

## Childbirth and pregnancy in prison: social belonging and vulnerabilities

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**Abstract** *Pregnancy and childbirth in prison can intensify power relationships and mechanisms that encourage inequality in care provided to women and children, with adverse consequences for the lives of both. This issue gave rise to research to understand women's experiences of pregnancy and childbirth in prison. Method: working from theoretical perspectives that address intersections among race, gender and social class, this qualitative study was conducted by interviewing women who had left a penitentiary in southern Brazil. The participants, mostly young, black women, reported being subjected to situations of violence from the first approach by the police. Once deprived of their freedom, they were subjected to humiliation, deficient access to health, as well as psychological and moral violence. The experience of childbirth was permeated by institutional violence and feelings of loneliness and helplessness. Noncompliance with legal provisions, reproduction of violence in relations with security agents and systematic neglect of social and health needs are additional effects of the gender, race and social class oppressions that affect pregnant women and nursing mothers in prison.*

**Key words** *Women, Violence, Prisons, Maternal health*

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## Introduction

Growing rates of imprisonment of men and women are a world trend. The International Centre for Prison Studies, a non-governmental organisation that monitors imprisonment figures worldwide, reports that Brazil has the world's fourth-largest prison population and ranks first among Latin American countries<sup>1</sup>.

Brazil's Penitentiary System Statistical Information System (Infopen) shows that women's situation deserves special attention. Since the early 2000s the total number of women in prison in Brazil has increased more than 600%, resulting in an occupation rate of 118.8%<sup>2</sup>.

Brazil's growing prison population has become a priority concern on both the human rights and public health agendas. This stems from the Brazilian State's being a signatory to the Bangkok Rules approved in 2010 by the United Nations General Assembly. Those rules establish an international ethical and legal consensus on the treatment of women in prison situations. They thus constitute a response to conditions that assault the dignity of women as mothers and reassert countries' responsibility for urgently implementing laws and policies to promote human rights<sup>3</sup>.

There is a consensus that the effects of imprisonment on women's lives and health differ from those suffered by men in the same situation, especially if they are experiencing pregnancy. Many are the guardians of their children and responsible for the financial upkeep of the household. In such situations, the family is impoverished even more by their imprisonment and it comes to need restructuring<sup>4</sup>.

This study in a women's penitentiary in a state capital in southern Brazil examined the meanings involved in the imprisonment of women experiencing pregnancy and childbirth in this environment and the impact of those experiences on their health and lives and on those of their children. This set of problems involved the mechanisms that foster inequalities in the care provided to these women. An intersectional gender perspective was deployed as an analytical category, because the interpersonal and institutional interactions reproduce extreme forms of oppression and violence already deep-rooted in the experiences of black women<sup>5-10</sup>.

With these considerations, the study aimed to understand women's experiences of pregnancy and childbirth in prison situations.

## Method

The methodology chosen was exploratory, descriptive, qualitative and grounded in theoretical perspectives that focus on intersections among gender, race and social class<sup>5-10</sup>. The study setting was municipalities in the state of Rio Grande do Sul, where the former women inmates had their domiciles. The inclusion criteria for participants in the study were: women who had experienced pregnancy and childbirth in the prison system and who were mapped by the health department of Rio Grande do Sul, a state in Brazil's South Region. Any impediment on the women's part to receiving the researcher's visit for interview was considered an exclusion criterion.

Data were collected from in-depth interviews in the second half of 2018, during which period 10 women were located by the health department mapping. Of these, it was possible to contact eight by telephone in order to invite them to participate in the study. One of them refused to take part, leaving a total of seven interviewees. The data collection instrument was developed so as to provide a sociodemographic characterisation and a narrative produced around the question: "What was your experience of pregnancy and childbirth in prison like from the moment you arrived through to when the baby was born?"

Data production was hindered directly by the impossibility of accessing the women inside the penitentiary, a problem that was solved by the strategy of recruiting former women inmates of the prison system at their place of residence. That strategy also proved complex, however, because there are practically no health projects and services that monitor women and children after leaving prison and provide data on their whereabouts. Once the access problem was solved, telephone contact was hindered by the women's changing number after leaving prison. When the researcher managed to make contact, she had to surmount difficulties in accessing the residences, which were located in peripheral areas dominated by the drug traffic or in remote towns entailing up to five hours' travel. It was always the researcher who travelled, taking with her the consent forms, a digital recorder and a mobile phone. The researcher was well received by all the women. The conversations were exhaustive and lasted up to two hours.

The interviews were recorded in full and transcribed. The data collected were organised using NVIVO® 12. The thematic analysis applied was that proposed by Minayo<sup>11</sup>, which is char-

acterized by three stages. In line with that technique, the data treatment procedure began with a preliminary analysis of the material collected. At that stage, a free-floating reading was made of the content of the interviews. This establishes a first contact with the material, permitting preliminary orientations as to interpretation. The subsequent stages, exploration of the data and treatment of the results, enabled core meanings to be identified and grouped by similarity among ideas and representative responses traced out in order to compose thematic categories<sup>11</sup>.

The study was approved by the research ethics committee of the Federal University of Rio Grande do Sul (CAAE: 84643518.0.0000.5347) and met the requirements of National Health Council (CNS) Resolution No. 466/2012 on research with human subjects. A free and informed consent form was used and participant anonymity was guaranteed by replacing identifying information by the names of Latin American women who have made a mark on recent history by their struggles for women's rights and dignity.

## Results and discussion

From the outset, the theme of pregnancy and childbirth in prison posed the need to obtain theoretical input from the field of gender and health studies<sup>10</sup> in order to understand the relation between, on the one hand, the health disorders affecting the women and, on the other, behaviour suppressing their freedoms and violence against their bodies. On considering the study participants' sociodemographic characteristics and other life-history information (Chart 1), it became obvious that the discussion had to be broadened by studying the intersections among race, gender and social class as components of the women's vulnerability in a prison situation.

To complement this information: two of the women had been released and five were under home detention – two of them with electronic tagging (anklets). Five had incomplete lower secondary schooling, one had incomplete upper secondary schooling and one had incomplete higher education. Their crimes were typified as follows: five were arrested for crimes connected with drug trafficking and two for crimes against life. Five were pregnant when imprisoned and three were pregnant in prison for the second time.

The study participants' sociodemographic profile accords with studies and reports<sup>2,12</sup> on the predominant characteristics of Brazilian wom-

en pregnant in prison: 70% are self-reported to be black, 56% are single, 48% have 1 to 7 years' schooling and 62% are imprisoned for involvement with drug trafficking. Seen from an intersectional perspective, that situation updates the understanding of the feminisation of poverty, racial and gender discrimination, the social effects of the criminalisation of drugs and the penal system's role in basing its practices on control over women's bodies, thus perpetuating social injustices<sup>5</sup>.

Historically, the gender focus, as a sociological construct and as an analytical category, has driven the understanding that, underlying oppressive behaviour against women are a set of social norms compelling them to adopt behaviour compatible with certain roles in society; otherwise, they become targets for moral harassment and misogyny<sup>13</sup>. As regards black women, other references point to a discursive practice committed to exposing the social and historical conditions that determine differentials in the social inequalities they experience. In the origins of American and Brazilian racism, for instance, the racial inferiority argument served as justification for slavery. This imaginary was engendered so powerfully that over time it has determined the pressure of poverty and institutional, political and social inequalities and injustices in the life courses of these groups<sup>6,7</sup>.

Calls for social justice for black women thus run through this history, because the priority demands of their lives involve situations of unemployment affecting them and their partners, a lack of opportunities to build a professional career and unjust treatment for their children<sup>6,7</sup>. Specifically as regards health, the reasons for concern include vulnerabilities that arise out of inferior access to, and quality of, health care as a result of institutional racism<sup>14</sup>.

In contemporary times, the notion of health vulnerability is designed to show that greater or lesser susceptibility to health disorders is related to the conditions available to individuals to protect themselves, within the scope of what they can manage to do for themselves and of the social rights guaranteed by governments<sup>15</sup>. That conception has clarified an important issue regarding the processes that increase the vulnerability of certain groups that are relegated for being women, for the black colour of their skins and for having a less highly regarded economic position in society. When overlaid, these categories produce a synergy of social inequalities and amplify these groups' disadvantages in caring for them-

**Chart 1.** Study participants' life history information.

| Participants              | Characteristics   |
|---------------------------|---|
| Claudia Ferreira da Silva | Woman, 42 years old, black, married, two daughters, unemployed. Enjoying freedom for the first time after 16 years in prison  |
| Elza Soares               | Woman, 38 years old, black, eight children, single, unemployed. At liberty with electronic ankle tag, caring for her eight children and two nephews   |
| Marielle Franco           | Woman, 34 years old, black, five children, single, unemployed. Caring for her sick father and two children on her own. Fighting to regain custody of three children that she lost when she was imprisoned   |
| Frida Kahlo               | Woman, 32 years old, white, three children, single, unemployed. Trying to rebuild her life, staying at the house of a friend she met in prison, because all her family ties were severed. Fighting for custody of two of her children. After the study, Frida was imprisoned again  |
| Carolina Maria de Jesus   | Woman, 27 years old, black, married, two children, unemployed. Using electronic ankle tag, waiting anxiously to see her oldest child, who was living with her ex-husband and whom she had seen only a few times during her time in prison. Carolina lived in an urban squat an hour and a half from the centre of the town, where she spent her days alone in a one-room house with her youngest daughter |
| Ivone Lara                | Woman, 22 years old, black, single, one daughter. After her first term in prison, was trying to make a life in a small town, where she was staying at a friend's house. One day before the interview, she had received the news that her home detention had been revoked (requiring her to return to prison)  |
| Maria da Penha            | Woman, 40 years old, white, single, two children, working informally. Waiting for court decision on the death of one of her daughters, which occurred after childbirth in prison (which she underwent alone, with no companion). After the study, Maria was arrested again  |

Source: Authors.

selves<sup>16</sup>. One of the most significant outcomes of this process of moral rejection and heightened social vulnerability is that it brings violence into the present as an experience that degrades dignity and the chances of prospering in life and of maintaining health<sup>17</sup>.

Three thematic topics produced from the specificities of the study participants' experiences revealed violence to be a flagrant trait of processes grounded in social belonging that sustained and heightened the vulnerability of black women from peripheral areas who were involved with crime.

### **Imprisonment and pregnancy: experiences of violence in prison and outside**

This section will describe the women's initial interactions with the police, their arrival in prison and the accommodation provided for women early in pregnancy.

The police approach that occurred at the time of their arrest – either at home or on the street – constituted the first intense moment of violence. That moment was marked by physical aggression, value judgements and scornful atti-

tudes to the women. Even though they were still only suspects, they were treated as guilty, which consequently triggered violent, punitive attitudes to the possible offence: "They took me to a room and tortured me: they laid me on a bed with a towel over my face and poured water from a five-gallon bottle" (Ivone Lara). "The policeman with a bag started to suffocate me, held it firmly and wound it up so no air would get in. My father said to the policeman: She's pregnant! He replied: Then it's now that she's going to have it (the baby)!" (Marielle Franco). "They said that, unless I collaborated, they were going to send my children to a shelter and call the child protection authorities and that I would lose the children!" (Frida Kahlo).

Prison amplified the vulnerabilities observed in the study participants' life histories and was probably one of the most critical events in their life trajectories. The analysis demonstrated that many of them underwent repeated bullying and they reported that episodes of threats, abuses, violence, abandonment and neglect were common at the time of the first approach by the police and in prison. These situations left them physically, mentally, socially and economically more fragile,

because they constituted double punishment, considering their condition as black women<sup>18</sup>.

Examination of the specific situations of the women who participated in this study revealed that violence, expressed in different contexts and forms, was a forceful phenomenon in the experiences of pregnancy and childbirth in prison – from the original event of the arrest, which included acts of torture by threat and suffocation, through to other forms expressed by exposure to psychological violence and negligence.

Arrival at the penitentiary was notable for the need to demonstrate and confirm pregnancy, because this, in the women's view, would ensure them greater protection both as regards antenatal health care and in dealing with possible conflicts with women connected with other criminal factions. Accordingly, on arrival, the women requested access to the prison's primary health care clinic to have the pregnancy rapid test: "I arrived and had the pregnancy test. They saw that I was pregnant and I went to the hall [an area where only pregnant women may circulate and stay]" (Ivone Lara). "They sent me there for screening and I explained how serious my pregnancy was. I had all my test results, the antenatal record card. Just as well I had my bag when I was caught" (Frida Kahlo). "I entered the prison in fear of the faction. Fear of going up to the gallery [a common area for all inmates]. On the day of the test, I asked God 'May I be pregnant', that way I won't have to go up to the gallery" (Marielle Franco). "[...] I said: I don't want to stay here, I'm pregnant!" (Elza Soares).

Proof of pregnancy guaranteed the women accommodation in the "hall", one of the specific areas for pregnant women in the penitentiary. Although the women who want to remain with their children after childbirth are referred to a penitentiary that has a mother and child unit (*Unidade Materno-Infantil - UMI*), which is supposed to be suitable accommodation, the women reported that this place too lacked infrastructure. That situation led them to stay on longer in the hall, a place they described as unhealthy and unsuited to a pregnant woman's minimum needs.

In the hall, their experiences included sleep deprivation, irregular food and fear of contracting diseases from the hygiene conditions in the place. In addition, the health care was insufficient, given that the interviewees reported difficulties in accessing vaccines, ultrasound examinations and blood tests and antenatal care. The women felt that their basic health needs went unmet: "It's horrible in the hall for pregnant wom-

en! There are eight beds in a small space. When more come in, they lay on the floor, they piled up there. There's only one window, no ventilation. You woke up in the morning and it smelled of cat pee" (Ivone Lara). "There's nothing in there, it's a long way from everything, you have to shout out for any care, ask for help" (Claudia Silva Ferreira).

The structural violence that is expressed on the bodies of pregnant women in prison or who stay with their children in the penitentiary includes everything from unmet basic needs and poor infrastructure conditions through to crueler, more insidious situations. Those situations annihilate them socially and reduce their children's opportunities for psychological and social growth and development<sup>19</sup>.

The deprivations included what the participants considered poor quality food, coinciding with what was already known about motherhood in prison<sup>20</sup>. Food is a right that applies not only to the act of eating, but to adequate quantity and quality. Another type of privation that the women reported related to the conditions for rest and sleep. Many complained that they spent weeks of their pregnancy in the penitentiary sleeping on the floor in overcrowded and unhealthy cells.

The women reported diverse forms of humiliation by prison guards. There were times when the expressions of derision were more aggressive in response to requests for something that they needed. Other moments were notable for attempts to lower their spirits by reference to stereotypes relating to being in "jail" and having an "unwanted pregnancy": "Instead of asking us what we want, they say: 'Be quiet, shut up! No-one's going to see you now! No-one's listening'" (Claudia Silva Ferreira). "When I called, they said: 'How many times have you been to jail? They've given up on you. We didn't say you're pregnant. Even I didn't want to believe you're pregnant'" (Elza Soares).

The psychological violence that the women reported, the offences and attempts to break their morale, aggravated their feelings of loneliness, fear and abandonment. The peculiar manner in which hostility was expressed in the prison and the neglect of the pregnant women's physical and emotional needs is a situation that calls for an analysis of misogyny in prison. In that context, many types of gender violence that exist in the environment outside prison are reproduced inside, but in still more brutal and unjust form<sup>21</sup>, because there is no possibility of self-defence. It is also stressed that, in some cases, the prison guards

themselves cause the friction, either because staff reductions make it harder to meet demands or influenced by the reproduction of discourse that holds women to be inferior<sup>22</sup>.

From imprisonment to accommodation in the prison “hall”, normally corresponding to the first and second quarters of pregnancy, violence forms part of the women’s daily lives. That situation takes on other forms over the course of pregnancy in prison, as described below.

### From detainee to “Mummy”

Under the influence of admission to the mother-and-child unit (UMI), the women begin acquire new attributes. There is a shift in their status, from “prisoners” to expectant mothers or “Mums”, a term commonly used by prison and health personnel in this environment.

This new identity leads to changes in the care the women receive, especially as regards a reduction in violent episodes. In this space, they go through the period of pregnancy when their abdomen is more prominent, signalling more explicitly that they are gestating. It is in these circumstances that the “Mum” identity emerges. They will continue to be referred to this way as long as they are pregnant and after their children are born. The notion prevalent among the women was that it was only in the UMI that they had access to certain services and care that previously had been neglected: “It was in the UMI that I started to get a bit more help. There was a social assistant, a psychologist, because in the gallery, they couldn’t care less” (Frida Kahlo). “I went to the UMI and it was only there that I met the doctor who looked after me” (Maria da Penha). “When I went to the UMI was when I was treated better” (Carolina Maria de Jesus).

The context of violence left a strong imprint on the women’s experiences, although some reports drew attention to a shift in focus, particularly relating to their pregnant condition. Many of them reported feeling more respected and better treated as their pregnancy became more apparent. At that point, the privations and aggressions they had been suffering were attenuated to some extent, a phenomenon probably associated with a view that prioritises protection for the unborn children rather than a concern for the women’s needs<sup>21</sup>.

Previous studies<sup>9,21,23</sup> that have identified this change in the pattern of care for pregnant and nursing mothers over the course of their stay in prison have pointed out that, while on the one

hand they are given more support, on the other, there are strict demands that they fulfil their role as mothers properly. One of these studies noted that these women’s vulnerability and their psychological and moral suffering were related to the pressure on them, which intensified in their interaction with the characteristic disciplinary mechanisms of the prison system and the self-control measures that the women were expected to take so as to provide care and protection for their children<sup>9</sup>.

Even in the UMI, a unit whose purpose is to house and provide care for pregnant and nursing women and their children, the women reported how limited the health services were. They stressed that there were too few antenatal appointments and difficulties in accessing the outside health system for tests, vaccines and appointments with specialised services. In addition, they highlighted the security obstacles (lack of staff and escorts) that arose in the logistics of transporting the women to the health services: “The doctor told me that she didn’t know how to deal with a high-risk pregnancy and asked them to take me for treatment outside, if possible, but they took a long time to do it, because we depended a lot on the escort, which was never available” (Frida Kahlo). “They were very unlikely to call me in for appointments [...] and I had discovered right at the start that it was a high-risk pregnancy” (Maria da Penha). “There wasn’t always a car and guard to go to the appointments [...] If there wasn’t a guard to stay behind in the prison, then we wouldn’t go to the appointment” (Carolina Maria de Jesus).

At childbirth, the violence took the form of aggressive and hostile attitudes on the part of security and health personnel, who raised obstacles to humanised procedures that would safeguard the women’s and children’s dignity. A review of the scientific literature revealed that the weaknesses in the care offered to women who are pregnant and have their children in the prison system not only result in harm to the health of the mother-and-child dyad, but raised the rates of maternal and neonatal morbidity and mortality<sup>19</sup>.

More favourable conditions were experienced in the final three months of pregnancy in prison. Once pregnancy was an established fact, the women’s status became that of mothers, which resulted in less exposure to situations of violence and better, albeit still limited, care for their health demands. Borderline experiences of violence began to re-emerge in the women’s accounts at the time of childbirth in the prison situation.

### Childbirth: violence and loneliness

Labour was seen as painful and anguished, not only because of the physiological characteristics of the condition, but also because of the degrading state of the care offered, extending from the transport from the prison unit through to conditions at the health institution. The interviewees produced reports of their own experiences and those of other women with the complicity of having shared the same hostilities, privations and neglect.

In prison, the progress of labour is monitored by the personnel of the primary health care unit, who evaluate when the women should be referred to the maternity facility. During the night shift or at weekends, it is the prison guards who – although lacking the professional prerogatives for the purpose – monitor the women and decide when to refer them to a health institution: “I called the guard and waited, because they didn’t think I was going into labour yet. Then I started to feel a lot of things. We started to shout out and the guards came and took me to the hospital” (Ivone Lara). “I went to the toilet and saw that there was a lot of blood. I told the guards and they took me” (Frida Kahlo).

The women acknowledged childbirth to be a time of great anguish and loneliness, even for those who felt they were receiving care. With no companion that they had chosen to go with them and often unable to inform them of the situation, the women were accompanied by prison guards. Although it is legally prohibited to use handcuffs in labour and childbirth, participants did report this practice on the way from the prison to the health institution: “No-one could go with me. They didn’t notify my family until after I had come back to the prison! I felt very alone! I was afraid, because it was a very risky birth” (Frida Kahlo). “Handcuffs? Yes! Whenever you go outside the prison, they handcuff you, whether it’s for a vaccine, appointment, to give birth..., handcuffed!” (Ivone Lara). “The escort was two men [...]. They slept with me there in the hospital! Very embarrassing, even when I was breastfeeding, they kept looking at my breasts” (Carolina Maria de Jesus).

The women perceived the treatment offered by the team at the health institution in different ways. Some praised it and were grateful to the health personnel who accompanied them during labour and the hospital stay. Others reported being treated with indifference, negligence and violence. However, even the women who praised the

care mentioned being stigmatised at some point: “In the hospital, it was incredible! The doctors always treated me well. I had done the other children’s antenatals there before, even though I was a prisoner” (Frida Kaho). “How they treat a person imprisoned at the hospital is totally different. They treat you as if you were rubbish! I was mistreated in there!” (Cláudia Silva Ferreira). “There are some that treat you with real indifference, they wouldn’t even talk to me. Because you’re in prison, you are the trash of society! Everyone sees you as a bad person” (Ivone Lara).

Violence during the process of childbirth has been an issue of mounting interest, given the significant number of reports and complaints in Brazil in recent years<sup>23-25</sup>. This integrative literature review indicated that the context ranges across situations expressed in acts of negligence, abuse, imprudence, omission, discrimination and disrespect<sup>23</sup>. These acts are committed primarily by health personnel, either in public or private, and are grounded in relations of power and authority over the women’s bodies or sexuality. The most affected by the problem were poor and black women, which converges with the profile of women who undergo pregnancy in prison. Vulnerability to the various different forms of obstetric violence increased among the group of women who belonged to ethnic minorities, were teenagers, were poor, had little schooling, had needs resulting from drug use, were living on the streets, had had no antenatal care and had no companion at the time they were treated<sup>12</sup>.

Their accounts also revealed a lack of attention to childbirth best practices and the use of interventionist measures to accelerate delivery. Prominent among these were the lack of a companion, the woman’s not being offered analgesic or non-pharmacological methods of pain relief, not being offered food during labour and repeated digital vaginal examinations without any need or technical criterion to justify them<sup>26</sup>:

*They insisted I have a normal delivery, and my twins were in the same placenta and one was turned and the other, sitting. On the day I went to the obstetric centre, they saw I wasn’t dilated. They stuck a finger into my cervix to open it anyway [...]. They pushed her back into my belly and took me for an emergency caesarean! After she was born, I didn’t even see her. I didn’t see her until the afternoon! They left me alone! The other one, I didn’t even see until after she had died!* (Maria da Penha).

*As soon as I arrived, they started inducing labour. I shouted and shouted! Called for help! They were doing digital vaginal examinations all the*

*time, the [male] doctor, the [male] nurse [...] they broke my waters, the sheet got covered in blood and me yelling in pain [...] They closed the door and left me alone with the guards in the room* (Claudia Silva Ferreira).

The scenes described and experienced by the women in childbirth in the prison context are extremely dramatic. In Maria da Penha's gestation of twins, a case that involved the death of one of the babies, there was no investigation of imprudence or negligence on the part of the health and security personnel in attendance. These episodes may be considered yet another indication that obstetric violence culminates in contexts where care is rougher and more humiliating when provided to poor, black women in situations of imprisonment<sup>25</sup>.

In the debate over the imprisonment of women who are pregnant or nursing, progress has been made towards recognising the factors that increase the risk and recurrence of involvement with crime, such as sexism, racism, low educational/economic level and a background of trauma and adversities. The women's interviews reveal manners of interaction with the health and public security sectors that do not foster conditions favourable to the women's protection, thus disclosing the pressure exerted by the factors mentioned above in these institutions to distort their functions when black women are involved. Given the evidence, it is appropriate here to state the concept of institutional racism as

*the failure of institutions and organisations to provide a professional service suited to people as regards their colour, culture and racial or ethnic origin. It is manifest in discriminatory rules, practices and behaviour in day-to-day work, which are outcomes of racial prejudice, an attitude that combines racist stereotypes, carelessness and ignorance*<sup>27</sup>(p.22).

In spite of efforts to embrace practices that are more humanised and designed to surmount institutional racism, little progress can be seen in dismantling systems that contribute to an unequal proportion of black women's suffering degrading experiences of pregnancy and childbirth in prison<sup>26</sup>. In these systems, the ensemble of oppression and violence, such as related here, demands interpretation from an intersectional perspective. In that regard, the concept of intersectionality presupposes dealing not with different groups of people, but undertaking analysis based on the overlap of certain personal characteristics. Accordingly, at the centre of the intersection among being a woman, a black person

and a poor person are women with darker skins, whose civil and human rights tend to be most disrespected<sup>8</sup>.

It is believed that, by considering the intersectionality among factors driving social inequalities along a trajectory of vulnerability for women who experience childbirth and nursing in prison, it is possible to instrumentalise better to address the violence that they suffer in that context. Programme strategies concerned with protecting and providing care for these women and their children will be successful to the extent that they manage to deconstruct the moral reasons and stigmatising content that influences the conduct of agents of State with regard to this public and unveil the mechanisms that reinforce inequalities of gender, race and social class.

## Final remarks

The experiences of pregnancy and childbirth of women in the prison system are permeated by violence that aggravates their social and health conditions and potentially those of their children. Despite legal frameworks designed to guarantee minimum conditions for the treatment of women in prison situations, the security system seems to be a mesh that is impermeable to human rights and gender equity. Note that the women in this study acknowledged the good work and positive attitudes of some security professionals and health service workers, which demonstrates that it is possible to transform prison by building on care practices that mitigate the oppression and violence that women suffer.

The challenge posed by the findings of this study is that it is not enough to identify the violence that women suffer in prison during pregnancy, childbirth and nursing. It has to be understood what sustains that structure and what institutional mechanisms should be activated to bar the phenomenon. In that regard, prison is a reflection of a sociocultural context marred by the intersectionality among racism, sexism and social class inequalities, in a process that, for poor, black populations from peripheral urban areas and for women, intensifies and expands exposure to State violence, omission and negligence.

Note particularly that the State should play a fundamental role in guaranteeing rights, because it is responsible for fostering and implementing public policies committed to justice and social protection. In such a scenario, health services and

health sector workers have a central role to play in combating all types of violence perpetrated against women, because they constitute an appa-

ratus that is available inside prisons and can intervene with inclusive, humanised care practices for these people.

### **Collaborations**

G Dalenogare worked on data collection. G Dalenogare, LB Vieira and R Maffaccioli worked on study design; data analysis and interpretation; discussion of results. LB Vieira, R Maffaccioli, DL Riquinho and DF Coelho worked on writing and/or critical review of the content; review and final approval of the final version.

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