interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

Gender issue in the perception of the health-disease process of people detained in police stations

A questão de gênero na percepção do processo saúde-doença de pessoas privadas de liberdade em delegacias (abstract: p. 17)

La cuestión de género en la percepción del proceso salud-enfermedad de personas privadas de libertad en comisarías (resumen: p. 17)

Ridiney Santos Oliveira[a]
<ridiney@bol.com.br>

Rafaela Schaefer[b]
<rafaschaefer1@gmail.com>

Henrique Cesar Correa Hamilko[c]
<henriquehamilko@gmail.com>

Deivisson Vianna Dantas dos Santos[d]
<deivianna@gmail.com>

Sabrina Stefanello[e]
<binastefanello@gmail.com>

[a] Pós-graduando do Programa de Mestrado em Saúde da Família em Rede Nacional (Mestrado), Universidade Federal do Paraná (UFPR). Rua Padre Camargo, 280, 3o andar, Alto da Glória. Curitiba, PR, Brasil. 80060-240.
[b] Graduanda do curso de Medicina, UFPR. Curitiba, PR, Brasil.
[c] Graduando do curso de Medicina, UFPR. Curitiba, PR, Brasil.
[d] Departamento de Saúde Coletiva, UFPR. Curitiba, PR, Brasil.
[e] Departamento de Medicina Forense e Psiquiatria, UFPR. Curitiba, PR, Brasil.

The study involved provisional detainees from two Curitiba police stations, state of Paraná, Brazil, one for males and one for females, to explore gender differences in this environment and to develop strategies to include gender in addressing this population in primary care. It was a qualitative study based on participant observation keeping a field diary, and 26 transcribed open interviews (13 male and 13 female), transformed into narratives and later into a grid for analysis. The female environment was more welcoming, and the perception of health-disease assumed a more strictly biological character for men, while women had more expanded concepts. Women missed the independence to seek medical attention because, unlike men, they were used to go to the Basic Health Unit before prison. Environment, control and relationships, as well as the perception of the health-disease process had gender differences.

Keywords: Gender. Health-disease perception. People deprived of freedom. Prisoners.

Oliveira RS, Schaefer R, Hamilko HCC, Santos DVD, Stefanello S. Gender issue in the perception of the health-disease process of people detained in police stations. Interface (Botucatu). 2021; 25: e200199
https://doi.org/10.1590/interface.200199

Introduction

The National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (PNAISP) began only in 2014 to include police stations activities regarding health care for persons deprived of their liberty. PNAISP postulates the access to the Health Care Network (RAS) in the territory, following the principles of the Brazilian National Health System (SUS), based on primary care as the cornerstone for this population[1]. Therefore, it is essential to health professionals, and especially to those in primary care, to get a closer view of the reality of these people in order to qualify their health actions.

The National Prison Information Survey reported that, until June 2016, the female prison population was 42,355 women, of whom 1,268 were in police stations, while the male prison population was 665,482, and16,662 of them were detained in police stations. Among the Brazilian prison units, 74% are for men, 7% for women and another 17% are mixed[2]. The police station is a police unit for serving the public, a base and administration of police operations, criminal investigations and temporary detention of suspects and prisoners caught in the act[3]. In other words, in the police station there are provisional male and female prisoners.

In the Brazilian context, to be part of the confined population influences the health-disease process, determining conditions of vulnerability as well as it interferes with access to health services. In addition to the social marginalization caused by imprisonment and generally unfavorable socio-economic situations, prior to imprisonment, a third punishment falls on women deprived of liberty: the imperatives of gender norms, in a historically patriarchal system that imposes definitions and prescriptions regarding what is - or should – to be a woman[4].

The present study explored the differences between genders in the environment of detainment and the perception of health and illness in police stations in a large Brazilian city, cared by a family health team in their territory.

Methods

The research method chosen was to carry out a qualitative study, in two police stations in the city of Curitiba, one for males and one for females, intentionally selected due to the researchers' easy access.

The tools used to obtain the data were two: the first was participant observation, elaborating a field diary, in which aspects such as the relationship between male and female prisoners among themselves and with health professionals and the police station, health care arrangements, the manner in which care was provided by the health team and police officers, as well as the physical structure. The frequency of observation was twice a week on average, and occurred during the interviews, during the visits of the health team and during the procedures to which prisoners were subjected, as in transfers to others sectors of the prison system, escorts to lawyers' interviews, among others. The average length of stay at the police station was 4 hours per visit. The records were taken in a notebook and, in the event of situations that created doubts in the researcher; it

was later clarified with the people involved in the service at that time. This methodology was important to complement the interviews, which had an average time of less than 10 minutes. The population deprived of liberty usually scarcely speaks, as well as they are afraid of reprisals on both sides (cellmates and police). Associated with this fear, there is a need to release the police officers to their activities at the police station as soon as possible, adding causes to the short time of the interviews. Therefore, it was essential to complement the method with participant observation and field diary.

The second way of obtaining the information was to conduct open interviews, numbering 26 (13 male and 13 female), recorded in audio, later transcribed in full. First, some questions were asked and discussed among the research group, and then a test was carried out to check if the triggering questions were able to extract necessary information from the interviewees. After a pilot test, some adjustments were made, leaving questions related to how health problems are understood, how health care occurs and how access is given to health professionals.

The sample size was defined by saturation; therefore, the suspension of inclusion of new participants occurred when the data obtained began to show a certain redundancy or repetition, therefore allowing –as per the researchers' evaluation- to consider non productive the continuation of the collection[5].

The invitations to detainees to participate in the study were made privately by the researcher during the time of leaving the cell for any procedure requested by the police. In order to avoid exposure, only those who would be transferred or released were invited to participate. Anonymity was preserved in the interviews and analyses, and any information that could be identified was removed from the texts. To preserve the identity of the participants and facilitate the recognition of each interview, we chose to call them M (male) and F (female), enumerating them.

Data collection was carried out over a 6 months period. The study excluded people with clear cognitive impairment, or those who posed some risk to the interviewer, according to an assessment by local guards. No invited person refused to participate.

Ricouer's hermeneutic phenomenology was chosen for the following stages, using the hermeneutic circle for transcription and building narratives, and the analysis-hermeneutics-dialectics. These techniques were chosen to ensure greater validity of the meanings and reliability of the interpretations, thus maintaining scientific rigor[6].

Phenomenology describes the phenomenon as it lends itself to be known. It is an open position of the researcher to understand the experience of the other respecting the uniqueness of each subject, seeking to understand and interpret a phenomenon[7]. While phenomenology is involved with the awareness and the life-world of the object of study, Ricouer's hermeneutics is based on analysis of texts and speeches recognizing the researchers' beliefs, values and temporality, being a technique that allows larger coherence, consistency and depth in interpretation, contributing to phenomenological analysis[8].

The transcripts sought to present not only the text of the speech, but also details -pauses, laughter, increased tone of voice- while remaining as faithful as possible to the essence of what was said.

In a following stage the transcripts were transformed into narratives, leaving the text that was in the form of an interview, a first-person speech. At this stage, it was important to understand the polysemy of language and the knowledge of slang used by detainees. For this, the field diary provided essential support material, as it presented much of the worldview of the interviewees, as well as the slang used by them. Additionally, it was necessary at times to "translate" the language used by prisoners and police station workers, so that the text would be comprehensible to all.

Each of these narratives was subsequently evaluated by at least 3 researchers, aiming to ensure a mediation between the experience and the discourse, maintaining a hermeneutical posture, and guaranteeing the maintenance of its temporality, avoiding to remove its chronology or merely keeping logic, two important caveats made by Ricoeur[9]. In addition, Ricouer admits that there are different interpretations, and these have different legitimacy, that is, it is necessary that the proposed interpretation is sufficiently vigorous and consistent, to the point of being able to survive the conflict of competing interpretations[8].

Data analysis was done through repetitive reading of the researcher's narratives and field diary, with focus on identifying possible differences in discourses and perceptions that may signal to differences in relation to the gender of detainees. Finally, an analysis grid was built, with the categories that emerged from the texts. From these categories, the core arguments used in the results were extracted.

The participants signed the Free and Informed Consent Form (FICF), submitted to the Ethics Committee of the Federal University of Paraná, approved and recorded on the Brazil Platform CAAE 80355317.0.0000.0102. All participants' doubts regarding participation in the research were answered before starting the interviews.

Results and discussion

Based on the interviews and field diaries, it was possible to organize the results in the following categories: "Everyday Life in Prison: Environment and Relations", "Gender and Perception of Health and Disease", "Search for Health Care" and "The invisible woman".

Everyday life in prison: environment and relations

The female police station lacked divisions between the cells according to the seriousness of the crimes committed, as they were open, with only the central door closed. The use of handcuffs was rare and inmates lived with approximately 25 women in total. It was observed a calm atmosphere in general, with the jail agent listening to the complaints of the inmates and the nursing staff was more welcoming when compared to male prisoners. The perception of insecurity among practitioners was lower when working with the female group than with the male group.

The male police station instead, had a division between the cells according to the seriousness and the danger of the crimes committed, housing almost four times more prisoners than in the female police station. The observed environment was more agitated and tense, guardians were more violent, and there was a great concern for safety, even during medical consultations, which were speeded to avoid a possible riot.

Violent behavior rates are lower among women than among men[2], explaining the difference between the numbers of prisoners in each police station. The use of violence by women makes a large impression, as it contradicts the social role of inferiority and victimization attributed to them[10]. This fact was observed in the female police station, as the police workers were shocked to have among the prisoners, a pair who had committed murder.

Currently, two different profiles of female crime stand out: the weakened and victimized woman, who enters the world of crime to help her partner, brother, son, i.e., she uses submission to a male figure as a justification; and the woman who does the crime autonomously and does not fit into the role of victim, having an aggressive profile, seeking to integrate organized crime[11]. The approximation of male and female roles happening in the social universe also resulted in the proximity of the genders in practices within the criminal universe[12].

The field diary detailed the relationships of detainees with each other: there was an organized society within the prison, with defined hierarchies, social values, norms of conduct and behavior and specific language. Such language was more widespread among prisoners. There was also a commercial system in both police stations in which products brought by visitors were transformed into currency.

Regarding the relationship between prisoners, there was a greater solidarity among women than among men, exemplified in the following statement, taken from the narratives:

> When the friend is quiet, she has a problem, right? so we have to help. (F08)

It was evident from the field diary, regarding the relationship with health professionals and the police station, that women were more receptive to help: they more open, more friendly conversations prevailing and contributing to more favorable results in health care. In the interviews, they communicated better than men and there was no climate of distrust. In addition to expressing themselves more, guardians allowed for longer interviews. On the other hand, men only answered extremely essential issues when interviewed, and their relations with practitioners expressed a climate of distrust and threats.

The emotional aspect was frequently emphasized by the practitioners in the female police station, documented in a field diary with comments such as: “working with female inmates, you need to be careful of what you say, otherwise, crying starts”, “you can’t shout too much as with a man, because a woman is prone to scandals ”.

The research found that women deprived of their liberty received oral hormonal contraceptives given by the family health team that cared for them, to avoid menstruation, as a measure of hygiene in the cells. In addition to contraceptives, the police station had availability of analgesics, antibiotics, ointments for allergies and gynecological treatment, and medicines brought from the primary care unit (UBS) by the responsible physician, as they were not provided directly by the State.

In the case of the use of reasons for the use of contraceptives, there is a rationale putting the institution's well being ahead of the women who were there. Even when they reported in the interviews that they were not obliged to take contraceptives and that they wanted them, the reasons were different from the usual in women's health. This use of so-called health interventions with at least heterodox indication can be considered a practice of social medicalization. The concept of Social Medicalization was defined as "the progressive expansion of the field of intervention of biomedicine through the redefinition of human experiences and behaviors as if they were medical problems"[13] (p. 62). The expansion of medical knowledge and health care as a strategy to "solve" human problems outside the sphere of health reached the point of generating a general decrease in what is called the index of good health: the ability to transform, autonomously, the life itself and the environment in which it is lived, aiming to preserve or increase the degree of "lived freedom"[14].

Such medicalization of the female body can hinder the freedom of some women related to the possibility of getting in contact with an important period of their female cycle through menstruation[15] also ignoring the side effects that can be caused by hormones[16]. In addition, smoking - a common practice among prisoners - is also a risk factor for thromboembolic phenomena[16], not recommending the use of contraceptives. On the other hand, as the cells are environments with little privacy and that do not favor personal hygiene, this feature can be beneficial to reduce the discomfort of inmates and facilitate their hygiene. This duality makes the issue complex and, in order to prevent the repetition of common senses about what this population may or may not have access to, the discussion is then about what actions a health team can offer to improve the environment and what are the desires of these confined subjects.

However, there was a frequent lack of medicines or they were not made available by the health team of the reference basic care, and friends or relatives needed to bring them on the visit days. When the detainees had no alternative to purchase the medication, they were dependent on the help of their pals, as mentioned in the narratives:

> We pay medicines for each other there, especially those who have no one here. (F10)

> There are people who are from other places, they don't have a visit, so we help our neighbor, help each other. (M23)

Regarding psychotropic medications, no prescription was noticed at the female police station, but there were no reports of previous use in the interviewed women. At the male police station, based on the observations recorded in the field diary, there was a "release" of psychotropic meds for those who previously used them and for those who were excessively "bellicose and poking", in order to reduce this behavior. The practice of medicalization of behaviors in prison environments is not new and is important even in the case of adolescents in deprivation of liberty, fulfilling socio-educational measures[17]. But it is interesting to realize that this may also be a practice

in police stations, with the justification, in our case, related to safety and hygiene. This fact corroborates the statute of social medicalization, where common life processes, such as menstruation, aging and being agitated or disgusted with a situation, are more and more being owned by medicine, becoming its field of knowledge/power, which can be a means of social control and regulation[14].

Gender and perception of health and disease

Gender is broadly defined, and does not necessarily coincide with biological sex[18]. In the reports of the field diary, we realized that the criterion of choice for referral to the police stations was based on biological sex, although there is an official resolution[19] regarding the right to choose which prison unit, male or female, the person wants go, in addition to the possibility of choosing to be separate in the case of transgender people. Perhaps due to this reason, added to the social stigma and fear of speaking in environments of deprivation of liberty, among the interviewees, sexual identities coincided with biological sex. These elements may have led to a limitation in the study, not perceiving nuances related to gender.

Therefore, analyzing and comparing the interviews, it was found that for men, health assumed a much more physical well being character - although other more comprehensive views appear in the reports as well, both exemplified below. The understanding of the men's health process was focused on the biological regarding self-perception and human behavior.

> Health is not having any kind of disease, is it? It's doing the daily exercise that you can do, exercise, flex, eat well, drink water. (M02)

> And I define health as good medical care, an appropriate place, dignity, without affecting the psychological. (M24)

Women's health perceptions presented a broader and more comprehensive view than the perception of men in general. In the feminine view of health, appeared many aspects related to mental and social health, freedom, productivity, communication skills and the meaning of life. In the field diary, it was noticed that female participants had more difficulty in defining what they consider health, perhaps due to having this broader concept in mind that is more difficult to verbalize. This increased perception of women's health has already been observed in other studies[20,21].

> And health for me is a good thing, which would be to help others, you are healthy, you have will, you can work, you can live your life in health [...] (F08)

Many definitions of what health and being healthy would be, praised freedom, humor, and the capacity for communication and extroversion, both in interviews of women and men deprived of their liberty

It was also observed that male prisoners in general were quieter, more introverted, saying only the necessary. When correlating the reports with what was observed, people living in situations of deprivation of liberty do not consider themselves healthy, because their health ideals and behavior in the prison environment were absolutely divergent.

> [...] For people who live here in this place, it is difficult to describe the person who is healthy, because it is very... the person's psychological too, it changes a lot, the person changes a lot, the person's strength changes. (F11)

This and other fragments, together with the notes in the field diary, indicated that deprivation of liberty might be sickening due to numerous factors. Restriction of freedom, overpopulation, hostile and unhealthy environment, poor hygiene in the area and high prevalence of infectious diseases are some of the conditions that would make life unfeasible and contribute to such illness.

Although the perception of health in the psychological sphere has been present in reports of both genders, no search for medical care was done due to psychic complaints, as the psychological suffering, although mentioned, did not seem to be perceived as a sufficient reason to get health care or to show that something is not going well, as already pointed out in another research[22].

Regarding another categorization, the health phenomenon is seen as a fact, an attribute, an organic function or a social situation, involving certain value judgments insofar as it can be defined negatively or positively. Negatively, health would mean the absence of diseases, risks, injuries and disabilities; positively, it would denote performance, features, capabilities and perceptions[23].

Both male and female prisoners represented health as positive and negative aspects. When compared to women, men tend to define health through negative aspects - although they also define it positively. Women focused more on positive definitions than men. Contrary to what is seen in the tradition of approaching health issues in primary care, the most recurrent and established concept was health as the absence of pain or illness. They treated health more like "you're smiling", "it's okay" and not taking medication.

Both male and female interviewees also define sick people as those who are sadder and quieter. Identifying a patient at the police station means analyzing how the person is, acts and behaves. However, for male prisoners, this change in behavior alone was not enough to state that a person is sick, and also needs to present some physical symptom:

> You see your friend playing and talking, then you see it quiet, then you know he is bad. We see when it is quiet, we have a fever, we are in pain, complain, we see a pal who is sick. (M24)

> If he is a little quiet like that, in pain, he is sick, sometimes he is quiet then I would ask him if he is in trouble, in pain, anything. (M02)

The association of diseases from emotional issues was more common among women. At different times during the observational process of the research, the researcher came across a woman crying while talking to another cellmate or a professional from the police station. During the consultations, several women cried, it is easier to observe the evidence of sadness among women than among men, since the externalization of emotional suffering was more frequent. Perhaps it is due to the fact that, inside prisons, depression is more prevalent among women[24], or because masculinity in prison reinforces the non-reproduction of relationship patterns considered to be female, that is, talking too much about feelings, weaknesses and fears[25]. In addition, when the prisoners tried to portray what a sick person would be, they cited someone sad, isolated and quiet (emotional aspects), even in the absence of physical symptoms:

> If my friend is sick, I see discouragement, because if you have known the person for a long time and from one day to the next they become discouraged, wanting to do no more, you know? So I think that each day gets worse. (F11)

> A sick friend is quiet, more quiet. She is quiet in the corner, so, without talking to anyone, isolated you know. (F12)

On the one hand, in the case of women, as they seek more services and talk more about themselves and their problems, the practitioners who care for them also tend to disqualify the complaint or to discount their suffering. In the field of health, for example, it is common to label them as "multi-complainers" which is a way of making the problem of mental suffering "invisible"[26].

A greater difficulty was perceived among prisoners when they needed to give a definition of the disease. The men described more symptoms in their speeches, both physical and psychic. Even though in both police stations we find it difficult to define disease, this probably was not due to the prison itself, but something previous, related to the fact that this population was already vulnerable and marginalized before being in prison. The demographic profile of the Brazilian inmates population derives from historical marginalization, from the lack of inclusive public policies, low education, and poor future outlook as well as the culture of violence[27].

Search for health care

Although women understood psychological symptoms as a disease, they did not report seeking assistance for such problems in police stations. The female prisoners also said that they felt embraced at the police station, and that mutual support was a protective factor for their mental health, which may have contributed to the lack of seeking care for psychic complaints.

Considering that access to health professionals at the police station was scarce, access still needed to overcome other existing filters. In addition to the inmates' pressing needs, the guards carry out needs-assessment; the other inmates had to accept the demand of any of the postulants for health care as well. Through the narratives, it was possible to perceive that women missed the independence they had before being arrested in order to seek health care:

> I'm a bit stopped here, you know, to ask for assistance, so much so that it's the first time I've been consulting. I think that if we had visits more often, it would be better. If they had a look, like this, with more attention to the prisoners, it would be good, because here it is not easy; it is very difficult to attend. (F5)

> Outside, I sought medical attention at health centers. Inside, we have to call the guards, right? (F16)

The "loss of freedom" becomes more evident when we link and contextualize the search for care with the relationship of these people with the health system, prior to incarceration. Women reported feeling more unassisted than men, since prior to imprisonment they had a greater bond with health services, in contrast to men. Men, on the other hand, did not report this health care so much before imprisonment, said they seek care when they felt pain or other symptoms that did not improve with time or home treatment:

> When I was out of here I sought care by going to the health center, this happened when I had frequent pain, a wound in my body. (M02)

> Out of here I sought help as a last resource, I did not do preventive measures. (M19)

Unlike men - who tended to delay the search for health care as much as possible - women went more often to the doctor for prevention, or for the slightest of symptoms. This is due to cultural aspects, such as the representation of caring as a female task and "male invulnerability"[28].

Among the female inmates, there was a greater concern with cleaning the cell, a larger attempt to keep the environment clean and sanitized, washing clothes, a separate place to dry them, intense adherence during the flu vaccination period. The same degree of care and concern was not identified in the male environment. This type of care is reported in the literature, where care with food, physical exercise and hydration was observed among inmates[29]. One hypothesis is the intent to transform a space that is hostile and unknown, into an environment that is closer to the known domestic daily life, hence the care with the arrangement of the space in order to transform it as close to a house as possible[30]. However, it can also be understood as one of the ways to endure suffering in environments of reclusion[31].

Such a movement reinforces the stereotypes of the macho structure of our society, where men grow up understanding that caring should be a female concern[32], leaving this task, be it their own care or the care of others, including men, invariably in the hands of women. What on the one hand reflects better health indicators, on the other hand reflects greater social oppression and a greater burden of activities that are considered inherently responsible[33,34].

The invisible woman

Both men and women depended on their families and people outside police stations, according to fragments taken from the narratives:

> [...] As I don't have a lawyer, I don't have, you know, total despair, so I depend on you to come here, it depends on you, there is no way, it depends on you, you have no family, right. (F18)

> If you don't have a family, you die in here!!! (M01)

It was noted that the female employees of the police station collaborated with the female inmates bringing personal and intimate hygiene products on their own, as they observed the abandonment by the people who were close to the prisoners before the detention.

It was observed that women deprived of their liberty received fewer visits to police stations than men. There was a greater movement of people visiting male prisoners, usually female visits (mothers, wives, daughters), usually taking personal hygiene items, groceries, clothes and cigarettes. This predominance of female visitors has been described in other articles[12,29].

However, it was noticed that some women did not think it was bad not to receive a visit. They commented that they were ashamed of the situation in which they found themselves. Many detainees also find the body checks that visitors go through as very "humiliating", and they prefer that they do not appear[31]. On the other hand, the solidarity among the female prisoners was more evident through the exchange of personal utensils, medicines or even by the more embracing attitude. Groups and mutual support among peers represent an important path for building collective resistance strategies for women[35]. The fact that many identify the environment of the police station as sometimes safer and more welcoming, reveals the sad reality that, at times, the oppression and violence of women in society can be even greater than the circumstance of deprivation of liberty.

The field diary showed that many women felt abandoned by the family, especially by husbands and partners, who generally did not accept the fact that they were in a situation of deprivation of liberty. When they received visits, just like at the male police station, the visits were usually from other women, such as the mother, daughters and sisters.

The prevalence of female visits in both police stations reinforces the norm that the role of caregiver is up to women, built from unequal gender relations related to the structural machismo of our society[32]. It is estimated that three quarters of the global unpaid care work is performed by women. While they spend, in general, 4 hours and 25 minutes a day in this care work, men dedicate, on average, 1 hour and 23 minutes; 3.2 times less[36].

Many women lose custody of their children while in prison[2]. An example taken from the field diary was that of a recluse who, when arrested, completely lost contact with her daughters. Family members assumed the care and did not inform the mother where their children were, something that was reported as a reason for suffering for the interviewee. In addition, as women deprived of their liberty were the main caregivers of their children, imprisonment reflects on consequences beyond the prisoners, affecting the lives of their children and the destabilization of family ties[37].

Visits reinforce the bonds with the family: while keeping contact with external people, they feel that they have not been excluded and outcast from the community[38]. They are also a support for the adversities of prison and a stimulus for social reintegration. Furthermore, the family visit is important to reduce the process of imprisonment, which would be the process of socialization in prison, in which the prisoner acquires customs and habits in the environment of deprivation of liberty[31], such as increased consumption of tobacco, idleness and neglect of health[29].

Visits are important not only with regard to emotional aspects, but also related to the quality of life inside the cells, as it was during these moments that family members took utensils that prisoners needed. There were reports of women deprived of liberty who did not receive any help from the family and depended exclusively on the State, lacking items that could provide comfort and symbolic affection[38].

The moral rejection of being imprisoned is much larger for women than for men[31]. Women deprived of their liberty end up doubly violating the social role for women in a patriarchal and sexist society like ours, resulting in greater social exclusion when compared to men. Violation of both the maternal representation that restricts the role of women in public policies, as well as the entry into a world that is expected to be exclusively male dominated, as is the case with criminality[38].

This could further deepen the feelings of loneliness and depression among prisoners, since, as previously analyzed, their health perception involves many more psychosocial aspects. As the visit would be an opportunity to communicate with the external environment, reducing the feeling of seclusion, therefore slowing down the reduction of the process of imprisonment and the feeling of exclusion, it allowed the person deprived of freedom to have a support to be able to deal with the imprisonment. But as women received fewer visits, there was a larger condemnation process compared to men, so there was a burden of legal and social condemnation.

Regarding limitations, the present study cannot be generalized to all police stations, since each one presents different practitioners and different types of prisoners. Each police station is responsible for working with different crimes, therefore presenting different characteristics. In addition, there is a possible bias of one of the researchers working directly with this population, but that was minimized

by the teamwork of the research group, as other researchers who were not part of the routine of the police station were the ones who carried out the analysis of the narratives. There were also regular meetings to discuss the progress of the research, maintaining criticism and multiple views regarding the interpretation of the data.

Conclusion

Additionally to the strategies for police stations and the flexibility of having to go to where prisoners are located, family health teams need to plan actions and approaches with different approaches depending on each environment.

Some relevant points were: (1) a greater concern for health care for female prisoners than for male prisoners in the moment prior to prison; (2) the broader and more comprehensive view of women's health than men's perceptions in general; (3) among women, seclusion hampered independence in the search for health care, causing a greater feeling of lack of care than among men and (4) women received fewer visits, which reinforces the helplessness feeling, indicating a condemnation that is not only legal but also social.

If the first two points help to understand why the environment in the female police station was clearly more embracing, with greater solidarity and receptivity among the female sex, the two last points present themselves as barriers to be overcome.

Therefore, primary care teams should have a better knowledge of how deprivation of liberty is happening in the country: there is no re-socializing aspect as is idealized in national documents, instead there are oppression and subhuman conditions of life, which make individuals sick and hamper their individual and social capacities. In addition, there is no way to leave out the aspects inherent to our society, practices of domination, discrimination and gender-based violence that have a significant impact on people's lives and are reproduced during incarceration.

Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

Copyright

Editor
Rosamaria Giatti Carneiro
Associated editor
Stela Nazareth Meneghel

Translator
Félix Héctor Rigoli

Submitted on
04/13/20
Approved on
08/23/20

References

1. Lermen HS, Gil BL, Cunico SD, Jesus LO. Saúde no cárcere: análise das políticas sociais de saúde voltadas à população prisional brasileira. Physis. 2015; 25(3):905-24.
2. Brasil. Ministério da Justiça. Departamento Penitenciário Nacional – DEPEN Informações Penitenciárias (INFOPEN) [Internet]. Brasília: Ministério da Justiça; 2018 [citado em 2 Fev 2019]. Disponível em: http://depen.gov.br/DEPEN/depen/sisdepen/infopen-mulheres
3. Silva AB. Delegacia de polícia não é cadeia pública [Internet]. Campo Grande: Correio do Estado; 2015 [citado 20 Fev 2019]. Disponível em: https://www.correiodoestado.com.br/opiniao/delegacia-de-policia-nao-e-cadeia-publica/243957/
4. Carvalho DTP, Mayorga C. Contribuições feministas para os estudos acerca do aprisionamento de mulheres. Estud Fem. 2017; 25(1):95-116.
5. Barcellos FBJ, Magdaleno JR. Saturação teórica em pesquisas qualitativas: contribuições psicanalíticas. Psicol Estud. 2012; 17(1):63-71.
6. Oliveira MM. Metodologia interativa: um processo hermenêutico dialético. Interfaces Bras/Can. 2001; 1(1):67-78.

7. Gonzáles AD, Garanhani ML, Bortoletto MSS. Fenomenologia Heideggeriana como referencial para estudos sobre formação em saúde. Interface (Botucatu). 2012; 16(42):809-17.
8. Melo MLA. Contribuições da hermenêutica de Paul Ricoeur à pesquisa fenomenológica em psicologia. Psicol USP. 2016; 27(2):296-306.
9. Ricoeur P. Mundo do texto e mundo do leitor. In: Ricoeur P. Tempo e narrativa. Campinas: Papirus; 1997. p. 320-7.
10. Martins IR. A criminalização feminina: o lugar da mulher no crime [monografia]. Brasília: Universidade de Brasília; 2016.
11. Santos VES. Mulheres criminosas: a evolução do discurso de vitimização da criminalidade de gênero em face a inserção da mulher no crime organizado. In: Anais CONIDIF; 2017; Campina Grande. Campina Grande: Realize Editora; 2017.
12. Silva LMS, Silva BM. Além cárcere: consequências metajurídicas da criminalidade feminina no Brasil. Rev Eletronica Jus [Internet]. 2016 [citado 30 Out 2018]. Disponível em: https://jus.com.br/artigos/46571/alem-carcere-consequencias-metajuridicas-da-criminlidade-feminina-no-brasil
13. Tesser CD. Medicalização social (I): o excessivo sucesso do epistemicídio moderno na saúde. Interface (Botucatu). 2006; 10(19):61-76.
14. Gaudenzi P, Ortega F. O estatuto da medicalização e as interpretações de Ivan Illich e Michel Foucault como ferramentas conceituais para o estudo da desmedicalização. Interface (Botucatu). 2012; 16(40):21-34.
15. Vieira EM. A medicalização do corpo feminino. Rio de Janeiro: Fiocruz; 2015.
16. Almeida APF, Assis MM. Efeitos colaterais e alterações fisiológicas relacionadas ao uso contínuo de anticoncepcionais hormonais orais. Rev Eletronica Atualiza Saude. 2017; 5(5):85-93.
17. Costa ND, Silva PR. A atenção em saúde mental aos adolescentes em conflito com a lei no Brasil. Cienc Saude Colet. 2017; 22(5):1467-78.
18. Pedro JM. Traduzindo o debate: o uso da categoria gênero na pesquisa histórica. Historia (São Paulo). 2005; 24(1):77-98.
19. Brasil. Conselho Nacional de Combate à Discriminação. Resolução Conjunta nº 1, de 15 de Abril de 2014. Estabelecer os parâmetros de acolhimento de LGBT em privação de liberdade no Brasil. Diário Oficial de União. 17 Abr 2014.
20. Mamede MV, Bueno JV, Bueno S. Percepção da condição de saúde entre mulheres. Rev Bras Enferm. 1993; 46(2):95-100.
21. Martins ELC, Martins LG, Silveira AM, Melo EM. O contraditório direito à saúde de pessoas em privação de liberdade: o caso de uma unidade prisional de Minas Gerais. Saude Soc. 2014; 23(4):1222-34.
22. Diuana V, Lhuilier D, Sánchez AR, Amado G, Araújo L, Duarte AM, et al. Saúde em prisões: representações e práticas dos agentes de segurança penitenciária no Rio de Janeiro, Brasil. Cad Saude Publica. 2008; 24(8):1887-96.
23. Silva AL, Ferreira J. O que é saúde? Interface (Botucatu). 2013; 17(47):983-6.
24. Constantino P, Assis SG, Pinto LW. O impacto da prisão na saúde mental dos presos do estado do Rio de Janeiro, Brasil. Cienc Saude Colet. 2016; 21(7):2089-100.
25. Santos HB, Nardi HC. Masculinidades entre matar e morrer: o que a saúde tem a ver com isso? Physis. 2014; 24(3):931-49.

26. Pedrosa M, Zanello V. (In)visibilidade da violência contra as mulheres na saúde mental. Psicol Teor Pesqui. 2016; 32(214):1-8.

27. Soares Filho MM, Bueno PMMG. Demografia, vulnerabilidades e direito à saúde da população prisional brasileira. Cienc Saude Colet. 2016; 21(7):1999-2010.

28. Schraiber LB, Figueiredo WS, Gomes R, Couto MT, Pinheiro TF, Machin R, et al. Necessidades de saúde e masculinidades: atenção primária no cuidado aos homens. Cad Saude Publica. 2010; 26(5):961-70.

29. Santos MV, Alves VH, Pereira AV, Rodrigues DP, Marchiori GRS, Guerra JVV. The physical health of women deprived of their freedom in a prison in the state of Rio de Janeiro. Esc Anna Nery. 2017; 21(2):e20170033.

30. Gomes R, Nascimento EF, Araújo FC. Por que os homens buscam menos os serviços de saúde do que as mulheres? As explicações de homens com baixa escolaridade e homens com ensino superior. Cad Saude Publica. 2007; 23(3):565-74.

31. Frinhani FMD. Mulheres encarceradas e espaço prisional: uma análise de representações sociais. Psicol Teor Prat. 2005; 7(1):61-79.

32. González DF. Entre público, privado e político: avanços das mulheres e machismo velado no Brasil. Cad Pesqui. 2014; 44(151):239-43.

33. Botton A, Cúnico SD, Strey MN. Diferenças de gênero no acesso aos serviços de saúde: problematizações necessárias. Mudancas Psicol Saude. 2017; 25(1):67-72.

34. Courtenay W. Constructions of masculinity and their influence on men's well-being: a theory of gender and health. Soc Sci Med. 2000; 50(10):1385-401.

35. Meneghel SN, Barbiani R, Brener C, Teixeira G, Sttefen H, Silva LB, et al. Cotidiano ritualizado: grupos de mulheres no enfrentamento à violência de gênero. Cienc Saude Colet. 2005; 10(1):111-8.

36. International Labour Office. Care work and care jobs for the future of decent work. Geneva: ILO; 2018.

37. Pereira EL. Famílias de mulheres presas, promoção da saúde e acesso às políticas sociais no Distrito Federal, Brasil. Cienc Saude Colet. 2016; 21(7):2123-34.

38. Scherer ZAP, Scherer EA, Santos MA, Souza J, Pillon SC, SN Pires. Mulheres privadas de liberdade: representações sociais de prisão, violência e suas consequências. Rev Bras Enferm. 2020; 73(3):e20180781.

O estudo envolveu reclusos provisórios de delegacias de polícia de Curitiba, estado do Paraná, Brasil, uma masculina e outra feminina, com a finalidade de explorar diferenças entre gêneros e auxiliar em estratégias para incluir essa questão na abordagem dessa população na Atenção Básica (AB). Foi um estudo qualitativo baseado em observação participante, com diário de campo e 26 entrevista abertas audiogravadas (13 masculinas e 13 femininas), transcritas e analisadas pela fenomenologia hermenêutica de Ricoeur. O ambiente feminino era mais acolhedor, e a percepção de saúde-doença assumiu um caráter mais restrito ao biológico para os homens, enquanto para as mulheres teve conceitos ampliados. As mulheres sentiam falta da independência para buscar atendimento médico, pois frequentemente iam à Unidade Básica de Saúde (UBS) antes de serem presas, diferentemente dos homens. Ambiente, controle, relações e percepção do processo saúde-doença tiveram diferenças entre os gêneros.

Palavras-chave: Gênero. Percepção saúde-doença. População privada de liberdade. Presos.

El estudio envolvió a reclusos (as) provisionales de comisarías de policía de Curitiba, estado de Paraná, brasil, una masculina y otra femenina, con la finalidad de explorar diferencias entre géneros y auxiliar en estrategias para incluir la cuestión de género en el abordaje de esta población en la Atención Básica. Fue un estudio cualitativo basado en observación participativa, con diario de campo y en 26 entrevistas abiertas audiograbadas (13 masculinas y 13 femeninas), transcritas y analizadas por la fenomenología hermenéutica de Ricoeur. El ambiente femenino era más acogedor y la percepción de salud-enfermedad asumió un carácter más restricto a lo biológico para los hombres, mientras que las mujeres tuvieron conceptos ampliados. Las mujeres sentían falta de independencia para buscar atención médica, puesto que frecuentemente iban a la Unidad Básica de Salud antes de ser presas, diferentemente de los hombres. Ambiente, control, relaciones y percepción del proceso salud-enfermedad tenían diferencia entre los géneros.

Palabras clave: Género. Percepción salud-enfermedad. Población privada de libertad. Presos.