Revista Brasileira de Enfermagem
REBEn
SUPPLEMENTARY EDITION 3
ORIGINAL ARTICLE

Health behaviors in sexual experiences of women in prison

Comportamentos de saúde nas experiências sexuais de mulheres em situação de cárcere

Comportamientos de salud en las experiencias sexuales de mujeres en la prisión

Karlayne Reynaux Vieira de Oliveira[I]
ORCID: 0000-0002-8920-5154

Amuzza Aylla Pereira dos Santos[I]
ORCID: 0000-0001-6299-7190

Jovânia Marques de Oliveira e Silva[I]
ORCID: 0000-0001-7452-2651

Maria Elisângela Torres de Lima Sanches[I]
ORCID: 0000-0001-8987-3825

Jessica de Melo Albuquerque[I]
ORCID: 0000-0002-9678-1387

Marianny Medeiros de Moraes[I]
ORCID: 0000-0001-8208-4268

[I] *Universidade Federal de Alagoas. Maceió, Alagoas, Brazil.*

How to cite this article:
Oliveira KRVO, Santos AAP, Silva JMO, Sanches METL, Albuquerque JM, Moraes MM. Health behaviors in sexual experiences of women in prison. Rev Bras Enferm. 2019;72(Suppl 3):88-95. doi: http://dx.doi.org/10.1590/0034-7167-2018-0092

Corresponding Author:
Amuzza Aylla Pereira dos Santos
amuzza.santos@gmail.com

Submission: 02-25-2018 **Approval:** 06-11-2018

ABSTRACT

Objective: to describe the health behaviors related to the sexual experiences of women in the female prison system from January to March, 2017. **Method:** descriptive study with a qualitative approach. A semi-structured questionnaire containing mixed questions and patient records was used. The data analysis was performed through the Bardin's content analysis and adopted as reference the Theory of Basic Human Needs. **Results:** 18 women, young, single, brown, with a complete fundamental level participated in the study. After this characterization, two categories were evidenced: Health behaviors in sexual experiences and Health care in the face of sexual experiences. 33.3% reported on health behaviors such as Sexually Transmitted Infections (STIs), 27.7% associated with male condom use, 16.6% on prevention of unwanted pregnancies, 11.1% on health care and hygiene. **Final considerations:** it was evidenced that the health behaviors reported by women in sexual experiences are associated with actions to prevent STIs, use of condoms, unwanted pregnancies, and health and hygiene care. However, it is possible to infer that they understand and possess superficial knowledge about health behaviors and that there is no adoption of regular practice in their sexual experiences.

Descriptors: Women's Health Services; Prisons; Sexuality; Health Behaviors; Comprehensive Health Care.

RESUMO

Objetivo: descrever os comportamentos de saúde relacionados às experiências sexuais de mulheres do sistema prisional feminino no período de janeiro a março de 2017. **Método:** estudo descritivo com abordagem qualitativa. Utilizou-se um questionário semiestruturado contendo perguntas mistas e consulta aos prontuários. A análise dos dados foi realizada por meio da análise de conteúdo de Bardin e adotou-se como referencial a Teoria das Necessidades Humanas Básicas. **Resultados:** participaram do estudo 18 mulheres, jovens, solteiras, pardas, com nível fundamental completo. Após esta caracterização, foram evidenciadas duas categorias: *Comportamentos de saúde nas vivências sexuais* e *Assistência à saúde frente às vivências sexuais*, onde 33,3% descreveram comportamentos de saúde como ações de prevenção a Infecções Sexualmente Transmissíveis (ISTs), 27,7% associam ao uso de preservativo masculino, 16,6% à prevenção de gravidez indesejada, 11,1% aos cuidados de saúde e higiene. **Considerações finais:** evidenciou-se que os comportamentos de saúde relatados pelas mulheres nas experiências sexuais estão associados a ações de prevenção a IST's, uso da camisinha, gravidez indesejada e cuidados com a saúde e higiene. Entretanto, é possível inferir que as mesmas compreendem e possuem conhecimento superficial acerca dos comportamentos de saúde e que não há adoção da prática regular nas suas experiências sexuais.

Descritores: Saúde da Mulher; Prisões; Sexualidade; Comportamentos Saudáveis; Integralidade em Saúde.

RESUMEN

Objetivo: describir los comportamientos de salud relacionados con las experiencias sexuales de mujeres del sistema prisional femenino en el período de enero a marzo de 2017. **Método:** estudio descriptivo con enfoque cualitativo. Se utilizó un cuestionario semiestructurado que contenía preguntas mixtas y consulta a los prontuarios. El análisis de los datos fue realizado por medio del análisis de contenido de Bardin y se adoptó como referencial la Teoría de las Necesidades Humanas Básicas. **Resultados:** participaron del estudio 18 mujeres, jóvenes, solteras, pardas, con nivel fundamental completo. Después de esta caracterización, se evidenciaron 2 categorias: Comportamientos de salud en las vivencias sexuales y Asistencia a la salud frente a las vivencias sexuales, donde el 33,3% describió comportamientos de salud como acciones de prevención a Infecciones Sexualmente Transmisibles (ISTs), el 27,7% se asocian al uso del preservativo masculino, 16,6 % a la prevención de embarazos no deseados, 11,1% a la atención de salud e higiene. **Consideraciones finales:** se evidenció que los comportamientos de salud reportados por las mujeres en las experiencias sexuales están asociados a acciones de prevención a la IST's, uso del condón, embarazo no deseado y cuidados con la salud e higiene. Sin embargo, es posible inferir que las mismas comprenden y poseen conocimiento superficial acerca de los comportamientos de salud y que no hay adopción de la práctica regular en sus experiencias sexuales.

Descriptores: Salud de la Mujer; Prisiones; Sexualidad; Conductas Saludables; Integralidad en Salud.

INTRODUCTION

Intensification of the number of people incarcerated in the world has been a situation of alert for all the institutions involved in this prison universe, especially with regard to health rights guaranteed through public policies. From this perspective, the precariousness of attention to women's health and health care in the prison setting is identified, mainly, referring to the specificities that permeate the female universe, such as the sexuality that, even in prison, they are able to experience experiences and have the right to exercise it[1].

Concerning the national panorama, data from the *Departamento Penitenciário Nacional* (DEPEN - Brazilian Penitentiary Department) (2014) reveal that the Brazilian prison population has surpassed the mark of 600 thousand persons deprived of their freedom, equivalent to a rate of 300 prisoners for every one hundred thousand inhabitants. As for the female audience, it showed a marked increase, represented by the increase from 12,925 in 2005 to 33,793 inmates until December 2014[2].

Corroborating the above data, this same report shows that Brazil has the sixth highest rate of prisoners per 100,000 inhabitants, considering the countries with a population of at least 10 million people, accompanied by the United States, Cuba and Thailand. Nevertheless, unlike those countries that have been reducing their incarceration rates, Brazil shows an increase in the imprisonment rate equivalent to 7% per year[2].

In Alagoas State, reality does not diverge from the statistics of the country. In 2014, prison population of Alagoas was equivalent to 5,785 people and in 2018 that number already reaches 7,955 people that are being reeducated. In 2007, the number of women inmates was 79, reaching 176 in 2013. According to the last report of the Prison Population published by the *Secretaria de Estado de Ressocialização e Inclusão Social* (SERIS - Social Reorganization and Inclusion Office) on February 2, 2018, this number peaked 224 women in prison at Santa Luzia Female Prison in Maceió City (EPFSL - *Estabelecimento Prisional Feminino Santa Luzia*)[3].

With the significant growth of prison population only at the end of the nineteenth century, there was a deepening of studies about the issues related to sexuality, consequently, maximizing their meaning, failing to be considered only for the reproductive aspect to incorporate pleasure as a human need and phenomenon that involves the whole existence of individuals[4].

The Brazilian Federal Constitution, in its art. 226, provides for the right to family planning, and in Federal Law 9.263 of 1996, guarantees equal rights of constitution, limitation or increase of offspring to women, men or couples, reaffirming the responsibility for family planning care and actions preventive and educational, recognizing the duty of the state to promote informative, educational and scientific conditions and resources to ensure the free exercise of this right. Regarding exercise of sexuality, Resolution 04 (06/29/2011) considers a reproductive right, constitutionally assured through legislation, of practices and policies made possible through intimate visits for men and women in deprivation of liberty, independent of the sexual orientation and should be ensured by penitentiary administrations[5-7].

Although the prison system is viewed in quantitative terms as a male universe, this should not be a reason to disregard the implementation of policies aimed at caring for women in prison. The constitution guarantees that everyone should receive health care assistance in order to meet their needs and a relationship between health promotion and prevention of diseases that may be associated with prison and its exclusion[1,8-9].

United Nations General Assembly Bangkok Rules was adopted in 2010 and have established human rights relating to motherhood, family, and women's health, including sexual and reproductive health, with a reaffirmation of countries' responsibilities for implementing laws and policies that aimed at guaranteeing the promotion and protection of human rights[10].

Women's health still presents itself as a challenge for the effective implementation of public policies, especially with regard to the guarantees of the principles of accessibility, completeness, resolution and humanization of health care provided in the Federal Constitution and in the guidelines of the Brazilian Unified Health System (SUS – *Sistema* Único *de Saúde*). Their rights are limited by the barriers imposed on the intramural experience, with numerous violations and constraints in which women in prison are exposed, producing risks, physical, psychological and moral damages[11-13].

In view of the above, the relevance of the study is justified by the need to describe the health behavior related to the sexual experience that compose the prison setting studied. The study aims to reveal the existence or not of regular health practices that may interfere in the health-disease process of the women living in this setting seeking to recognize the necessary assistance to reduce the diseases related to the diseases associated with unsafe sex.

To know them will provide subsidies to better assist them through a multidisciplinary care to encourage healthy and safe behaviors, aiming to effect the right to health and sexuality, especially when it is understood that the sexual life should be understood as a multifactorial aspect that integrates with the perceptions of social groups of specific cultures and can involve innumerable feelings and initiatives. Thus, it would not be limited to the experience of the sexual act, a condition that prison suffers multiple influences and restrictions inherent in prison[14-15].

OBJECTIVE

To describe the health behaviors related to the sexual experiences of women in the female prison system from January to March, 2017.

METHOD

Ethical aspects

Study originated from the performance of the extension project titled "*ações de cuidado* às *mulheres em situação prisional: estratégias para integralidade e equidade da assistência na promoção da saúde e prevenção de agravos*" by nursing academics of the School of Nursing and Pharmacy of the *Universidade Federal de Alagoas* (UFAL).

The authorization for the performance of the research was issued by the *Secretaria de Estado de Ressocialização e Inclusão Social* (SERIS - Social Reorganization and Inclusion Office) and by the Research Ethics Committee of the *Universidade Federal de Alagoas* (UFAL) under CAAE (*Certificado de Apresentação para Apreciação* Ética - Certificate of Presentation for Ethical Consideration).

57828516.0.0000.5013. Thus, the study was developed and the participants involved in the research were clarified as to the purpose of the research. They signed the Free and Informed Consent Term (FICT) and followed the recommendations of Resolution 466/2012 of the Brazilian Health Board (*Conselho Nacional de Saúde*). In order to guarantee the anonymity of the information, the participants were characterized according to the chronological order of the interviews, referred to by the initial letter W from "Women that are being reeducated".

Theoretical-methodological framework

The study context was anchored in Wanda de Aguiar Horta's Theory of Basic Human Needs, developed on the basis of Maslow' Hierarchy of Needs, which is based on basic human needs organized into five hierarchical levels: (1) physiological needs; (2) security; (3) love; (4) estimates and (5) self-achievement[16].

The theory is based on the fact that human beings have basic needs that can be classified into three levels: psychobiological needs (related to the physical body: oxygenation, nutrition, sleep and rest, shelter, physical integrity, sexuality, locomotion, and elimination), psychological and spiritual those that derive from the beliefs, etc.) and psychosocial (related to their coexistence with other human beings: security, love, freedom, among others)[16].

These basic needs have varied characteristics resulting from the interaction between the internal and external environment that can generate states of balance and imbalance with time and space. The adoption of health behaviors can be interpreted as universal human needs, since sex is inserted in this context directly related to existence and survival common to all individuals. However, they may have varying representations of one another depending not only on how they are manifested, but the significance that a given need represents for women deprived of their liberty, the external conditions that influence that need, and the ways in which they can be suppressed[17].

Type of study

This is a descriptive study with a qualitative approach, employing the interview technique through a semi-structured questionnaire and medical records.

Methodological procedures

Study setting

The study was developed at Santa Luzia Female Prison in Maceió City (*Estabelecimento Prisional Feminino Santa Luzia*), Alagoas State, the only state that is able to house incarcerated women.

Study participants

The sample consisted of 18 women who accepted to participate in the study during data collection period and who met the inclusion criteria: having sexual experiences in the Prison Women's Office, being able to be in provisional or already condemned prison, wishing to share their sexual experiences and behaviors prisons, in a position to respond to the questions.

Collection and organization of data

Data collection was performed from January to March, 2017. The interview technique was used through a semi-structured questionnaire/script containing 27 closed questions and 5 open questions divided into two parts: the first with questions related to social status (schooling, marital status, occupation), demographic (age, naturalness, and address), gynecological, obstetrical and sexual history. The second phase was related to the object of the study, with questions about the description and definition of health behaviors, the adoption and regularity of these behaviors in sexual activities and the description of the behaviors adopted in sexual experiences.

Data analysis

The data explicit in the characterization of the study participants was analyzed by descriptive statistics based on the percentage of relative and absolute frequencies. In order to categorize the collected data concerning the categories, they were transcribed in full and analyzed according to Bardin's Content Analysis described as a set of communication analysis techniques by systematic and objective procedures that allow the inference related to the production and reception of knowledge. In this phase, the data collected and analyzed were organized into thematic categories[18].

RESULTS

Presentation of the results of this study was divided into three moments: the first one refers to the characterization of the participants of the research that was subdivided into sociodemographic and gynecological and obstetric data; the second refers to the thematic categories *Health behaviors in sexual experiences* and *Health care in the face of sexual experiences*.

Characterization of study participants

Sociodemographic data

Regarding age group of the 18 participants, 55.5% (10) were between 18 and 24 years old, 50% (9) reported being single, 27.7% (5) married and 22.2% (4) a stable union. The number of women who were reeducated with a complete fundamental level corresponded to 44.4% (8) of them, 44.4% (8) also with incomplete elementary education and 11.1% (2) reported having completed high school. It was observed the predominance of 66.6% (12) participants who declared themselves to be brown, and 44.4% (8) declared themselves Catholic. Regarding the place of residence of the interviewees, 33.3% (6) are from Maceió City (Capital) and 44.4% (8) from different cities in Alagoas State.

Gynecological and obstetrical data

Regarding gynecological and obstetric variables, it was obtained that in relation to the menarche, 61.1% (11) reported that it occurred up to 12 years. As for the first sexual intercourse, the majority 44.4% (8) reported that occurred between 12 and 15 years. Regarding obstetric background, 77% (14) stated that they

were mothers. Regarding the number of gestations, 27.7% (5) had 2 deliveries and the same number for those who had 3 deliveries. Regarding age group of women in the period of maternity, 71% (10) reported that they were mothers for the first time between 15 and 20 years. Regarding the number of abortions, the majority 83.3% (15) reported that they never suffered abortion.

Health behaviors in sexual experiences

The study evidenced that in terms of understanding the concept or definition of health behaviors without relation to sexual experiences, 72.2% (13) of women who are being reeducated said they understood what these initiatives are.

Among the participants, 77% (10) reported adopting some health behavior at times in sexual relations, 38.5% (5) reported never having adopted and only three (23%) used behavior whenever they related, according to reports described:

> *Health behavior is that the person should have been followed up since the beginning as it is important for health.* (W014)

> *Health behavior is care with health in first place to be protected.* (W016)

Regarding health behaviors in sexual experiences, the most cited were: the practice of health behaviors aimed at the prevention of sexually transmitted diseases, not specifying the form of prevention adopted with 33.3% (6), the use of contraceptive method – condom with 27.7% (5) prevention of pregnancy associated with the only health behavior with 16.6% (3), health care in general without further explanation with 11.1% (2) and 5.5% (1) gynecological consultation with behavior, among these values, some women had more than one response, 22.2% (4) of the respondents did not define the type of behavior adopted. The described findings can be observed in the reports below:

> *I was fifteen years old and I knew all methods. I used to take pills and injections, but when I got pregnant I did because I wanted to get pregnant in the first try.* (W015)

> *I have always cared for myself, I always knew that my husband used to hang out with other people, so I was afraid of getting anything from him.* (W011)

The study revealed the understanding of those who establish homosexual relationships receive intimate visits and maintain relationships with fixed partners. They affirmed the absence of the practice of health behaviors, considering that the stability of the relationship and trust did not imply the need to prevent it, and for others, without penetration there would be no exposure to the risk of contamination, as can be verified:

> *I wear nothing, nothing comes in here, and now, what else should I prevent? I am the man of the relationship, I only mess around with them, they put nothing in me.* (W002)

> *I do not wear condom because I trust my partner. I didn't feel any pain in sex and I had a fixed partner.* (W013)

When asked about Sexually Transmitted Infection (STI), which questioned whether the woman who is being reeducated contracted STIs at any time in their lives, 16.6% (3) reported having contracted some STIs and 71.5% (13) any type of STI.

In the study, 11.1% (2) assumed to be carriers of the Human Immunodeficiency Virus (HIV) and their speeches refer to the absence of health behaviors because they understand that because HIV positive, there is no more serious pathology that could be affected, for this reason did not see the need for protection, as the speech below describes:

> *I have AIDS already, what else can I prevent myself?* (W002)

> *My husband was married to another woman that used to do drugs and had sex with other men to get drugs. She used to get injections and he must have caught it from her. I realized I had AIDS here in prison. He does not even know he has it, I still have not seen him. At the beginning I used to wear condoms with him, but not after we got married* (W018)

Regarding preventive exams, specifically, oncotic colpocitology, the study brings the total of 82.5% (15) who, at some point in their life, have already undergone the cytology exam. Of these fifteen, only 20% (3) did the exam more than two years ago and three did not remember the periodicity. Nevertheless, 60% (9) had access to the procedure within one year.

Health care in the face of sexual experiences

The justifications presented in relation to health behaviors made it possible to establish the relationship through the interviewees' speeches between the absence of behaviors and the failure or lack of health care in a comprehensive way. Women related assistance to punctual behaviors, as described in the:

> *At the day when people visit us once a month we go to the place, we get towels, soap and condom to wear it with the partner.* (W007)

> *I even think they give us condoms, so we do not get pregnant in prison and not to be one more problem, right?* (W005)

> *It's been a long time since we have got vaccinations and do those tests, but then nobody shows up. They call us and we do it without knowing the results!* (W009)

The concern with sexual and reproductive health, a factor that, for them, deserves attention because it is a physiological need that, for some, produces states of imbalance and because it is related to the psychobiological factors that are neglected in prison, a condition that significantly interferes in the experience of the period of incarceration and in the promotion of self-care, as some women in their reports:

> *I feel like being with my husband, but even for getting intimate visits is complicated, and as I am doing nothing why should I protect myself? We end up getting used to it. All we have here they deliver medicine and ointment.* (W018)

> *This situation of my husband being with someone else and me unaware of the situation. It is driving me crazy, it is all messed up in my mind and I only want medicine to sleep.* (W001)

Illness due to chronic and acute health problems also needs to be considered and receive appropriate care depending on the

level of complexity. They show an interest in receiving secondary care if the establishment's health team does not have the resources to perform, as evidenced in the reports:

> *I have several health problems. I have allergy, kidney stones, stomachache, insomnia, and these problems may be there because my husband now has someone else, then we arrive here and they make us repeat medicines.* (W006)

Most women emphasized a type of absent or even very incomplete care depending on the health care classification adopted by each. It is unanimous to recognize that they are not assisted in the way they need and deserve, the context exposed is identified by women who are being reeducated and they refer to the need as described:

> *I realized I was pregnant outside and I underwent all examinations with that equipment that shows everything. Equipment here does not show the baby's heartbeat! We do not even have the right to have an ultrasound!* (W018)

> *Even medicine, my family brings me because here there are certain medicines missing. My family brought them with my name on them and all, and I still have not got them!* (W010)

DISCUSSION

Health behaviors were described as nonspecific actions adopted to prevent STIs, the use of a male condom (condom), care for the prevention of unwanted pregnancies, and general health care that include intimate hygiene, medical consultation, knowledge of body changes and gynecological consultation. Nevertheless, it has been observed that the behaviors described are not related to the adoption of these practices on a regular basis in sexual experiences, and that certain initiatives are still small in view of the importance of these practices in women's health. In this sense, the participants' correlation with the irregularity or absence of health behaviors in the sexual experiences associated with the discrete, ineffective and negligent participation of the professionals involved in the comprehensive health care in prison was evidenced from the speeches.

Health behaviors do not represent an effective relationship with the practices adopted in sexual experiences on a regular basis, even though there are individual actions aimed at the prevention of diseases that may compromise the health of women, especially those who live in prison. General sexual health care and unwanted pregnancy associated with condom use are still small initiatives in view of the importance of these practices in women's health. Therefore, from the speeches, the participants' correlation with the irregularity or absence of health behaviors in the sexual experiences that are associated to the discrete, ineffective and negligent participation of the professionals involved in the comprehensive health care in prison environment were evidenced[19].

The present study identifies the importance of considering factors such as individuality, gender, race, age, schooling, existing affective relationships, economic factors and physical environment associated with health conditions during incarceration and the health behaviors of women in deprivation of freedom. The panorama presented, with 122 women from the Espírito Santo Prison is similar to the characteristics described in this research. It showed that the sociodemographic profile of this group is of low-income women, brown, married or in stable union, in the average age group of 30 years, with little schooling, work without qualification. As for health care, they did not use any type of contraception, despite receiving weekly intimate visits, never or rarely used condoms as a contraceptive method or for STD prevention[20].

The speeches reveal that even with the limitation of establishing a relation of previous and current health behaviors in the moment of deprivation of freedom, the fact that they are aware of the importance of health behaviors and already use some type of behavior at a certain point in life, such practice cannot be interpreted as a current and present affirmation in their experiences. This condition may be associated with unprotected sexual relations, prostitution and drug use that occur during incarceration and are conducive to behaviors predisposing to the spread of sexually transmitted pathogens[21].

From this perspective, it can be seen that access to health care for socially discriminated groups is a central aspect that allows women's family and reproductive rights to be guaranteed as strategic elements necessary for the effective fulfillment of the right to health. With regard to sexual and reproductive rights, there is not the same connotation of female prisoners as men, and this is quite clear when referring to the simple intimate visit, a right guaranteed for the male population for more than two decades and whereas in most prisons it is not ensured for women[22].

Given this assertion, the speeches made it possible to infer that there is fear, fear and insecurity of women in relation to the practice of health behaviors, considering a risk to deconstruct this relationship established with so many difficulties, highlighting the duty to recognize the universe of risk factors that women who are being reeducated are exposed when it comes to the theme of "health behaviors in sexual experiences", since the adoption or not of these behaviors is directly related to the needs inherent to the human person[22].

Considering the lack of supplying this basic human need, the establishment of amorous relationships in prison involves much broader issues that are not restricted only to the adaptation of institutional needs and rules. Social insertion in this context is a means of status between the group and an escape before the uncertainties of the future revealing a significant asymmetry between man and woman in the relations of gender and sexuality, which acts as an organizer of the sexual experiences[23].

A very different picture of male penitentiaries where the exercise of sexuality is more acceptable and informal, in these places sex has always been well tolerated, however, in female prisons sexuality and homoerotism have been repressed until recently. In this perspective, the presence of exclusionary and discriminatory traits in different spheres is reaffirmed, when sexuality is understood and made feasible as a necessity only for men where, in the male prisons, women represent a significant portion on the days of visitation, a totally contrary fact to the condition of wives when imprisoned. Not only is their partners expected to abandon it, as women themselves find it understandable that they follow with their lives[23-24].

Recurrent aspect in the speeches is the choice for homosexuality assumed in the period of imprisonment, motivated not only by institutional and bureaucratic obstacles, but by the need for

sexual and emotional satisfaction, where they share most moments of solitude, sadness and lack. For many, homosexuality is an alternative capable of meeting the need for support they would find in their husbands and companions[25].

Goffman[26] affirms that compulsory segregation exerts a powerful influence on the identity of prisoners, the acquisition of new identities in their affective and professional relationships, where the daily and social interactions of prison spaces produce new identity attributes resulting from experiences in prison. This practice can be explained through the Adaptation Law set forth in the Theory of Basic Human Needs, which considers the adaptation that the individual develops to the environment that is involved, aiming to find their maximum potential of balance[17].

Based on this condition, the study showed that women interviewed who establish homosexual relationships, where they relate the absence of health behaviors to the precariousness of qualified care, health care and poor professional orientation based on their sexual choices revealed the absence of practice of health behaviors strictly related to the sexual act. In their speech, because there was no penetration in the sexual act or contact with men, there was no risk of contamination or diseases that could compromise their health, such as STIs[19].

The recurrent speeches associated the practice or not of health behaviors in the sexual experiences with the lack of health care and the difficulty to have access to the services and examinations in the condition of prisoner, besides the shortage of eudcational activities, conversation rounds, informative lectures, reproductive planning, distribution of condoms and contraceptives, with the exception of women who receive an intimate visit, since they are the only ones who receive condoms at the time of the visit.

Nonetheless, it is worth noting that it was created according to Interministerial Ordinance 1,777 of September 9, the *Plano Nacional de Saúde no Sistema Penitenciário* (PNSSP – freely translated as Penitentiary System National Health Plan). This provides for the inclusion of the penitentiary population in the SUS, ensuring that the right to citizenship becomes effective in the perspective of human rights, in accordance with the principles and guidelines of the SUS, through joint work between the Ministries of Health and Justice. It was instituted to organize the access of the population deprived of liberty, under the State's tutelage, SUS actions and health services in a comprehensive, universal, equanimous, continuous and with quality. The ordinance provides for the structuring of Basic Health Units in prisons[27].

In this perspective, the daily reality goes through a different path from the priorities defined in the *Caderno de Atenção Básica sobre Saúde Sexual e Reprodutiva* (freely translated as Primary Care Guide on Sexual and Reproductive Health), where its actions must be based on respect for the rights of individuals, not restricted to contraception and conception initiatives, but on offer information and continuous monitoring of individuals during their sexual and reproductive life. In this way, the assumption described by Wanda Horta defines care that respects and maintains the uniqueness and individuality of the human being, glimpsing the supply of basic human needs by means of comprehensive actions where the individual can be become active element of his self-care[28-29].

Corroborating with the previous determinations, the *Política Nacional de Atenção Integral à Saúde da Mulher* (freely translated as National Policy for Comprehensive Care for Women's Health) defines that the SUS should be oriented and trained to care for women's health that contemplates the actions of promotion, protection, assistance and recovery of health, considering the health needs of the female population, guaranteeing the right to health in all life cycles respecting their specificities[29].

Therefore, care should be guided by the principle of humanization, contributing to the recognition of health care as a right that enables the women's level of information regarding their bodies and living conditions, increasing their capacity to make choices appropriate to their context and moment of life.

Contributions to Nursing, Health and Public Policy

Through this material, reality could be explored and, in this way, it aims to give visibility to the setting that women are exposed to. Through this study, it is suggested that care changes, the search for qualification strategies of the professionals involved in care for this public and that can positively influence care for women, regardless of the sexual condition and experiences lived in prison. In this way, other paths can be traversed in order to overcome such a complex challenge that is the quality of health provided, not only for those deprived of liberty, but for all those who have this right guaranteed in the Federal Constitution as citizens.

Study limitations

The limitations of the study refer to interviewers' difficulties in accessing interviews, since women, to participate in the studies, they would have to be escorted by penitentiary agents, and because there were not enough, sometimes the interviews were canceled.

FINAL CONSIDERATIONS

The present study allowed to describe the health behaviors in the sexual experiences associated to actions of prevention of STIs, condom use, unwanted pregnancies, health care and hygiene. Nonetheless, it is possible to infer that they understand and have superficial knowledge about health behaviors, and in the condition of deprivation of liberty, a high number of women who do not adopt health behaviors regularly in their sexual experiences.

There was evidence of inadequate information and knowledge about issues related to these initiatives, risks and health practices by women in prison. From their point of view, the professionals involved in the health care of the prison system have contributed to the permanence of these erroneous and harmful practices, justifying their guilt from the inefficacy of comprehensive care support, when in their daily actions they represent the health work from fragmented initiatives that do not include health promotion, prevention and recovery. Thus, care cycle may even begin at some point in the seclusion, but it is not complete. In this way, women cannot be considered as having full access to health services.

ACKNOWLEDGMENTS

A special thanks to all women in situations of deprivation of liberty in the Alagoas State, for sharing their experiences in the intimate, enabling the revelation of the critical eye developed in this research.

REFERENCES

1. Carvalho MLB, Freitas LDA. As faces e os disfarces dos presídios femininos: violações x direitos. In: XII Seminário Nacional Demandas Sociais e Políticas Públicas na Sociedade Contemporânea, 2016 Mar 19-20. Rio Grande do Sul: Universidade de Santa Cruz do Sul; 2016.
2. Ministério da Justiça e Segurança Pública (BR). Departamento Penitenciário Nacional. Levantamento nacional de informações penitenciárias – InfoPen Atualização: junho de 2016 [Internet]. Brasília: Ministério da Justiça e Segurança Pública; 2017 [cited 2017 Aug 5]; Available from: http://depen.gov.br/DEPEN/noticias-1/noticias/infopen-levantamento-nacional-de-informacoes-penitenciarias-2016/relatorio_2016_22111.pdf
3. Alagoas (estado). Secretaria de Estado de Ressocialização e Inclusão Social. População Carcerária [Internet]. Maceió; 2016 [cited 2018 Feb 20]. Available from: http://www.seris.al.gov.br/populacao-carceraria/mapa-07-11.07.2016.pdf
4. Ribeiro MAJ, Silva ICR. A saúde no sistema prisional [Internet]. Goiás: Pontifícia Universidade Católica de Goiás; 2013 [cited 2017 Jun 12]. Available from: http://www.cpgls.pucgoias.edu.br/8mostra/Artigos/SAUDE%20E%20BIOLOGICAS/A%20saúde%20no%20sistema%20prisional.pdf
5. Senado Federal (BR). Constituição da República Federativa do Brasil de 1988 [Internet]. Brasília: Senado Federal; 1988. Available from: http://www.planalto.gov.br/ccivil_03/constituicao/constituicaocompilado.htm
6. Presidência da República, Subchefia para Assuntos Jurídicos (BR). Lei nº 9.263, de 12 de janeiro de 1996. Regula o § 7º do art. 226 da Constituição Federal, que trata do planejamento familiar, estabelece penalidades e dá outras providências [Internet]. Brasília; 1996 [cited 2018 Jan 7]. Available from: http://www.planalto.gov.br/ccivil_03/leis/L9263.htm
7. Conselho Nacional de Política Criminal e Penitenciária (BR). Resolução nº 4, de 29 de junho de 2011. Recomenda aos Departamentos Penitenciários Estaduais ou órgãos congêneres seja assegurado o direito à visita íntima a pessoa presa, recolhida nos estabelecimentos prisionais [Internet]. Diário Oficial da União, no 139, 2014 July 23 [cited 2018 Jan 7]. Available from: http://depen.gov.br/DEPEN/depen/cnpcp/resolucoes/2011/resolucaono4de29dejunhode2011.pdf
8. França MHO. Criminalidade e prisão feminina: uma análise da questão de gênero. Rev Ártemis. 2014;18(1):212-27. doi: 10.15668/1807-8214/artemis.v18n1p212-227
9. Nicolau AIO, Ribeiro SG, Lessa PRA, Monte AS, Bernardo EBR, Pinheiro AKB. Knowledge, attitude and practices regarding condom use among women prisoners: the prevention of STD/HIV in the prison setting. Rev Esc Enferm USP. 2012;46(3):707-14. doi: 10.1590/S0080-62342012000300025
10. United Nations (UN). United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules) [Internet]. Geneva: UN; 2010 [cited 2018 Feb 21]. Available from: http://www.ohchr.org/Documents/ProfessionalInterest/BangkokRules.pdf
11. Ventura M, Simas L, Larouzé B. Maternidade atrás das grades: em busca da cidadania e da saúde. Um estudo sobre a legislação brasileira. Cad Saúde Pública. 2015;31(3):607-19. doi: 10.1590/0102-311x00092914
12. Presidência da República, Subchefia para Assuntos Jurídicos (BR). Lei nº 8080/90, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências [Internet]. Brasília; 1990 [cited 2018 May 18]. Available from: http://www.planalto.gov.br/ccivil_03/leis/l8080.htm
13. Diuana V, Ventura M, Simas L, Larouzé B, Correa M. Women's reproductive rights in the penitentiary system: tensions and challenges in the transformation of reality. Ciênc Saúde Colet. 2016;21(7):2041-50. doi: 10.1590/1413-81232015217.21632015
14. Araújo IA, Queiroz ABA, Moura MAV, Penna LHG. Social representations of the sexual life of climacteric women assisted at public health services. Texto Contexto Enferm. 2013;22(1):114-22. doi: 10.1590/S0104-07072013000100014
15. Melo GC, Trezza MCSF, Reis RK, Santos DS, Riscado JLS, Leite JL. Behaviors related to sexual health of people living with the Human Immunodeficiency Virus. Esc Anna Nery. 2016;20(1):167-75. doi: 10.5935/1414-8145.20160022
16. Leopardi MT, Wosny AM, Martins ML. Teorias em enfermagem: instrumentos para a prática. Florianópolis: Papa-Livro; 1999.
17. Horta WA. Enfermagem: teoria das necessidades humanas básicas. Rev Enferm Novas Dimens. 1979;5(3):133-6.
18. Bardin L. Análise de conteúdo. 70ª ed. Lisboa; 2011.
19. Miranda AE, Merçon-de-Vargas PR, Viana MC. Saúde sexual e reprodutiva em penitenciária feminina, Espírito Santo, Brasil. Rev Saúde Pública. 2004;38(2):255-60. doi: 10.1590/S0034-89102004000200015
20. Brewer TF, Derrickson J. AIDS in prison: a review of epidemiology and preventive policy. AIDS.1992;6(7):623-8.
21. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Maternal and child health in Brazil: progress and challenges. Lancet. 2011;377(9780):1863-76. doi: 10.1016/S0140-6736(11)60138-4
22. Ferrari IF. Mulheres encarceradas: elas, seus filhos e nossas políticas. Rev Mal-Estar Subj [Internet]. 2010 [cited 2017 Apr 12];10(4):1325-54. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S1518-61482010000400012
23. Cordeiro F. Criminalidade, gênero e sexualidade em uma penitenciária para mulheres no Brasil. Trivium. 2017;9(1):1-15. doi: 10.18379/2176-4891.2017v1p.1

24. Heilborn ML. Corpos na cidade: sedução e sexualidade. In: Gilberto Velho (Org). Antropologia urbana. Rio de Janeiro: Jorge Zahar; 1999: 96-102.

25. Oliveira MGF, Santos AFPR. Desigualdade de gênero no sistema prisional: considerações acerca das barreiras à realização de visitas e visitas íntimas às mulheres encarceradas. Cad Espaç Fem [Internet]. 2012 [cited 2017 Dec 14];25(1):236-46. Available from: http://www.seer.ufu.br/index.php/neguem/article/view/15095

26. Goffman E. Prisões, Manicômios e Conventos. São Paulo: Perspectiva; 1996.

27. Ministério da Saúde (BR). Secretaria de Atenção à Saúde. Departamento de Ações Programáticas Estratégicas. Plano Nacional de Saúde no Sistema Penitenciário [Internet]. 2ª ed. Brasília: Ministério da Saúde; 2005 [cited 2018 May 27]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/plano_nacional_saude_sistema_penitenciario_2ed.pdf

28. Ministério da Saúde (BR). Manual de Controle Doenças Sexualmente Transmissíveis DST [Internet]. Brasília: Ministério da Saúde; 2013 [cited 2018 May 27]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/manual_controle_das_dst.pdf

29. Ministério da Saúde (BR). Política Nacional de Atenção Integral à Saúde da Mulher: princípios e diretrizes [Internet]. Brasília: Ministério da Saúde; 2011 [cited 2018 May 28]. Available from: http://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_mulher_principios_diretrizes.pdf