited by the scarcity of studies addressing this theme, however, in studies with women in deprivation of freedom are reports of physical and sexual violence practiced by other inmates, prison security officers and police officers.[13,14]

As a way of contributing to the expansion of the national and international scientific debate about people deprived of liberty (PDL) in the prison environment, especially those who are experiencing the gestational/puerperal period, the study aims to reveal narratives of women deprived of their liberty about the obstetric care offered during the experience of the pregnancy-puerperal cycle.

METHOD

Exploratory research with a qualitative approach conducted according to the guidelines of the Consolidated Criteria for Reporting Qualitative Research (COREQ), using the theoretical assumptions of the oral history (OH) technique as support. The choice of this methodology was made by facilitating the understanding of common personal experiences related to events or facts constituting the stories reported.[15]

For the development of the study, testimonial oral history was used, which is the typology of oral history, which apprehends narratives about traumatic and/or serious experiences. Unknown and still little explored, trauma situations need visibility since traumatic repercussion events are generally not highlighted.[15]

The research scenario was the largest and most populous female institution of deprivation of liberty in a state in the Northeast of Brazil. In oral history, the selection of collaborators is linked to the identification of the destination community, which refers to a group of individuals with common memories and with the possibility of providing reports related to the research question, being, in this research, the 273 women who were in prison. After identifying the community, the colony choice stage was followed, which consists of a portion of people from the community

who share common characteristics, which corresponded to the experiences of women who were at some point in the pregnancy-puerperal cycle at the institution, originating the participation of seven women. Subsequently, the interview network was defined, a subdivision of the colony, initiated from the first woman who made herself available to share her story and, from her, other collaborators who were also in the referred cycle were appointed. In the end, six women accepted to participate voluntarily in the research, with only one refusal to participate, due to the collaborator being on an intimate visit at the time that researchers were allowed to enter the institution.

The empirical material was produced between the months of May and June 2018, from a single interview conducted by guiding questions, audio recorded and with an average duration of 30 minutes. As it is a prison institution, the schedules had to adapt to the institution's internal security rules, with a reserved space and a penitentiary security agent being made available to researchers for the security surveillance of the entire research team involved. It should be noted that, as a way of ensuring privacy and secrecy, the agent maintained a distance of approximately 15 meters from the place where the interviews took place.

After the material was seized, the interviews were listened to and transcribed in their literal sense. Then, textualization took place, when the guiding questions and excesses or repeated words are removed, leaving the text in the form of a documentary corpus. Finally, the transcreation was done, in which the text was recreated by ordering paragraphs, with some words and phrases being removed and added according to observations and notes, but without changing the meaning of the text, thus creating , a memorial about the collaborators' stories.

In view of this, the text was taken to the collaborators for the content conference, being approved in full by all participants. At that time, pseudonyms were also defined as a way to keep identities confidential, adopting the letter "E" followed by the cardinal number of the interview sequence.

The material analysis was guided by the content analysis method. The operationalization of this analysis took place in three stages, namely: pre-analysis, with the reading of the material obtained in order to systematize the main ideas and subsequent steps; data exploration, with coding and categorization; and treatment of results, intending to elaborate interpretations and inferences, relating to the theoretical foundations.[16]

The analytical description follows, in which, based on the theoretical framework and readings of the material obtained (immersion), the material is organized into categories. The categorization, by itself, does not exhaust the analysis, as it is essential that the researcher goes beyond the mere description, seeking (in an effort of abstraction) to establish connections and relationships that enable the proposition of new explanations and interpretations, adding something to the existing discussion on the focused subject.

The study was developed based on the ethical aspects of research in accordance with Resolution 466/12, of the National Health Council, and submitted to the appreciation of the Research Ethics Committee involving human beings, having approval under number 1,133,120 and CAAE Nr. 45905915.3.0000.5188.

RESULTS

The characterization of the study collaborators showed women aged between 18 and 30 years, single, with a history of emotional abandonment after incarceration, with an average of two children and low education. As for reproductive aspects, all were already pregnant at the time of incarceration.

After analyzing the interviews, five thematic categories were identified: a) when the basics are lacking: un (assistance) in prenatal care; b) I feel, but I don't see: unperceived experience of obstetric violence; c) the pain of giving birth alone: feelings of abandonment during delivery; d) light at the end of the tunnel: demonstrations of empathy in the maternity hospital; e) they were not supposed to be here: lack of an adequate environment for newborns.

When the basics are lacking: un (assistance)prenatal care

This category highlights the difficulty of pregnant women deprived of liberty in having access to the pregnancy test. It is noteworthy that a positive pregnancy diagnosis is a prerequisite for its transfer to the special cell for pregnant women, mothers, and newborns. Thus, this difficulty in access causes losses and delays in obstetric care for these women:

> *When I got here, I was already suspicious that I might be pregnant, but I didn't take the exam because every time I was postponed and I was stuck here in the pavilion* [...] *there was a day that my husband, who is also in prison, sent for his lawyer a pregnancy test, only then it was confirmed and I was able to go to the pregnant women's cell* [...] (E1).

> [...] *I noticed my belly growing and I started asking for an exam, but they always denied saying that there was lack of itin the house* [prison] *and so the time passed* [...] *when the result came, I was close to having my girl, that's when I went to cell 15* [destined for pregnant women and puerperal women] (E3).

> [...] *when I arrived here at the prison, I didn't know I was pregnant, I started to feel very sick and dizzy, so I asked to go up and went to take a test but the result only arrived after a month* (E4).

There was also a certain difficulty in relation to obtaining pharmacological treatment to treat specificities during the gestational cycle, either due to scarcity in the service or due to the lack of humanization of the assistance of the professionals involved:

> *I still felt a lot of pain due to the urinary infection and they said that the medicines I had were only for those who did not have a visit, except that sometimes the visitors are unable to buy* [...] *the girls here could not bear to see me suffering with so much pain there, then they were given me their medicines* (E1).

> [...] *I had a severe anemia, my prescription remained up there and they didn't want to give it to me so that I could give it to my mother on the day of the visit, so I stayed here without taking any medicine that only arrived almost at the end of the pregnancy* (E2).

> *After I returned with the results of the exams, there was a problem with my blood, but I already knew it was syphilis because I heard her* [the doctor] *telling the other nurse there at the maternity hospital* [...] *they didn't give me any medicine, they said that here in the prison it was missing, only at the very end even though they gave me 10 tablets of ferrous sulfate, but there was only time to take five* (E3).

I'm sorry, but I cannot see: unperceived experience of obstetric violence

According to the reports, it was identified that the pregnant women did not demonstrate satisfactory knowledge about practices equivalent to obstetric violence. The occurrences were represented by invasive procedures, physical, psychological aggression, and negligence.

> [...] *they took me to get eight stitches, if they cut me, what they did to me! I do not even know anything about, because they just told me I was going to have to get a stitch! I had a vaccine in my arm and two in my butt that I still feel pain, but I also do not know what it was for* (E1).

> [...] *I said: doctor, I just want a clean clothing to my daughter and medicine because I was feeling a lot of pain, she looked at my face, turned her back on me and left* (E2).

> *They evaluated me and placed me in the waiting room, the doctor said she would wait for me to reach 10 centimeters to have my daughter. But I was very nervous and those two centimeters that were missing did not increase, so they administered serum using an intravenous line on me to increase the contractions* (E5).

The pain of giving birth alone: feelings of abandonment during delivery

Just as the absence of prenatal care was demonstrated, the narratives below expose (un)assistance during labor and the immediate puerperium. The reports of the study participants demonstrate the anguish of not being able to count on the presence of family members in this singular moment of life and the institutional abandonment by the professionals who provide obstetric care:

> *I was nervous, I felt like an abandoned person there* [...] *I know that if my family were there with me I would not have felt that way, because when we go to have a child they do not tell the family anything, only when we return from the prison with the child already, so we are alone there, abandoned in every way you can imagine* [...] (E5).

> *When my daughter was almost born, the police officer went crazy, running from one side to the other side calling someone, but when the nurse arrived the girl was already in the middle of my legs, I had her alone without help from anyone* [...] (E6).

Light at the end of the tunnel: demonstrations of empathy in the maternity hospital

Despite the negative results seen in the previous categories, the empathic and human look emerged in some moments of the passage of these women in hospital care, minimizing the stigma experienced by parturient women in situations of deprivation of liberty. Support was also present through the construction of bonds with other pregnant women and puerperal women attended at the service and professionals committed to good practices in delivery care.

> *There was a nurse there who supported me and helped me a lot in some things, including she even fought with another who did not treat me well, she saw that I was still nervous, took me to a room, gave me water and talked to me always treating me in a very nice way. I felt safe, because I realized that there were still people who had no prejudice against aprisoner, she hugged me, she was not afraid to get close to me because I was handcuffed... I knew that at that moment I would not be mistreated, I felt protected* (E5).

> [...] *what made me to come down the most was the other companions who came to say a word, it comforted me somehow*[...] *there were many people who defended me there, they wanted to call a reporter in order to make a video! But even with all this, they did not let belongings of my baby to go inside* (E6).

They were not supposed to be here: lack of adequate environment for newborns

This last category reflects the inadequacy of the prison environment for newborns and infants, as well as the limitation of social assistance, health and leisure geared to the specificities of these individuals.

> [...] *there was a time when my daughter made me tired* [...] *I cried in this grid I asked a lot that my God help my daughter! And they* [the prison officers] *just said: go today, go tomorrow, go today, go tomorrow* [go to consultation] *and we never know when we will go!* (E1).

> *My daughter came here without being registered* [...] *I was waiting until she was six months old and nothing, I picked it up and registered it, only someone came here after a month that I had already registered* (E3).

> *When I came back here, when I reached the gate, the floor opened up for me, I'm not going to lie to you, I felt like crap for having to bring my daughter to a place like this, paying for my mistake* [...] *people do not understand that this environment is not for children, this is not for us! If you do not respect mothers, you must respect at least the children* [...]. (E6)

DISCUSSION

The sociodemographic profile of the participants corroborates other studies found in the literature.[17,7] The low level of education, the number of children and marital status are conditions for the monitoring of prenatal care, especially to analyze the vulnerabilities to which these women are being exposed.[17]

When analyzing access to consultations, resistance soon showed itself in detecting pregnancy. The delay in delivering the exams was the main complaint of the participants, however, since the public network offers rapid pregnancy tests in the basic health units, these tests can be easily arranged in the prison units, reducing the waiting time for prenatal care be started earlier.[18]

Despite being a right, this reality denotes that pregnant women are not only deprived of freedom, but also of the possibility of autonomy, whether in participation in decisions involving pregnancy, delivery, or self-care.[19]

In the category of when the basics are lacking: un(assistance) prenatal care, the conduct of health professionals characterized some of the adversities encountered. It is known that the activities of low risk prenatal care are the responsibility of the Nursing professional and, because they are in more contact with the individual in the care process, they must welcome pregnant women in prisons so that this moment is not just of biological assistance and curative, but rather a space for exchange, bonding, active listening, health education and empowerment of these women.[8]

Still on this aspect, attention to prenatal care includes actions to prevent and treat complications and injuries. The absence of medication, as mentioned in the statements, directly influences negative outcomes in the mother/baby binomial, increasing the incidence of iron deprivation in the mother and/or child, due to the lack of ferrous sulfate or, in the case of syphilis and urinary infection, prematurity, restriction of uterine growth, low birth weight and increased fetal and maternal morbidity and mortality.[18,20]

In the case of obstetric violence against women deprived of their liberty, it is worth discussing the consonance with institutional and gender-based violence. The inequalities of treatment exercised by health professionals in hospitals, which involve situations of humiliation, escorting and imposing the use of handcuffs - although prohibited during delivery and the immediate postpartum period, through Law Nr. 13,434 of April 12, 2017,[21] institutional violence. In turn, gender-based violence implies disparaging attitudes, resulting from the historical inequality between men and women, which express conditions of subordination, fragility and attribute the meaning of reproduction to the female body.[19,22]

Women who live in this situation, in addition to suffering from the abovementioned violence, are unaware of obstetric violence, exemplified by non-consented amniotomy, induction with oxytocin, restricted position for delivery, excessive vaginal touch and lack of clarification.[11] In this sense, suffering during delivery is seen as a punishment for the woman's judicial status, however, this type of conduct violates the reproductive rights, inherent to women, and human, when they also involve the child.[13]

The repercussions of these practices in the puerperal period can cause obstetric complications and psycho-emotional fragility. Postpartum hemorrhage is associated with one of the main causes of maternal mortality and can be detected previously with the identification of signs and symptoms. Furthermore, conditions such as headache related to anesthesia and infection of the surgical incision of obstetric origin were prevalent in a national study, signaling the need for strategies that guarantee appropriate care, patient safety and reduction of complications.[23]

From the psychic point of view, the intrinsic psycho-emotional changes of the perinatal cycle, congruent with the stress induced by incarceration, constitute a high-risk factor for the appearance of mental disorders. Depression is the most common disorder, according to a study in which 70% of pregnant women experienced depressive symptoms and compared to the incarcerated female population, depression levels were significantly higher.[4]

The absence of social support can also be related to the occurrence of depressive symptoms. The deprivation of liberty causes several losses for the woman and her family, as there is a disconnect with the social environment; reduced frequency of visits, due to incompatible schedules; family disorganization, since

women are responsible for caring for their children; and difficulties in social reintegration.[17]

During the hospital stay, these symptoms are accentuated and justified by fear, loneliness, helplessness, and discrimination. However, as observed in the category of light at the end of the tunnel: demonstrations of empathy in the maternity hospital - these symptoms can be mitigated by good care practices, contrasting what is exposed in the literature, in the same way that they can be re-signified by strengthening the network support with other mothers and bonding with nurses to promote the initiation of breastfeeding, an important component for emotional development with the baby.[24]

Although the children of mothers in prison can remain with them until the age of seven, in Brazil the reality is limited to six months. It is during this period that exclusive breastfeeding is essential, as in addition to offering benefits to the baby's health and well-being, it facilitates exclusive dedication without worries of domestic activities and enables feelings of completeness and self-worth for mothers.[25]

Due to the limitations of studies that portrayed the general conditions of children in the prison system, it was not possible to discuss the assistance given to this population. Thus, this investigation describes a challenge for public managers, in order to invest in the infrastructure of prison units, social and health rights, as well as the professionals who are involved in the process of care and attention in the pregnancy-puerperal cycle.

FINAL CONSIDERATIONS

It was possible to identify, in the oralities of the speeches, weaknesses in the health care of women in the pregnancy-puerperal cycle. Such difficulties concern un(assistance) prenatal care, unperceived experience of obstetric violence, feelings of abandonment during delivery and lack of an adequate environment for newborns.

The study showed that, in the situation of incarceration, there is weakness in the exercise of the rights of women deprived of liberty and their children. Such noncompliance has been caused by disciplinary and constitutional actions, which make it impossible for this public to obtain adequate and singular assistance during the postpartum pregnancy period.

Moreover, it is essential to reorganize the health care system, due to the consequences inherent in the absence of perinatal care and burden on the lives of women and their children. It also indicates the need for training penitentiary agents on good labor practices, since they are constantly living with a vulnerable population and with specific needs.

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