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Paths and inter-mediations between Brazilian Health Services and Youth Detention Centers

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Abstract *Socio-education is an educational and (re)socialization proposal for young people having troubles with the law, a law which also includes the right to health care guaranteed by the Unified Health System (SUS). This study aims to investigate the relationship between health services and socio-educational units in Paraná state, from the perspective of service workers and managers. The qualitative and exploratory research consisted of sixteen semi-structured interviews in five municipalities in the state, with subsequent categorization of the narratives based on hermeneutic analysis. As a result, there was considerable weakness in the coordination between the network's facilities to promote overall health care, specifically the mental health of young people. Security issues have a strong influence on the regulation of actions, even health actions, in socio-education. The current policy of comprehensive health care in socio-education, implemented in Brazil in 2014, is, however, an important counterpoint for the reordering and nudging policies in this area.*

Key words *Health of Institutionalized Adolescents, Incarcerated persons, Health Services*

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Introduction

Present child and adolescent care is the result of historical transformations. Social welfare and health care policies, as well as the legal understanding of adolescents as subjects of rights are relatively recent constructs, aligned with the re-democratization movements.

Socio-education, like the Unified Health System (SUS), emerged in Brazil at the end of the 1980s, together with drafting of the Federal Constitution. Based on the Statute of the Child and Adolescent (ECA in the Portuguese acronym), whose guideline is the Doctrine of Comprehensive Protection of Children and Youth[1], it consists of a proposal to replace the punitive and coercive model with an educational path and (re)socialization of young people in conflict with the law[2,3]. Socio-educational measures are applicable to offenses – conduct considered to be crimes or misdemeanors – while internment (deprivation of liberty) is an exceptional measure, i.e. only applicable in cases of serious threat or violence to the person or as the last viable alternative after all previous possibilities have been exhausted[4].

With regard to the right to health, the ECA and the legislation of the National System for Socio-Educational Assistance (SINASE in the Portuguese acronym) guarantee access to health. In this sense, full access to comprehensive child and adolescent health care through the SUS is provided for as a right of adolescents in socio-educational measures, considering all spheres of health care, either health promotion, protection, prevention or recovery, in accordance with the principles and guidelines of the SUS[4,5].

These prerogatives are made possible through the National Policy for Comprehensive Health Care for Adolescents in Conflict with the Law, in Internment and Provisional Internment (PNAISARI in the Portuguese acronym), which seeks to integrate the Health System and the Socio-Educational System[6,7]. Its proposal is aligned with the logic of territorial care and organized into health care and care networks, benefitting from Primary Care as the coordinating point, directly linked to the territory of the subjects-users of health services[8,9].

In this way, the very principles and guidelines of the SUS, socio-education and the social security system point us in the direction of a community and intersectoral approach - health, justice, socio-education and human rights. Therefore, here we understand health and socio-education devices in relation to other institutional and social spaces that must ensure, in an articulated and integrated way, comprehensive health care for these adolescents, as well as other social rights.

The aim of this study is, therefore, to investigate the development of the relationship between health services and socio-educational units in the state of Paraná, from the perspective of service workers and managers.

Methodology

This article is a partial product of a master's thesis, part of a research project that studies health practices and management in the context of socio-educational units in the state of Paraná and health care network services. This is an exploratory qualitative study.

The field

The socio-educational system in the state of Paraná is a part of the current Department of Justice, Family and Labor (SEJUF in the Portuguese acronym) and is divided into 3 administrative regions in which the socio-educational units are distributed, with a total of 19 units in the state in 16 municipalities[10]. The choice and delimitation of the field of study defined municipalities with socio-educational units in the 3 regions of the state. The municipalities chosen were Curitiba, Fazenda Rio Grande, Londrina, Pato Branco and Laranjeiras do Sul, as they are municipalities with reference units for their respective regions. Socio-educational units of different sizes were also chosen, as they only dealt with adolescents in longer periods of detention, allowing us to explore the differences between different institutional structures and municipalities of different sizes.

Research participants and data collection

The study included health workers and managers who worked in socio-educational units and health services, linked to the health care of adolescents undergoing socio-educational detention, or in the coordination and/or management of this process. At least two interviews were carried out per municipality, including one professional manager/coordinator and one professional providing direct care to young people.

The regulations in this area, when dealing with the issue of health, do not provide for a minimum composition for the health team in each

socio-educational unit. There is a requirement for a health team, the composition of which must comply with SUS legislation and local needs and can be determined by the director of the unit[4-6,11].

A total of 16 interviews: six with health workers linked to socio-educational units and ten with health workers and managers of municipal health care services or departments (collected from December 2019 to June 2021). The research posed open-ended guiding questions, seeking to address the topics freely and at length.

The aim was to explore how the relationship between socio-educational units and health services is organized in terms of care, prevention and health promotion, the main demands identified in the process and the team's own perceptions of the relationship and health care for adolescents serving detention. Initially, the guiding principles and actions set out in the PNAISARI (promotion, prevention, care and rehabilitation)[7] were taken as a basis. Each interview was recorded and lasted between 25 and 50 minutes.

Analysis

The interview transcripts were organized into narratives, using first-person discourse based on the interviewee's narration, in an attempt to adopt a hermeneutic stance as a way of understanding the text and discourse[12]. Repeated fragments of speech and language vices were removed, maintaining the meaning of the participant's speech. This is the discourse that emerges from and characterizes the relationships between social actors, as well as their tensions, located in a historical context[13].

After successive readings of both the transcripts and the narratives, we sought to extract the meanings and significance that emerged from the accounts, organizing an analysis grid with categories of analysis. Narratives and categories of analysis were validated by another researcher who was part of the research group in a process of mediating the understanding of the text, as proposed by the hermeneutic approach. The material analyzed was returned for group validation, where the contextualization of the results, the positions and prejudices of the different researchers were noted in order to minimize a priori interpretations[12].

The intention of the researchers in constructing the script was to capture the experience lived by the participants, instead of the more general explanations they might have about a topic. Prioritizing the experience itself facilitated the construction of narratives that make it possible to recover the perspective of human praxis, an approach advocated by hermeneutics. For Ricouer, if an action can be narrated, it is because it is already inserted into the world through social action, therefore being symbolically related to its context[13].

All the material was organized by codes in order to preserve the confidentiality and identity of the participants. Each narrative was linked to an identification of the letter "T" corresponding to the worker, and this was complemented by the letter "C" for workers in the socio-educational centers (CENSE in the Portuguese acronym)) and the letter "R" for workers in the municipal health networks. In addition, each combination of letters was given a sequential number according to the chronological order in which the health network interviews were conducted, which was also applied to the coding of the CENSES interviews.

The research was analyzed and cleared by the research ethics committee under No. 4.379.624/CAAE 02353018.3.0000.0102.

Results and discussion

A total of 16 interviews were carried out in the five municipalities in the sample, six of which were with health workers from the Socio-Education Centers (CENSE) and 10 with workers from municipal health services: Curitiba, Fazenda Rio Grande, Laranjeiras do Sul, Pato Branco and Londrina. The participating health workers were all from Psychosocial Care Centers (CAPS in the Portuguese acronym) and Primary Care support teams (Expanded Family Health and Primary Care Nucleus - NASF-AB in the Portuguese acronym).

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The issues involved in receiving health demands: between the institution of deprivation of liberty and care in a territorial network

Municipal health network workers cited communication with health professionals within the CENSE as facilitating processes. In the case of socio-educational units that have a medical professional, there is a tendency for care to be more centralized in the institution itself. As in the fragment below:

With regard to access to health care, on the medical side, today we don't need it anymore because we have Dr. Azaleia (TC2 - Calendula).

In some municipalities, primary care was seen as the main gateway into the organizational scope of the health system and its care networks, and was therefore assigned to the articulation and coordination of health care in accordance with the National Primary Care Policy (PNAB in the Portuguese acronym)[14], as well as the principles and guidelines of the Health Care Networks and the PNAISARI[9].

In other interviews, however, it was mentioned that the socio-educational units had a Basic Health Unit of reference, but, at the same time, they reported fewer joint actions between the services. One of the professionals, who had previously worked in a NASF-AB team, said that she had no direct contact with adolescents, indicating that not all professional categories get involved in direct actions with adolescents. Some reports indicated that the actions centered around the management and supply of medication to the professionals in the socio-educational units, who would then administer the medication to the adolescents internally in the CENSE.

Look, there are hardly any health promotion and prevention actions carried out by primary care. There have been, but few, compared to what we could have had [...] (TC5 - Crisantemo).

Some interviews mention that initially there was difficulty among health workers and managers in understanding the demand for assistance for adolescents in conflict with the law as a municipal competence. This movement has been observed by other authors and studies[15]. There was a question mark over the adolescents' place of origin. In that way, the health field sometimes seems to point to the socio-educational unit as not belonging to the territory.

There is a potential gap in the articulation of actions and in the healthcare provided by Primary Care in relation to the socio-educational units studied. Although this phenomenon has been described in other studies by Ribeiro *et al.*[15], contextualizing the findings from a hermeneutic perspective can help raise other questions. Firstly, there is the fact that all the municipalities studied have CAPS, which can lead to generating flows in which basic health units may be overlooked in relation to mental health services (which are indicated as the preferred contact units by socio-educational professionals). Secondly, socio-educational units in Brazil experience the incompatibilities inherent to institutions of deprivation of liberty, marked by a punitive and segregating ideology[16]. In the sense that what is reproduced is a state of isolation, which ends up being incompatible with the logic of care in the territory and articulated in networks. In this way, such distancing can be a co-production of the two policies (Health and Socio-education) that cannot be seen separately. Changes and closer ties between primary care and socio-education may also require changes in the very structure and set of ideas of socio-education.

Additionally, there is the specificities of the situation of primary care itself, experiencing lack of funding, management reorganization based on managerialist paradigms, changes in team configurations, and de-prioritization of the Family Health Strategy (ESF in the Portuguese acronym) and Family Health Support Centers (NASF in the Portuguese acronym)[17-20]. All of these elements contribute to hamper these two policies in their goals to provide comprehensive and coordinated health care.

As for specialized care, it is available on demand and the interviews indicate that it is more difficult to get it, experiencing delays or the impossibility of finding a place during their time in the socio-educational units. In the interviews, there are statements that point sometimes to easiness and sometimes to difficulties in accessing the health network and/or external health services. This, according to them, is due to the limited number of places, either because of a reduction in the number of workers, due to high demand, or both. According to the participants, mental health is the specialty most in demand. Mental health crisis situations are referred to the Emergency Care Units (UPA in the Portuguese acronym), as are other urgent and emergency situations. However, they report that mental health crises can also be referred to CAPS.

Generally, when you need assistance from the network, it's with a psychiatric disorder that requires a little more care. [...] In the case of a crisis, the UPA is the place to go. If the doctor thinks that hospitalization is necessary, it's done and then it's dealt with there (TC2 - Calendula).

The centrality of the issues that workers consider to be mental health problems in socio-education is something that recurs a lot in the interviewees' speeches. Vilarins[21] estimates that 97% of adolescents receive a diagnosis of mental disorder after entering detention, which is generally attributed to an unsocialized conduct disorder, i.e., linked to their ability to adapt socially. Several studies point to a tendency to pathologize

and medicalize adolescents in socio-educational measures[21-23]. From this point of view, the understanding of their socio-culturally structured complexity is set aside and leads to the obliteration of their historicity and the context in which they are inserted. This context dialogues with the names given to adolescent crises by the interviewees: these names were almost exclusively given to signs and symptoms stemming from psychiatric psychopathology.

According to the interviewees, in cases where adolescents are taken to health facilities there is a demand for logistics and planning, considering that a team is needed to accompany them, as well as to find an available means of transportation. In some of the interviews, this configuration was mentioned as a factor that made it difficult to travel to external appointments. As a result, there was a preference for care in the CENSE itself, indicating a tendency to centralize care in the socio-educational unit. Care that required leaving the socio-educational unit was generally only associated with crises, urgencies and emergencies. This is another aspect that here also seems to imply a distancing from the territory, since for any other action or health care, the preference is for it to be carried out inside the socio-educational unit.

[...] when they have the doctor available inside the CENSE, it's much better, because there's a whole security logic to getting the boy out of there. So the health team usually goes to the CENSE (TR2 - Canario).

The number of professional staff also appears to be a critical issue. The interviews indicate the need for more health workers in the socio-educational units, in relation to the existing number. Some interviews point out that concentrating activities in the same professional generates exhaustion, as well as compromising the execution of activities.

[...] In my opinion, human resources are not enough, especially in relation to health professionals. Sometimes the work overload, the work environment and a stressful environment is a heavy environment (TR3 - Gaviao).

Another important aspect that was highlighted, is the fact that adolescents go handcuffed to outpatient clinics, as well as accompanied by a security team. This is associated with embarrassment. Because of this, many professionals point out that health services tend to prioritize these appointments, in order to avoid long waits, seeking to direct adolescents to a more reserved waiting room, or trying to schedule appointments at times when there is less flow in the services. These alternatives aim to prevent them from being exposed during their stay at the health service.

[...] it's embarrassing for us to arrive at the unit with these boys handcuffed. There are all those old ladies sitting at reception, waiting for ages, and we arrive with the boy and go straight to the doctor's office. It's unpleasant for them and for us too, because nobody wants to take anyone's turn (TC2 - Calendula).

In addition, the so-called security aspects and the use of handcuffs are factors that prevent adolescents from taking part in collective activities within health services such as CAPS. This restricts group activities and socialization within their therapeutic plan at the service. With regard to the execution of activities inside the socio-educational units by external service teams, the interviews point to a need to restrict materials and people, also justified by maintaining security.

[...] in these spaces, we have to have all the material accounted for, what comes in and what goes out. That's a matter of organization there and it's something we have to respect (TR4 - Arara).

The procedural aspects of security end up guiding the actions and activities to be carried out with the adolescents[21-24]. In addition, these aspects – security, staffing and material availability of vehicles – are crossed by what the interviewees described as "embarrassment", which seems to be linked to the way in which adolescents in conflict with the law are seen as subjects of rights, and this includes their right to health.

It is as if the dimension of the criminal offense removes them from this place, based on a break with social morality[2,15,23], and then directs a double punishment at them: deprivation of liberty and the contestation of their right to health. This indicates that there is still a punitive bias, which goes against the socio-educational proposal.

In this sense, studies[15,24] point to the stigmatization and prejudice attached to adolescents in conflict with the law, and how such conditions negatively influence the recognition and realization of their right to health. Cavalcanti *et al.*[24] also point to the tendency to superimpose the punitive logic in contrast to the condition of subject of rights, therefore of social guarantees, and the social dimension of the infraction.

Therefore, these authors indicate an isolation of the guarantee of rights concomitant with the isolation of adolescents, whose institutions tend to act in order to remove them from social life[24]. Other studies[21,25] identify not only an isolation of the adolescent from the territory, but also of the

health teams in the socio-educational units, who often end up isolated from the service networks of the different social policies. In this sense, in the interviews, the professionals sometimes referred to the difficulties of getting appointments with other services and the limitations of coordinating multiple sectors simultaneously.

In the process of building and validating the narratives, these four elements presented here: (1) the social mandate of socio-education, which still has a punitive bias, (2) the understanding of the problems of suffering as mental disorders, (3) the preference/imposition of health care within the socio-educational units and (4) the predominance of the logic of protection in the work processes of socio-education seem to be related, given their repetition and concatenation in the speeches. In this way, these concepts, in their fundamentals, distance themselves from territorial health care. In turn, socio-educational units are closer to the total institutions described by Goffman[26]. In these, all aspects of the inmates' lives take place in the same place and under the command of a single authority, with activities guided by collective rules that prioritize safety and control[26].

These structural crossings affect the health care of these young people. The institution of deprivation of freedom, in itself carries within the ideology of "recovery" and "adaptation" of the subject to a given moral and social norm considered to be correct and just. This implicit desire on the part of the "socio-educational institution", together with the elements mentioned above, can constitute important barriers to comprehensive and territorial health care based on primary care. Shining a light on these issues in current public policies helps to re-examine the extent to which some of these foundations stand in the way of building more effective and territorial health actions.

What actions are carried out in the context of socio-education and health?

The actions characterized as lectures appear to be the most cited, and were carried out by professionals from the health services or from CENSE itself, either together or individually. There was no regularity to them and the topics involved guidance on the use of medication (adherence to treatment), mental health, sexual and reproductive health, nutritional health, food, oral health, planning actions with the School Health Program (PSE in the Portuguese acronym). It's worth noting that, despite the comprehensive approach needed for adolescent health, it's mental health issues and, more specifically, the measures that need to be taken to alleviate suffering, the topics that mobilize workers the most, as mentioned earlier in the text.

Other interviewees, on the other hand, reported projects that set out to work on aspects of health education and life projects in an interactive way with adolescents. In these projects, according to the interviewees, the adolescents become multipliers of health education actions, based on prior training that emphasizes dynamic methodologies and ongoing monitoring. As a result, they carried out activities with adolescents from the CENSE, mediated by the project's own adolescents, working on sexual and reproductive health.

[...] two teenagers who were more resourceful went there to talk about sexual health. As it's only boys and they're also boys, it was nice. The conversation was different between them, right? They asked questions that perhaps they would never ask me. [...] But we just had a chat with them [...] (TR2 - Canario).

Other health education proposals take the form of workshops, covering topics such as: support networks and human relations; emotional aspects; alcohol and other drugs; and life projects. In one of the intersectoral actions, one of the interviewees told of a music festival involving different sectors: health, socio-education and social assistance. According to the reports, some adolescents are included in internships in the administration of the municipalities of reference, after their internment, while others are directed to apprenticeship courses and other after-school activities.

Even with the intersectoral actions described above, participants report difficulties when these actions should be individualized around the construction of a therapeutic project.

Still there a larger difficulty among all departments. [...] There's the health department, CREAS, CRAS, there's a lot involved. Not all the adolescents are from the municipality. I think we might have had this difficulty in articulating, for example, in the network meetings, difficulty in everyone taking part [...] (TR2 - Canario).

In that way, health education actions, even though they take place in an intersectoral manner, here again end up being limited by the aspects of maintaining security and the possibility of organizing different sectors to carry them out within the existing limits. Sousa *et al.*[27], in their study, point to a predominance of programmatic

and care actions, based on a biomedical and neoliberal model of health care and which are consistent with the imposed logic of security, which limits the expansion of care activities, such as collective and territorial activities, for example.

In one of the interviews, the primacy given to safety protocols over all the activities carried out was reported. Often activities can't be carried out, a pencil or other utensils can't be used by inmates if they are considered a risk in some way. According to the interviewees, this limitation may be due to the greater number of inmates in each center, which makes it more difficult to manage the adolescents, as well as to the reduction in staff, but also to the existence of various protocols focused solely on security that supersede in importance others that are more socio-educational in nature.

At this point recurrent speeches appear, both in socio-education and in health, which relate these structural and paradigmatic elements as possibly responsible for limiting the activities in the centers, whether they are activities related to health promotion or even socio-educational activities. In their study, Robert *et al.*[28] discuss the importance of the occupational meaning of the activities carried out with adolescents. Listening to adolescents in relation to their interests makes it possible to design activities that encompass their sociocultural and identification universe, implying actions that are more aligned with the development of autonomy and the strengthening of personal identity. On the other hand, when activities don't make sense to those practicing them and their mechanical nature and mere time-wasting stands out, they tend to refer to institutional logic and restriction.

About PNAISARI

Some interviews mentioned PNAISARI as means of ensuring mobilization to think about and guarantee health actions for adolescents in conflict with the law, as well as intersectoral relations. Although many people are aware of the policy, they report a lack of more concrete actions for its actual implementation.

There has to be a policy, a guideline [...]. So, I think it came about to improve the relationship between the health units and the other services. Because now we have this relationship, we make the action plan together, we end up talking more [...] (TR1 - Curió).

They say that at the beginning of joining and implementing PNAISARI, they faced difficulties in describing actions and activities, establishing responsibilities, in other words, schematizing actions that they were already carrying out, as well as applying the policy's provisions in effective actions. They did, however, report that the policy mobilized meetings which revealed a lack of knowledge of the institutional and professional roles in each service, of the activities, of how they worked and the need for actions to bring those involved closer together and raise awareness.

In this sense, aspects of disarticulation and fragmentation may be perceived, a lack of knowledge of the activities and roles of each institutional actor, which can lead to the need for constant day-to-day re-agreements in order to implement actions[15,24], indicating a policy that is still unstructured, making it difficult to achieve comprehensive and intersectoral actions. In the interviews, professionals linked to management and service coordination tended to be more aware of the aspects related to PNAISARI, in the sense that they were aware of its key points, guidelines, planning, implementation and evaluation points. However, some health care professionals show little knowledge of the policy, which may indicate little participatory planning in relation to policy implementation.

On the other hand, the professionals who are aware of it stress the need for its content to be disseminated more widely, both to health professionals and to society in general.

And the challenge is that this document needs to be extremely socialized. It needs to be known, especially by health workers. [...] Because in order for [...] it to be operationalized, this knowledge and articulation is necessary. And also, investment within the area of this public policy, mainly from states to municipalities [...] (TR5 - João-de-barro).

Cavalcanti *et al.*[24], for example, cite aspects that can be troublesome in the intersectoral implementation of public policies, such as management models, the organization of work processes, the different agendas prioritized between the federative spheres and the structure of the networks in which the policies are materialized. In addition, the processes and structures of each policy often tend to close in on themselves, with health policy often being distant from other social security policies.

Fernandes *et al.*[25] pointed out to the importance of public policy as an instrument for building preventive strategies in the reality of adolescents. Having legal frameworks such as PNAISARI is therefore of great importance for inducing these policies. Despite the important promotion, the interviewees reported the still

small financial investment, both for the implementation and execution of PNAISARI, as an obstacle to the adequate structuring of health networks and services, as well as the hiring of professionals. The interviews show that there has been an opposite movement, with services becoming more precarious and financial resources being cut over the years.

[...] a loss of financial investment and a loss of human resources. There are a few people who have to cope with the workload, which continues to be huge, although there used to be a larger number of people (TR7 - Cacatua).

The context of the results emerging here show, that the historical process of consolidating the SUS, in line with what was proposed from the Health Reform, is crossed by political and economic aspects, setting its boundaries. There is a concrete limitation to the expansion of public infrastructure, the result of historical underfunding, where the largest subsidy goes to the private and philanthropic sector, the influence of foreign capital, a recent aggravation of the processes of dismantling public policies and a reduction in state investment in social security and support policies and services[29].

At this point, we have identified some limitations of the study. The study is based on workers' perceptions, so, as this is qualitative research, it only presents one view of the picture, and does not make it possible to generalize in relation to all aspects of material reality, pointing instead to aspects that can show its path.

Final considerations

The study showed hindrances in the articulation of care between primary care and the socio-educational system. The greatest demand and, consequently, the greatest role in the articulation of care between the two policies is in the field of mental health. It can be hypothesized that socio-educational units and adolescent inmates are far from the territories in which they are located, making access to health actions difficult. External health actions tend to focus on one-off, quick services and are more concerned with security. Therefore, the issues of security, professional contingent and security logistics tend to be the guiding aspect of the management and planning of these actions.

In this way, health care for adolescents tends to be centralized within the socio-educational units, even though more recent policies such as PNAISARI try to advocate the opposite. This reinforces elements typical of total institutions, where all aspects of inmates' lives take place in the same place and in a segregated manner. However, the PNAISARI itself appears to be an important promotion policy that is moving in the opposite direction. It was important for inducing meetings between members of both the health and socio-educational sectors, developing networks and articulations that, although slow and with little institutional support, reshaping the care networks with the aim of including different health facilities in the care of adolescents. Although there is a theoretical and normative framework for this intersectoral approach, it clashes against institutional traditions based on centralized management logics that make it difficult. This configuration is crossed by structural problems regarding the structuring of the health system and the services that make up its health care networks, the result of historical underfunding, a worsening of the processes of dismantling public policies and a reduction in state investment in social security and support policies and services.

Mental health is a major area of demand when it comes to the health of adolescents in trouble with the law. The interpretation of the crises experienced by these adolescents goes more by diagnostic nomenclatures than by looking at the context of how the environment of deprivation of liberty, deprivation of activities or even the offer of activities without a co-constructed meaning can influence them. In this way, the social focus on adolescents in the field of mental health can tell us about the very stigma to which these young people are attached, but it can also point to the idea of care based on isolation and the stigmas of exclusion still associated with the field.

Improvements in the linkages between health and socio-education must take into account both the organizational arrangements in health policy, but also the structural and paradigmatic issues in the socio-educational units in this territory. Changes in the work processes of the latter, aimed at reducing the characteristics of total institutions, can facilitate alignment with the health network, which is based on territorial care. Socio-educational units with capacity for a smaller number of inmates, with the structure to guarantee the mobility of inpatient adolescents when necessary and with permanent education that generates constant reflection on the paradigms that govern the daily life of these institutions are some of the elements that could help in this alignment.

Finally, it can be seen that issues relating to the moralization and stigma attached to adolescents in conflict with the law, as a result of committing misdemeanors, result in punitive conceptions that imply an understanding of these adolescents as people with rights, and consequently in relation to their right to health. In spite of the advances and incentives induced by the PNAISARI, the logic of care needs a major boost towards the comprehensiveness of health actions.

Collaborations

DVD Santos participated in the design, execution, analysis and interpretation of data and writing. S Stefanello participated in the conception, execution, analysis and interpretation of data and writing. C Federhen participated in the design, execution, analysis and interpretation of data and writing. GSC Albuquerque participated in the design, execution, analysis and interpretation of data and writing. PS Farínhuk participated in the analysis, critical review and approval of the version to be published.

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