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Sexual and health behavior among women of convicts: an exploratory study

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ABSTRACT

Aim: to learn the sexual and health behavior of women of convicted men. **Method:** This is an exploratory, qualitative study conducted in November 2015 in a small prison in Paraná, Brazil. The data were collected through a semi-structured interview with 19 women and later submitted to content analysis, thematic modality. **Results:** it was found that women of convicts, in addition to being vulnerable, neglect care measures for their own health, prioritizing the health of partners and relatives. In addition, they exhibit risky sexual behavior favored by incarceration conditions of the partner and by establishing unprotected extramarital relationships. **Conclusion:** women are a vulnerable population, which implies the need for changes in the care and hosting of this public.

Descriptors: Women's Health; Sexual Behavior; Spouses; Prisoners.

INTRODUCTION

The National Policy for Integral Attention to the Health of Persons Deprived of Liberty in the Prison System (PNAISP, acronym in Portuguese) establishes goals regarding the health of the Brazilian prison population. In this context, one of the elements mentioned is the importance of thinking about the health-disease-care process beyond the individual, thus involving an extended network, which includes family and networks of sociability[1].

The family is a pillar of support for condemned persons, but the relationships between them are set in a vulnerable environment, marked by the total absence of privacy, especially for women who are exposed to intimate visits within prisons[2,3]. Although the right to an intimate visit is guaranteed to the detainee by the Federal Constitution[4], the implementation of this right falls under the authority of the state penitentiary system, which is linked to the respective public security office according to local demand.

It should be noted that the prison environment offers physical, psychological and infectious disease transmission risks due to the heterogeneity of incarcerated individuals. In this sense, the condition of vulnerability of both the convict and their relatives, especially the woman who visits intimately, should be considered and prioritized in the planning of health care actions. Even because women generally have less freedom in their sex lives and less power to decide on them, in addition to being more frequently victims of domestic/everyday violence, including in the sexual sphere, which makes them a priority and vulnerable population[3,5].

A study on the health conditions of the prison population in Rio de Janeiro state highlights gender distinction regarding visits to prisons: the percentage of those who do not receive visits from relatives is much higher among women, who justify such absences because they had to assume the care with their children, live very far away or, also, for fear and embarrassment before the "inspections" carried out to enter prisons[6]. As to partners, it is common for women prisoners to report that they are also incarcerated or in other relationships[6,7], thus it is assumed that intimate visits to them are also less frequent. Reverse reality has been observed in male prisons: wives/partners of prisoners often visit them, and in the eagerness to provide some comfort in prison, upon their request or demand, they even risk taking them forbidden objects and drugs[6].

Health care practices refer to comprehensive individual care, disease prevention and continuity of treatment of pre-existing diseases. On the other hand, sexual behavior identifies posture, care and prevention against sexually transmitted infections (STI)[6,8], together with factors of extreme vulnerability in which these women and their partners are exposed within a prison environment.

Given the condition of vulnerability experienced by such women, the objective of this study was to apprehend the sexual and health behavior of women of convicts. It is believed that their results may support the actions of the health services and favor the development of strategies necessary for the promotion of continued care for the health of these women, as well as their partners.

METHOD

This is an exploratory research, using a qualitative approach, carried out with women of convicts, in a prison located in the northern region of the state of Paraná, Brazil. At the time of the study, there were 152 inmates, of whom approximately 80% received intimate visits, held on the first, second and third Wednesdays of

each month; the last Wednesday is for the visits of children and other relatives.

The study participants were approached on the same days that they attended the prison, while waiting for the opening hours of the visits, obeying the following inclusion criteria: to be 18 years old or older, to be a partner/companion of convicts with access for intimate visitation and to have arrived at the prison more than one hour before the time set for the visit. The search for new participants occurred until the moment data began to become repetitive and the purpose of the research was reached. The saturation was reached with 19 women, who were then the study sample.

Data were collected in November 2015, through semi-structured interviews, performed in an individual care room inside the prison itself, before the release time for the visit. They were recorded on digital media and had an average duration of 40 minutes.

The instrument used during data collection was a script consisting of two parts, the first addressing issues related to sociodemographic characterization, behaviors and health conditions; and the second containing the following guiding question: Talk about care for your health after the incarceration of your partner. Some questions of support were used in order to favor the approach of aspects not reported freely. They were: Regarding your sex life after your partner's arrest, what do you have to tell me? Tell me more about it. How do you feel about your sex life? What care do you take to prevent disease?

For the data treatment, the interviews were transcribed in full and submitted to content analysis, thematic modality, followed by the pre-established stages of pre-analysis (identification of relevant aspects from the study objective); exploitation of the material (identification of common and specific aspects related to the health condition and sexual behavior of women); and processing of data (delimitation of categories)[9].

The study was developed after approval of the Research Ethics Committee of the Center for Higher Studies of Apucarana (Opinion no. 1,330,747). Participants signed the Free and Informed Consent Term and, to ensure their anonymity, the extracts from their reports were identified with the letter E, indicative of interview (Entrevista in portuguese), followed by a number indicative of the order of interview and another of the age of the deponent (Ex: E2-52 years).

RESULTS

The 19 participants in the study were aged between 18 and 52 years, with an average of 28 years, 12 of whom declared themselves white, four black and three brown. The majority had a maximum of four years of study (n=13) and average of two children. In relation to the marital situation, 13 were cohabiting and six were married. The average family income was a minimum wage (R$ 788.00 at the time of the study); and 14 of them had a regular job.

Concerning health, ten reported being users of alcohol and tobacco; 11 denied the existence of health problems, five reported depression and three said they had hypertension. In addition, 14 of them mentioned not performing physical activity.

From the analysis of the data of the interviews emerged two categories that will be described next.

The priority is to take care of others: "I don't have time for myself"

When asked about care actions for their own health, some interviewees reported that

they did not have time to take care of themselves, due to the role of "caretaker" of the family and for being the head of the house after the imprisonment of their partners, as well as for the burden of responsibility for the convict partners and concern for their health.

> I paid Unimed (health insurance) for him and for my daughter only because he has heart problem. I'm afraid he'll need emergency surgery or an appointment. (E2-52 years)

> I do not have much time to take care of myself, I worry a lot about supporting my daughter and paying the rent. I take medicine when I need it. When he gets out of here, I'll look after myself, because I'll have more time then. (E1-22 years)

> I can't take care of my health; I have the children, so I don't have time for myself. The time I have is mostly geared for them and to come here and bring things to him. (E3-23 years)

> I don't have much desire to take care of myself, I really worry about his health, because he has several health problems. (E4-49 years)

In the following speeches it can be observed that when the interviewees talk about their own health behaviors, the care actions are related to a pre-existing illness, which is why some of them seek health services.

> As for health, I even take care of myself, I have vitiligo and I treat it with ointment and medication. I was five years old when the vitiligo was discovered; before I went to the doctor every three months, now I go every month. (E5-22 years)

> I take care of my health in the CAPS [Psychosocial Care Center, acronym in Portuguese], I do treatment for depression. I've changed the medicine twice. The doctor and the nurse told me that I have to go to the gym, go for a walk, but I can't. (E18-18 years)

However, most of the time, such care is not periodic or continuous.

> I don't smoke, I don't drink, I don't walk, I don't do any physical exercises or exams. I do the preventive, because I've had a discharge, but I don't remember the last preventive I had. I think it was before getting pregnant in 2013, but I also don't know the result of the exam; I didn't look for it. (E7-23 years)

> I take care of health from time to time, but I've never had anything serious. Despite the spoiled life, I have good health (laughs). But I go in the health center only when I need to, when I am in pain or feeling bad. (E19-29 years)

The interviewees' fears about the demand for the health service were also observed because they bear the stigma of being "woman of convict men".

> I ask that girl from the health center to set the exam for me, and she says she'll set it, but she just keeps winding me up. I think she's afraid of me, sometimes

> she thinks I'm just like my husband. I have a strong discharge and pain down my belly, but I'll wait and see if she'll set it. (E8-35 years)

> These days someone gave a medicine to my husband here at the police station and they told me to take it too. The discharge has improved but returned, and the pain during the relationship continues. I've already had syphilis, but I treated it when I was pregnant. I don't go to the health center first because I don't have the time and also because they give me a disproving glance, I think it's because he's in jail. (E6-23 years)

> I've already dealt with the discharge; he also had to treat it once, it was something that we both had to treat; I don't know what it was, and I also prefer not to know anything. People think we are ignorant, especially because my husband is in jail, so they don't explain things. (E9-20 years)

Sexual behavior in prisons: "When you really love you go through everything"

In this category it was evidenced the adoption of risk behaviors related to sexual health in a prison environment, such as, for example, exemption from condom use for a variety of reasons:

> It's a bit different, it changes a bit inside, but when you really love somebody, you go through everything. The thing is, we need to avoid thinking too much, I come here to enjoy my time with him, you know? You have to forget. I use the pill, they give us condoms here, but I don't use them because I take medicine. (E12-24 years)

> I take that medicine that people take the next day, you know? Only when it's necessary. We avoid it; we do that little table, but from time to time we forget, then I must take it. He doesn't like condoms.. (E10-38 years)

> I don't use any pills or condoms because I'm lacquered. I've never had a problem here [...] not to mention that the environment here is embarrassing, you don't even think about using a condom. (E13-22 years)

Confidence in the partner and the belief that screening in the prison system function as "protection" factors was also observed.

> We have relationships here in the jail on the day of our visit, and I trust him a lot, because here they do all sorts of exams, and every time he does it the results are normal. But if I didn't have these exams, I would use condoms, because I'm afraid. (E15-24 years)

> [...]There are condoms here; they give it to us, but we don't use them. I am lacquered and trust my husband very much. (E14-30 years)

The lack of privacy, embarrassment and humiliation were pointed out as feelings experienced during the intimacy of the couple in prisons.

> As to my intimate life, I feel very embarrassed by the place, but now I've gotten used to it. There is not much privacy in the place; I feel shame sometimes, many men together, the environment [...] but it's my husband, my marriage. (E16-37 years)

> It's embarrassing to have sexual intercourse in here. I feel a lot of shame, humiliation, there are the other prisoners, it is as if the others are listening and seeing everything (she lowers her head and sighs deeply). We don't feel like doing it; it's very uncomfortable, but he is my husband. (E3-23 years)

The conditions of hygiene of the prison environment were also highlighted by the interviewees:

> Hygiene here is very precarious, the hygiene of the beds you know? [...] you have to bring a small towel, but then we wet the body and it gets damp, there is no way to use hygiene products. (E4-49 years)

> [...] you lie on a bed that has fungus, mycoses [...]. It's very complicated. We take care of the hygiene at home, but then we arrive here and there are these dirty walls, without sunlight, and there are many kinds of things there. So that's very bad for their health and ours, especially me, because I've been married for 30 years, always with the same husband. It gets complicated, because any little thing that happens is your fault. Then when you see, you got things right here [...]. We get inhibited, we don't relax; it doesn't matter that you've known him for so long. I, for example, know my husband, have children with him, but, anyway, it's a very difficult relationship. Time is very short and women are different, they need time. Besides the intimate visit, you need to talk about everything about your life; the family [...] There should be more time for us, especially for intimacy. (E4-49 years)

> Wow, having relationship in there is very difficult. There are several times when I couldn't [...] today it's a little better (crying). We leave here depressed. (E17-25 years)

> I don't use condoms; I don't like these things very much. The intimate visit inside is already an inconvenience and if we get involved with these things, it doesn't work, because it is a riot, a lot of people, and there is no privacy. (E14-30 years)

Infidelity was also highlighted as an influential factor in women's sexual behavior:

> [...] I know that his ex-wife comes here from time to time to bring his children to see him and I don't know what happens, but I don't even try to talk about the subject very much, otherwise we fight, you know? Because I don't cheat on him, but I think he cheats on me; no woman comes here just to bring her son (laughs), but it's in his conscience too. As I love him, I overlook this issue, and if I don't do my part he'll cheat on me!! (E5-22 years)

> Even though he is in prison, he betrayed me to another woman who came to visit his brother. It was at the time that I was punished [pregnant] and we stayed more than six months without intimacy. They met in the courtyard and he ended up staying with her, having intercourse. Today I don't trust him, but I know that if I don't do it, he does it with another woman. (E7-23 years)

However, infidelity is not always only on the part of the victims, as observed in the following reports:

> He's already betrayed me, I know. But I also got my revenge. I like him, but I also like myself and he knows I got my revenge. I tell him that if he betrays me again, I will do it again [...] he is afraid because if I leave him here, there is no one for him. (E11-27 years)

> I left him once, got involved with another prisoner, from another city, but it didn't work because he left the police station and got another one. Then I came back with this one. Loneliness is very hard, then there are days when I get desperate and feel like not being lonely, but at the same time you already find yourself stuck here too! (E9-20 years)

> I've had a relationship with another man outside [...] I've tried. But it didn't work. Out there they want just that. So I'd rather be with him, at least I know what he wants with me. (E18-18 years)

DISCUSSION

Imprisonment causes changes in the entire family life context, and most of the time it is the woman who exclusively assumes the economic maintenance of the family, domestic duties, childcare, and the accompaniment of all criminal proceedings of her partner[3]. All these responsibilities, together with the stigma of society, contribute to women prioritizing care for others and distancing themselves from the care of their own health, restricting them to the treatment of preexisting diseases[6,10], as perceived in the lines of E1 and E2.

The stories of the women of convicts in the search for health services express discrimination, frustrations and violations of rights and appear as a source of tension and psychic-physical malaise[11,12]. Corroborating this, it is observed in the statements of the interviewees 6, 8 and 9 that the access to health services and the quality of care and reception are influenced by the fact that their spouses/partners are incarcerated. In addition, the social determinants also directly influence the perception that women have of the care with their own health, besides reflecting in the knowledge and conditions of access to the services.

Thus, we can see the gap in health professionals' efforts to promote the reception of these women, in order to break the barrier that keeps them away from the health service. Thus, the quality of care for these women, in particular, needs to be planned with a focus on ensuring the promotion and respect for human rights, which strives for integral health and well-being[8,10].

Considering the situation of vulnerability in which the female partners of convicts are due, among other things, to the lack of care with their own health, it is necessary to propose an integral care, planned and permeated by reception and sensitive listening of their specific demands,

valuing the influence of individual factors in the health process and in the different types of behaviors for disease prevention[8,13,14]. In the attention to women's health, integrality occurs through the implementation of care practices that guarantee access to resolutive actions, built according to the specificities of the female life cycle and the context in which the needs are generated[5].-

In this perspective, for full care it is necessary to consider sexual rights, since sexual activity, according to the World Health Organization, is one of the domains of quality of life. In order to do this, the multiprofessional team can use several strategies that allow the survey of needs, such as the active search of these women in the prison system on days of intimate visit, individual care and the organization of groups. Regardless of the action used, health care needs to be planned with a focus on promoting and respecting human rights, with emphasis on integral health, well-being and sexual rights.

Therefore, care must be permeated by the reception with active listening of their demands, educational actions involving men and women, and also that promote the interaction of members of the health team in a way that allows multidisciplinary action[3,8]. In this regard, it is worth mentioning that listening to women in situations of vulnerability and interest in their history contribute to the improvement of care and to the identification of difficulties encountered in health monitoring[14].

It should be noted that the prison environment in Brazil is recognized by the overcrowding of unhealthy cells, poor lighting and insufficient natural ventilation. There is also a lack of personal hygiene, adequate food, access to safe drinking water and adequate and continuous health services[13,14]. These conditions contribute to the propagation and dissemination of diseases among the victims, as well as their relatives, especially of the women who carry out an intimate visit[15].

It is also observed that women in distress suffer discrimination, including gender, because sometimes they are controlled and monitored by the partner who uses other sources. This behavior generates fear and anguish, making them subject to the control situations exercised by the imprisoned partner[3]. This is reflected in some reports that show the non-use of condoms and even the acceptance of partner infidelity (E7) or the non-adoption of positive sexual health behaviors due to the established trust relationship with the partner (E14 and E15).

Therefore, in the particular context of women in distress, vulnerability is even greater, as well as being influenced by unequal relationships in the individual and collective spheres, including in relation to sexuality, which shows the inequality in the vulnerability to which the genders are exposed as a result of their unprotected sexual behavior, placing trust in the partners[16].

The Bulletin of the Joint United Nations Program on HIV/AIDS indicates that in a male prison in São Paulo, almost 6% of the population had HIV; among women from another penitentiary center in the state capital, the index reached 14%. According to the study, the level of knowledge about STIs and HIV was high among the prison population, but access to prevention and care within prisons was considered inadequate[11].

As pretexts for the non-use of condoms, studies point to women's assessment of their partner's sexual-affective history and the reliability established from reports on sexual life, shyness, and inexperience[2,15]. In other cases, both men and women stop using condoms when the extramarital relationship is no longer casual and assumes a fixed character. However, it is important to emphasize that women have less

freedom in their sexual lives, have difficulty deciding and have less decision-making power over unprotected sex, which increases vulnerability and the incidence of diseases among them[2,15,17].

In this study it was also identified that women, to a certain extent, justify the "careless" when affirming that their partners conduct examinations periodically in the prison environment. This type of justification indicates that they need to be clarified about the tests that are performed, which aim at the detection and not the prevention of diseases.

Moreover, some women justified not using condoms because of the use of other contraceptive methods (table, oral contraceptive and morning-after pill). This shows that the provision of condoms in penitentiaries, although fundamental to facilitate access, is insufficient if not accompanied by educational work. Attitudes such as these demonstrate that the role of condoms in preventing STIs is totally disregarded. This may be due to misinformation about the different types of STI, the question of whether women may be asymptomatic, the absence of educational work that could favor the identification of these pathologies by the population and the underestimation of these disorders[13,15].

In the speeches of some female partners of convicts, the feeling of loneliness, lack of affection and overload of problems in their daily life is perceptible. Faced with this scenario, women become victimized, trying to get out of the situation in which they are, and can even get involved in other relationships. A qualitative longitudinal study with women partners of African-American convicts emphasizes that the involvement of these women with other partners is also associated with financial conditions, that is, they try to guarantee shelter and support for the family[18].

It is noteworthy that some women reported knowledge that their partners have extramarital relationships, and yet remain submissive to them. A cohort study conducted at a prison in North Carolina demonstrated the influence of incarceration in personal relationships and in the transmission of STI/AIDS, due to instability in relationships due to substantial barriers to contact with the convicted partners[16].

In dealing with conditions that are specific to women, health professionals should look at aspects of the disease that are different in women or have important gender implications. The ability to apply this information requires practitioners to adopt culturally and generally sensitive attitudes and behavior, assigning care in an integrated way to women[6,8].

Knowing the daily life of these women, their knowledge of experiences, their understanding of health, their popular practices of health care and their sexual behaviors opens possibilities to broaden the understanding about the health needs of the women of convicts. This strengthens new research and the creation of new strategies in the field of health care in the SUS, with the aim of broadening inclusion and dialogue with understandings and popular ways of health care, especially vulnerable groups.

CONCLUSION

The results show that the women of convicted men, besides experiencing vulnerability, neglect care for their own health, prioritizing the health of the partner and children. In addition, they exhibit risky sexual behavior favored by conditions of inmate imprisonment and unprotected extramarital relationships.

In view of this, strategies to promote sexual health in prisons should encompass the complexity and peculiarities experienced by women in distress. The strengthening of subjects' autonomy as the essence of the educational process must consider that science, knowledge and opi-

nions congregate the contexts of environmental, social and cultural vulnerabilities. In addition, it is suggested that health professionals be attentive to sexual and health behavior in contexts of great vulnerability, such as prisons, so that they can act in an integral and qualified manner.

As a limitation of the study, it is worth noting the impossibility of generalizations, given the qualitative nature and purpose of studying the reality of a specific scenario. Thus, it is suggested to carry out new investigations, in other contexts and with other methodological approaches in order to broaden the understanding of the sexual and health behavior of these women.

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