

Experiences of deprivation of freedom from the perspective of men and its implications to health care*

Vivências de privação de liberdade na perspectiva de homens e implicações para o cuidado em saúde

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Special Call - Promoting the health of vulnerable populations

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ABSTRACT

Objective: to understand the experiences of deprivation of freedom from the perspective of men and their implications to health care. **Methods:** qualitative study carried out with 10 men serving sentences on probation. Data collection was carried out in individual interviews using a semistructured questionnaire. Data was submitted to content analysis. **Results:** three categories emerged, which were: Crooked life: living before being deprived of freedom; Caged bird: being a man deprived of freedom; and Time bomb: health care in the prison system. The deprivation of freedom is an experience marked by the lack of safety, considering the health risks in the prison environment, the perception of participants of being vulnerable to disease, and the denial, on the part of the state, of the right to health. Since the access to health is not guaranteed, relatives were the most commonly responsible for organizing care. **Conclusion:** an unhealthy situation was found, with vulnerability to disease and denial of the right to health in the prison environment. **Contributions to practice:** this study contributed for sensitizing professionals who work in the prison system, emphasizing the importance of guaranteeing human rights during imprisonment.

Descriptors: Men's Health; Prisons; Prisoners; Right to Health.

RESUMO

Objetivo: compreender as vivências de privação de liberdade na perspectiva de homens e as implicações para o cuidado em saúde. **Métodos:** estudo qualitativo realizado com 10 homens que cumpriam pena em regime aberto. A produção de dados foi realizada por meio de entrevista individual, na qual se utilizou um roteiro semiestruturado de perguntas. Os dados foram submetidos à análise de conteúdo. **Resultados:** emergiram três categorias, intituladas: Vida torta: o viver antes da privação de liberdade; Passarinho preso: ser homem privado de liberdade; e Bomba relógio: a assistência em saúde no sistema penitenciário. A privação de liberdade se revelou uma vivência marcada pela insegurança em razão da insalubridade do ambiente prisional, percepção de vulnerabilidade às doenças por parte dos participantes e negação ao direito à saúde por parte do Estado. Na falta de garantia de acesso à saúde, familiares se destacaram na organização do cuidado. **Conclusão:** evidenciou-se um cenário de insalubridade, vulnerabilidade às doenças e negação do direito à saúde no ambiente prisional. **Contribuições para a prática:** o estudo contribuiu para a sensibilização de profissionais atuantes no sistema prisional e ratifica a importância da garantia de direitos humanos durante o encarceramento.

Descritores: Saúde do Homem; Prisões; Prisioneiros; Direito à Saúde.

Introduction

Currently, there are 1,507 prison facilities registered in Brazil, with nearly 730 thousand people deprived of freedom. These units are often overcrowded, housing up to, approximately, 45.0% more than their total capacity. The high number of men in deprivation of freedom shows the relevance of this topic and justifies the development of scientific research that addresses it⁽¹⁾.

National and international scientific literature have suggested the growth of the population deprived of freedom in the last three decades, especially in American countries, showing the inequality and health needs in this setting. Although Brazil is the third country in the world in absolute number of people deprived of freedom, the prison system in the country has been historically affected by a lack of government investment, hazardous environments, overcrowding, permanent confinement, and violence. Deprivation of freedom in these conditions contributes to expose participants to traumatic events, stress, health issues, and disease processes⁽²⁻³⁾.

The epidemiological profile of the population in deprivation of freedom is distinguished by the presence of sexually transmitted diseases (influenza, rubella, tetanus, diphtheria, tuberculosis, sexually transmitted infections, leprosy, etc.), mental disorders, and violence. This epidemiological profile shows the need for the implementation of integral health care in the prison system, based on a model of primary care that enables access to a healthy life in prison, in addition to strengthening and maintaining social bonds to guarantee social reintegration⁽³⁾.

The numbers of the Brazilian prison population are in stark contrast with the scarce Brazilian research that addresses gender and imprisonment. Although the topic has been on the rise in scientific production, it is far from a priority from an academic standpoint. Another important issue to highlight is the fact that literature about the prison system is still reproducing gender stereotypes. Gender perspective, for example,

has been much more addressed in regard to women deprived of freedom, and, in these works, discussing topics such as maternity and marriage/sexuality becomes relevant. On the other hand, in studies about imprisoned men, the topics of death, violence, sexuality, and masculinity are focused⁽⁴⁻⁵⁾.

Freedom deprivation in the prison system is experienced differently by men and women. This experience involves aspects that go beyond biological characteristics and which reverberate on health. Psychosocial issues of men deprived of freedom, such as the use of psychoactive substance and the continuous exposure to stressors associated with imprisonment, in addition to the poor socialization conditions, learning, and leisure activities, create a hostile environment that makes reinsertion in society more difficult⁽⁶⁾.

Among factors associated with diseases and health issues commonly presented by men deprived of freedom, the following stand out: high rates of violence, unsafe sexual practices, use of psychoactive substances, disregard for the adoption of healthy habits, stigmatization of the convicted who seek health care, need to maintain a virile image that can command respect, among others. These elements show male vulnerability as related with the behavior adopted by men in confinement⁽⁷⁾.

This study is justified by the gap in literature about the topic of freedom deprivation from the perspective of men, as well as its interface with health care in the prison system in the Brazilian midwest. This study was created considering the following questions: How do men experience the deprivation of freedom? What are the implications of this type of experience to health care?

Our goal was to understand the experiences of deprivation of freedom from the perspective of men and their implications to health care.

Methods

This was a qualitative study, following recom-

mendations from the Consolidated Criteria for Reporting Qualitative Studies (COREQ) to carry out the research project and write the article. The research was carried out in the *Estabelecimento Penal de Regime Aberto e Casa do Albergado* (EPRACA), which is a facility to house persons on probation in the city of Campo Grande, Mato Grosso do Sul, Brazil.

The study population was represented by an universe of men on probation ($n=576$). Inclusion criteria were being male, 18-years-old or older, and being on probation for at least one year. The exclusion criteria was: diagnosed mental disorder or cognitive limitation, as identified by the prison system, that would prevent data generation.

At first, we advertised the research and invited participants through banners placed by the institution in its facilities for 15 days. Only one person showed interest in participating. Later, we counted on the support of a social worker who is part of the technical team of the institution and who, during service or cell visits, informed participants who were in accordance with inclusion criteria about our research and invited them to participate, explaining how they could contact the researcher responsible if they were interested in participating. In this stage, 11 other men showed interest in participating. None of the 12 men selected asked to abandon the study.

An early interview script underwent a pilot test with the first two participants. It was necessary to rewrite three questions to facilitate the understanding of the participants. The information collected from the two interns in the pilot test were not used in the analysis of this study. The final sample was formed by 10 men. The number of participants was determined according to data satisfaction criteria.

Data was produced from October to November 2020 through individual, in-person interviews, using a semistructured script with questions about sociodemographic (age, educational level, religion, color, number of children, crimes committed, time of deprivation of freedom), in addition to the following guiding questions: What is the story of your life? How

have you been experiencing deprivation of freedom? How is it being a man deprived of freedom for you? How do you see the health care provided to you during your deprivation of freedom? Do you want to say something else?

The interviewer was male, graduated in psychology, and experienced in the production of data in scientific research. The interviewer and the participants did not have any form of contact before data collection. Interviews took place in a private room, lasted for a mean of 60 minutes, and were recorded digitally. Their content was transcribed in full. There was another meeting with each participant, where the transcriptions were read and they could add comments or correct the content. To guarantee anonymity, the name of each interviewee was replaced with the term "Participant", to which a number was added indicating the order in which the interviews were carried out.

Information found was organized in three empiric categories, named: Crooked life: living before being deprived of freedom; Caged bird: being a man deprived of freedom; and Time bomb: health care in the prison system. The categories emerged from the content analysis of the narrative of the participants, which, according to the thematic modality, respected the following steps: operationalization and systematization of earlier ideas, skimming of the documents collected, selection of those who were analyzed, grouping of elements with later exploration of the materials, and treatment of the results obtained with a discussion considering scientific literature that addressed the topic at hand⁽⁸⁾.

This study was approved by the Research Ethics Committee at the *Universidade Federal de Mato Grosso do Sul*, under opinion n^o 3,981,746/2020, following all ethical standards required.

Results

Most participants were young adults, with a mean age of 34.4. The youngest participant was 25 years old, while the oldest was 60. Five participants

had incomplete elementary school, four had not finished high school, and one was illiterate. The ten participants had a record of menial work (bricklayer, mechanic, upholster, farmer, cook, janitor, production assistant). They had been deprived of freedom due to crimes that involved some type of violence (homicide, attempted homicide, theft, gun trafficking, drug trafficking).

The mean time of deprivation of freedom among participants was 6 years, with a maximum of 14. Six men self-declared black or brown; three, self-declared white; and one self-declared indigenous. Seven participants self-declared Christian; one, as a spiritist; two had no religion. All participants had children. Three of them became fathers while deprived of freedom.

Below we present the categories found that express the content of the interviews carried out with the participants.

Crooked life: living before being deprived of freedom

It was possible to discern, from the narratives, certain elements of the life stories of the participants, such as the life in a social context marked by the presence of violence, crime, and psychoactive substances. The following excerpt illustrates this finding: *I was born in a poor family, in a slum, there was a lot of drugs and crime. The first thing I saw when I left my house was crime, drugs, booze, parties. I went down that road. I think I didn't have good references* (Participant 8).

There were common allusions to family dysfunction, including abandonment from the father, in-family violence, and psychoactive substance abuse at home: *My mom created alone me and two brothers. There were always discussions, fights. Even with my younger brother. A lot of the time, when he arrived, we fought. He stabbed me. I got married, started living with my wife. Started going to the bar, arriving drunk the other day. My wife would ask me to stop drinking, using drugs. I started using drugs at home* (Participant 6).

The narratives also showed that, when confronted with socioeconomic adversities (poverty, misery,

and hunger), participants saw themselves as the heads of their family from a young age. They mentioned the need to work in childhood/adolescence, leading them to abandon school. The narrative excerpt below is an example of these findings: *Since I was young I was responsible for caring for my family because I didn't know my father. My stepfather died early, when I was very young. I had a child early, at fifteen. I married early, I worked since I was young. I was the man of the house. I had to leave school to work* (Participant 8).

From the perspective of some participants, financial trouble, added to unemployment, contributed for them to start criminal practices. For others, attempts to explain their criminal practices involved moral, religious/spiritual, and rationalistic aspects. The excerpts below illustrate these statements: *My greatest difficulty at a young age was hunger. I didn't want to see my family hunger, complain about not having food on the table. At that time it was really hard for a woman to support four children working from home. Unfortunately I was too young, nobody wanted to give me a job. So I chose steal* (Participant 3). *If I had thought a bit better I wouldn't be in a place like this. I know the "enemy" (referring to the Devil mentioned in the Bible) comes to destroy a man's life. I didn't have my guard up. Thank God I'm alive and I still have time to regret and get to the path of God, so when I die I can be saved. Going hell is no good* (Participant 6). *I got involved with bad people and went the wrong path. I always wanted to get involved with the people who used to do drugs at the corner of my house, but I always turned away. What I did, I did under the influence of another kid who was living this crooked life, I was already drunk and high* (Participant 9).

Caged bird: being a man deprived of freedom

For the participants, the experience of deprivation of freedom was lonely and discriminatory. The narratives suggest that this type of life led to separations and ruptures in social, familial, and affective bonds, both due to the isolation demanded by imprisonment, and due to the social stigma associated with the criminal practice. Loneliness emerged in reports of being abandoned by the family and having no affective bonds after becoming a part of the prison system. The excerpts below exemplify this finding: *When I fell in*

prison, I became distant from them (family). I have no contact anymore. They live far away. Even my contact with my partner was broken, I don't know where she is. I don't have any contact with my daughter even, I lost everything! No one visits me (Participant 1). It's hard. When you're free it's hard, imagine when in prison. After I was locked in, I don't even like seeing birds in a cage anymore. I know what it's like. After I was locked in, there was no more friendship, I was always alone (Participant 2).

Other narratives suggest family support during the experience of deprivation of freedom, especially from female relatives (mother, aunt, wife), as opposed to the absence of male figures (father and brother). Family support took place through in-person visits to the institution, emotional support, and a place to live: *My mom helped me a lot after I came to EPRACA. My mom is more present. We live together, me, my mom, my wife, and my two children. Nowadays my mom helps me a lot* (Participant 4). *My mom is helping me a lot, she doesn't throw it in my face, she only brings good things. She used to visit me in prison, she still visits me, she gives me support. After I get away from here I'll go to her house. My brother and my father never visited* (Participant 5).

The experience of deprivation of freedom was permeated by guilt, anger, revolt, embarrassment, resignation, acceptance of the disease, regret, and impenitence. These feelings were sometimes related with their criminal history, sometimes to the hazardous environment where the sentence was served. The excerpts from the narratives from Participants 4 and 6 are examples of this statement: *Nowadays, no, I don't think about committing crimes. I think about leaving, quitting my debt to justice and staying with my family and my children. The children can't stay without us, we have to buy things, diapers, milk, create our children. This world out there I don't want for my children* (Participant 4). *I feel guilty for my attitude. I feel really angry and revolted, I didn't want to be in a place like this. It's not the first time I've been to jail, I've been in other prisons too. I think if I thought a little longer I wouldn't be in a place like this* (Participant 6).

Often in the narratives the feeling of revolt was associated with situations of discrimination experienced due to the deprivation of freedom. To some participants this feeling made it more difficult to reintegrate in society and contributed for them

to continue a life of crime, as the following excerpt shows: *Society looks at you different, they don't see you as a normal person. They see you as a person with no self-control. When we leave it's only discrimination, they don't give you a job, they turn away. We get disappointed and continue doing crimes. We are not treated like we were anymore, not by our relatives, not by anyone. There's always that bad look. They say: "he'll never change", that you did something wrong, you're not worth anything. I did what I did and did not regret. I didn't do it for fun, I didn't do it for glory, but I did it to help my family* (Participant 8).

Time bomb: health care in the prison system

The narratives from the participants showed the feeling of vulnerability to disease and insecurity due to the precariousness and hazardous nature of the prison environment: agglomeration, violence, unhealthy diet, unhealthy work conditions, and lack of health care. For the participants, these particularities increased the risk to their safety, physical integrity, physical and mental health: *What a point! No one knows, something can happen at any time. Here there's only evil, the inmates are only evil. It's like a ticking time bomb: it can blow up or not!* (Participant 2). *When I was arrested, I learned how to use drugs. I didn't like it, but there I learned to use it a lot, it was easier to find* (Participant 6).

The deprivation of freedom in the prison environment contributed to the morbimortality in men deprived of freedom, especially when coupled with psychic suffering, with the use of psychoactive substances, accidents, and infectious and transmissible diseases: *I started coughing, I got tuberculosis. I had to treat it for six months If I depended only on the health care in the prison system... I saw a lot of people dying sick* (Participant 7). *I was working with a chemical, it hit my eye, it burned. I felt a lot of pain in the maximum security. I could only get medicine months later and because of the inmates, their families took it. I had to take a vitamin but I didn't have any of that... The food is bland, no seasoning, made on water like that you give to pigs. Not even animals are treated like this. Many inmates can't take it and die too early, many of them get insane. You just stay there, locked in with a million men day and night. When there's a lot of people together, one sick person contaminates the others and dies, if he depends on the system, he dies* (Participant 9).

There was a remarkable absence of actions of health promotion and prevention, and there were few targeted at health recovery in the prison system. In critical moments, where signs and symptoms were too strong, the absence of actions from the State to guarantee health care was made clear, forcing the family of the imprisoned to find ways to provide care.

Participants found health care in the prison system to be faulty and poor. This perception was related to the absence of health workers from the prison system, the lack of health care and access to exams: *I got coronavirus there because I couldn't get out of there nor could I be visited. They didn't do any exams to see if I got better, they simply isolated me for 15 days. Today I have no health issues, but I don't know if I have diabetes or something in my blood. There are many flaws in the prison system in the care of inmates*(Participant 9). *Since I started probation my health improved. Back in prison it was really complicated, there was no health team to care for us. Here in probation I can always get out and go to the hospital, to a doctor, schedule an appointment* (Participant 10).

The narratives of the participants also suggest they believe their health condition improved as they advanced into probation and, therefore, into a lower level of deprivation of freedom. The possibility of leaving prison and continuing serving the sentence on probation allowed them to seek health services, both due to their own initiative and to attempts to associate the prison with health services from the municipality: *If we get sick, if there's a serious issue, they call an ambulance. If we can, we go to the doctor (by themselves) and then come back to EPRA-CA* (Participants 2).

Discussion

The profile of the participants of this study is similar to that of the Brazilian prison population as a whole, which includes more than 726 thousand people, mostly young adult men (up to 29 years old), mostly brown or black, with complete or incomplete elementary education. This population has certain characteristics capable of leading to a social exclusion cycle, reiterating the selective, racist, classist, and

marginalizing nature of the Brazilian prison system. The conditions to which these people are submitted in prison show institutional violence, trouble accessing health services, and the reproduction of social injustices that reflect on health⁽⁹⁻¹³⁾.

The findings from the first empirical category show that the participants experienced social contexts characterized by elements frequently associated with crime (family dysfunction, poverty, unemployment, situations of violence, psychoactive substance abuse, peer influence, etc.). The life story of participants coincides with the history of most families who have someone deprived of freedom. They tend to be associated with economic deprivation, and a history of abandonment and violence, scarcity or difficulties accessing basic services, including health services⁽¹⁴⁾.

Deprivation of freedom was found to be an experience permeated by solitude, fear, little social support, isolation, rejection, broken family bonds, prejudice, and social stigmatization. These emotional and psychosocial aspects of imprisonment can have an impact on the quality of life and mental health of the person deprived of freedom, potentially leading to the emergence or worsening of mental disorders^(13,15).

In addition to the loneliness, the impact of deprivation of freedom includes adapting to the new rules of prison and to an experience of resignation, acceptance of the sentence, of getting busy to keep one's mental health, and becoming conscious of the gaps left by the State. When the sentence is served on probation, men deprived of freedom deal with the stigma of being a previous inmate, which leads to having little opportunity to work, and to their social identity to be disturbed, causing the return to criminal activities to once again become an alternative⁽¹⁶⁾.

Two phenomena stand out in the experience of deprivation of freedom of our participants: paternity, and the responsibility assumed by female figures to care and keep contact with the imprisoned man. The first phenomenon seems to represent a way to resist the way prison removes one's capacity of agency. The second suggests a representation that considers wo-

men as caretakers of men, and starts in childhood, through teachings passed from women to children, and are naturalized as female practices⁽⁶⁾.

The experience of deprivation of freedom had implications to the health of the participants. The prison environment was hazardous and determinant of health conditions, not only due to its unhealthy nature, but also to the fact that, there, the right to health is denied. Shortcomings in health in the prison system contributed to the morbidity and mortality among the convicted, forcing relatives to provide care to the men deprived of freedom.

The experience of deprivation of freedom took place, predominantly, in precarious, degrading environments, incompatible with the preservation of human dignity and the guarantee of health as a right. There is a consensus between scholars according to which, during the time the sentence is being served, several basic human rights are not respected. Dignity is lost, and the convicted are exposed to difficulties in accessing health services, insufficient sanitary and food conditions, overcrowding, sedentarism, violence, access and use of psychoactive substances, emotional instability, in addition to the emergence of diseases or the worsening of previous clinical frameworks^(15,17).

The universality of the constitution is not compatible with exceptions, including even of those deprived of freedom in the prison system. The restriction of the right to freedom in prisons does not include the restriction of the right to health. This population should be included in services in the health network, in or out of the prison system⁽¹⁰⁾.

The guarantee of the right to health seems to be a distant reality in this context, and, due to the precariousness and overcrowding of cells, coupled with the lack of health care, people deprived of freedom are easily affected by infectious and transmissible disease. The human immunodeficiency virus (HIV) and tuberculosis, for instance, are among the main causes of death in the prison system, despite being avoidable and having treatment available in the public health network. Nonetheless, only 0.7% of those who die

while deprived of freedom access health services outside of the prison, which shows the little integration of people deprived of freedom in the Single Health System and in the implementation of the National Policy of Integral Attention to the Health of People Deprived of Freedom⁽¹⁸⁻²¹⁾.

The results also show the perceptions of convicts regarding stress, passivity, and loneliness as important causes of suffering and psychic diseases. Elements such as hopelessness, long confinement, inability to solve problems, in addition to the use of psychoactive substances, in addition to feelings of guilt or shame due to the crime committed, are often associated with the development of mental disorders⁽¹⁵⁾.

Long sentences served in unhealthy environments with a faulty access to health care also promote the development and worsening of chronic diseases and their risk factors. We must also consider the high prevalence of dyslipidemia, sedentarism, smoking, excess weight, and arterial hypertension in people deprived of freedom. Guaranteeing the right to health in the prison environment, focusing on universal, humane, and longitudinal care, provided by an efficient, effective, and equal care network, is a public health challenge⁽²²⁾.

Reorienting the health care model in the prison system is another challenging aspect of this process of guarantee of rights. The care provided by health teams in the prison system is still based on the biomedical model and depends on the permission of security workers who, in general, are the first to listen to the complaints of the convicted. This permission for health care involves social stereotypes of danger and dissimulation often attributed to the man deprived of freedom, which can lead to the dismissal of their complaints. Psychic suffering, for example, has not been considered reason enough for the provision of health care. This shows the lack of training from health workers who seem to find a solution through the administration of medication with no criteria⁽¹⁷⁾.

Health teams in the context of the prison sys-

tem deal with a serious process of work degradation caused by complex structural and managerial processes, such as the outsourcing of workforce, occupational dissatisfaction, lack of coherent professional qualification, and shortcomings in the processes of health management. This reality has negative repercussions on the assistance offered to people deprived of freedom, and health workers often find themselves in a dilemma, having to provide the best possible care, as opposed to all the necessary care⁽²³⁾.

The National Policy of Integral Attention to the Health of People Deprived of Freedom solved some gaps left by previous decrees, and promotes healthy spaces with many different forms of professional funding and association in prison units. States and cities can choose whether to adhere to this policy. In these spaces, Unified Health System public policies are often not incorporated, showing how difficult it is for the State to recognize the right to health of convicted persons⁽¹¹⁾.

In addition to being fruitful academic topics, health rights, intersectorial dialog, integral care, and the diversity of prison units still need to be enhanced through strategic supporting actions from the government. Aligning these actions with the directives prescribed by the National Policy of Integral Attention to the Health of People Deprived of Freedom will still require overcoming challenges found in the Brazilian prison system (few human resources, precarious access to specialized services, lack of intersectorial dialog, and others), and can provide universal and integral health care, with equality and humanization⁽²⁴⁾.

Study limitations

This study was carried out during the height of the COVID-19 pandemic, making it impossible to interview men in regular prisons or in periodic detention. Moreover, considering the usually long period between the start of the prison or periodic detention, and the start of probation, relevant events of the life of deprivation of freedom may have been omitted by the

interviewees during interviews. These can be important limitations of this research.

Contributions to practice

The results contribute to raising the awareness of prison system professionals, including health workers, about the broader characteristics of the experience of deprivation of freedom. It is essential to guarantee access to health in and out of prison, reorienting the model of assistance in this setting, so multidisciplinary teams can establish therapeutic relationships with the convicted that are permeated by ethical and social values, encouraging them to express their needs and make healthier choices.

Conclusion

The experience of deprivation of freedom was characterized by ambivalent feelings related with the rupture of social and affective bonds, precarious conditions in prison, and to the social stigma related with the figure of the man who commits a crime. Results highlighted the insecurity caused by the unhealthy nature of prison, the perception of being vulnerable to disease, and the denial to the right to health in the prison environment. This context contributed to the morbidity and mortality among convicts and forced the provision of care on the part of relatives. In this setting, it is necessary to materialize integral and humanized access to health for inmates, with multidisciplinary teams sensitive to the experience of deprivation of freedom.

Authors' contribution

Conception and design or analysis and interpretation of data: Mendes FDB, Lopes ZA, Martins AM, Lima HP. Writing the manuscript or relevant critical review of the intellectual content: Mendes FDB, Lopes ZA, Martins AM, Lima HP, Amorim MF.

Final approval of the version to be published: Mendes

FDB, Lopes ZA, Martins AM, Lima HP, Amorim MF.
Responsibility for all aspects of the text in guaranteeing the accuracy and integrity of any part of the manuscript: Mendes FDB, Lopes ZA, Martins AM, Lima HP, Amorim MF.

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