LUMEN ET VIRTUS
ISSN: 2177-2789

# INTEGRAL APPROACH IN THE CONTEXT OF DEPRIVATION OF LIBERTY: REFLECTIONS OF FAMILY AND COMMUNITY MEDICINE ON PRISON HEALTH

https://doi.org/10.56238/levv15n42-031

**Submitted on:** 08/10/2024 **Publication date:** 08/11/2024

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## ABSTRACT

Family and Community Medicine is structured as a medical specialty in a movement against the fragmentation of the human being, with a humanistic look and considering the impact of social determinants of health on the health-disease process. Through her work aligned with a vision of medicine centered on the person, and not on the pathology, she understands the importance of bonding and comprehensive care in full knowledge of stressors and threats to physical and mental health, in a vision of multimorbidity. In this training based on principles with the valorization of social medicine, but enhanced by the development of empathy, the specialty has in its lines of action a direction towards working with marginalized populations, having in its history of construction and evolution aspects similar to the process of stigmatization of marginals. From this perspective, within the integral approach of family medicine, an understanding of the community context is sought, impacting life cycles and contributing to the manifestation of diseases, prioritizing, with a view to equity, contexts of extreme marginalization that lead to human rights violations of historically neglected populations, such as the case of the population deprived of liberty. This article seeks to deepen the discussion, in the light of the literary study of aspects that compromise integrated care and the guarantee of health as a human right to populations

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deprived of liberty, with an analysis of how the process of construction of the marginal and the lack of investment in reintegration and re-education in the prison system aggravate crime as a biopsychosocial phenomenon.

**Keywords:** Mental health, Prison health, Family and community medicine, Neglected populations, Primary care.

## INTRODUCTION

The essence of FCM training consists of a humanized look at the physician's self and the bonds of affection in an encounter with the patient, thus understanding the influences of the sociocultural environment on the representations of suffering and disease. (RAMIREZ; NORMAN, 2020) Thus, the resignification of pain, the exchange and clarification of medical and social issues that shake the patient's perception of disease, seek to bring a greater sense of understanding and empowerment of the patient about their own health care, conducted by the family doctor as a facilitator of this care, integral and person-centered. Thus, the understanding of the term patient is changed to person by the specialty, considering that the term patient has in its structure an allusion to the passive attitude with an understanding of "one who waits and does nothing". With the modification of the terminology and holistic understanding of the individual, the conceptual change of term from patient to person is studied, which represents the notion of an agent individual, a protagonist of the maintenance of one's own health and one of those responsible for the search for cure and overcoming in its biopsychosocial dimension, with the figure of the physician united with the patient to assist in this continuity of care, without impositions or hierarchies.

The structuring of stigma in an object is a label that leads to the discrediting of the function and identity of its intrinsic, potential, and extrinsic representation in the face of the possibility of acting in the external, social environment. (MIRANDA; GOLDBERG; BERMUDEZ, 2022) He is given a devaluation surrounded by a negative character, the target of repulsion, ridicule or fear due to a sense of dangerousness linked to the objective of fear leading to the behavior of repulsion and desire to be distant, thus perpetuating the social place historically imposed on the marginal being. The present work seeks, through a reflective discussion, based on a literature review in a narrative character, to debate the interface between origins and values of Family and Community Medicine (FCM) aligned with the importance of integrated and people-centered care from a perspective of neglected populations, highlighting as the target of the study the process of marginalization of the population deprived of liberty.

## METHODOLOGY

This is a narrative review of the literature, of a reflective nature, on mental and physical health inserted in the view of comprehensive care and social threats in the context of deprivation of liberty, in dialogues on the contributions of FCM to the view of equity and person-centered to neglected populations, in the context of prison health. To carry out the

research, the Scielo database was used, using only in Portuguese the words "mental health" and "prison health", added by the Boolean operator "AND", in the combination "mental health" "AND" "prison health". The decision not to use other databases or descriptors in English occurred because the focus of the discussion was on a cut of the situation of deprivation of liberty and psychic suffering linked to the physical and social, inserted more specifically in the reality of Brazil. The final balance of the research was 20 scientific articles, published in the thematic areas of Health Sciences and Human Sciences. The articles were found with a publication year range from 2006 to 2024. Of the 20 articles found, 8 were selected for the construction of the present work, associated with the debate of 3 other articles chosen for the approach of marginalization in the context of prison health, the challenges of social reintegration, the profile of illness in the penitentiary system and the integral approach centered on the person of FCM. Thus, 11 articles were used for the construction of the present work.

## RESULTS AND DISCUSSION

### ORIGINS OF FAMILY AND COMMUNITY MEDICINE AND DIALOGUES WITH MARGINALIZATION

Created with a proposal to change traditionalist thinking in the face of the medical act of caring for the human being, FCM as a specialty emerges in a questioning segment of the idea of medical fragmentation of the individual. It problematizes and contributes to breaking the maintenance of truths created in a process of medical education based on scientistic thinking, rooted in the clinical practice of the twentieth century. This movement directs its actions and discussions in the precariousness of ties inherent to the doctor-patient relationship, considering this impact as an essential factor for the process of healing and health care of individuals. (RAMIREZ; NORMAN, 2020)

Within the practical scenarios of FCM, the central plan of activities is directed to Primary Health Care, encompassing the varieties and main needs in population health, a fact that allows the specific training of FCM to increase clinical problem-solving, thus avoiding the hyper-fragmentation of care and unnecessary referrals. From this perspective, health systems with an organization focused on strengthening PHC, with a specialty with great potential for clinical resoluteness in the coordination of care and gateway, are optimized in terms of care coverage of populations, in view of patient satisfaction, increased quality of life and consequently longevity, reducing unnecessary health expenses and waste. (RAMIREZ; NORMAN, 2020)

However, FCM does not occur exclusively in Primary Care, being focused on primary health care directed to other segments of population care, thus allowing an integration of care between health services and strengthening the articulation of networks. Thus, in a view of prioritizing the most vulnerable, FCM seeks to highlight and allow a look of equity in the care of historically marginalized populations, who suffer the consequences of a problem beyond medical fragmentation: the invisibility and neglect of access and continuity of health care for population segments considered unwanted by the current structural traditionalism. Thus, the work of FCM promoting comprehensive care for the person and integrated into care networks is materialized in a double resistance to breaking archaic models that seek to subordinate segments that are more fragile by a colonial historical process. Among this follow-up of neglected populations, we highlight the homeless population, people with mental disorders using psychoactive substances, and the population deprived of liberty. These marginalized population groups have a common intersection based on direct impacts of social determinants of health and a colonialist view of the construction and structuring of geographical, political spaces and the structuring of medical academia in an elitist and stigmatizing view. (RAMIREZ; NORMAN, 2020)

In the origins of the formation of marginalization, the act of excluding the different and the resistant to the standard of normality is developed as a form of invalidation and attempt to suffocate a potential on the rise in the breaking of traditionally rooted structures that benefit specific hegemonic groups, the holders of power. This materializes in a process of continuity of marginalization and invalidation of undesirable populations to the maintenance of what is socially determined as normality by those in power. From this perspective, those who choose to follow studies and care of rescue, elevation and assistance in liberation, empowerment and comprehensive care are targets of exclusion. Thus, inserted in the philosophy of consolidation of the practice of FCM in the light of Ian McWhinney, the organismic thinking of this scholar and family physician has in its characteristics aspects that intersect with such idealization of the process of marginalization of the different and the projection of exclusion and inferiorization of groups that seek to help the marginal in the liberation and evidence of these neglected populations. Thus, organismic thinking, when developed in part of the performance of FCM, proposes to understand the human being as possessing properties in the organism capable of learning, finding a cure, performing self-organization, and thus regenerating, growing and finding self-transcendence. (RAMIREZ; NORMAN, 2020) Inserting this perspective in the heart of the rise of FCM based on the Person-Centered Clinical Method (MCCP), the work of FCM with marginalized populations seeks to help free themselves from blockades, chains and

prisons historically delimited by those in power and that directly influence the conditions of manifestation of biopsychosocial illness, maintenance and deterioration of physical and mental illness, perpetuating the conditions of inferiority and neglect that directly harm the survival and maintenance of human rights to life of these populations. (RAMIREZ; NORMAN, 2020) As a consequence, helping to strengthen and grow a specialty that seeks liberation on health fronts, understood as quality of life, human rights, and social protagonism, would be synonymous with elevating the specialty that seeks to break down structures created to exclude and feed the growth of the illness process, in its biopsychosocial view. Thus, society creates the social disease and then responds with punishment and exclusion. Investment in re-education is neglected, as well as the concern for the protection of marginalized persons, creating and perpetuating scenarios of human rights violations that make it impossible for the segregated person to reintegrate psychosocially. From this perspective, focusing on one of the most marginalized segments of society, the population deprived of liberty, the social conditions historically developed by power-holding elites feed criminalization to later lock it up, remove it, segregate it and punish it. However, locking up is not treating, much less caring, without mobilizing efforts and acting for the causes and roots of this complex problem. In a view of institutionalization and pathologization of what is structured as misconduct, the lack of investment in care and guarantee of human rights makes crime a biopsychosocial phenomenon. From this perspective, investing in care and strengthening areas of medicine that seek to empower and rescue such neglected populations, as well as empowering this segment as protagonists, in leaders who have speech, voice, choices and promote changes in social segments is not a wise choice for the traditionalist elite, which dictates the rules and has decision-making and organizational power. In this process of formation, the emergence and maintenance of the stigma of working with neglected populations occurs, with fronts of inferiority from the devaluation of the object of work, to the form of work and the structure of the workplace, in an implicit search for breaking and deconstructing groups and segments that emerged as a restlessness and an anti-fragmentation movement, elitization of the differentiated look at the care of the human being. Thus, it is justifiable in a historical perspective of social construction, of cities and of the consolidation of traditionalist and biological medicine, that FCM is not validated as a medical specialty and that it is slowed down in its expansion of potential for the full exercise of all its values and capacities. Thus, the stigma and invalidation by traditionalist medicine of FCM is a reproduction of the fear of changes inserted in the proposals and potentials of this specialty, in a way analogous to that performed in neglected populations. This process is potentiated and continues to be

perpetuated for the exclusion of the two groups, the one that cares and the one that needs care, for a great and fundamental reason: the immersion of the person in the process of marginalization, believing in their inferiority imposed by a colonial process and trapped in blockages that prevent them from consolidating change starting from a social movement at the base of the structural system.

A study carried out in Rio de Janeiro analyzed the case of deinstitutionalization in the prison system of individuals in deprivation of liberty and people with mental health issues, in a period from 2014 to 2021, based on an articulated organization of the Psychosocial Care Network. Among the actions of the work, there was a division of actions at the entrance doors of the prison system and in the health system, directed to care activities for patients with mental disorders, in the light of the legislation for the protection of the rights of people living with mental disorders, formalized by Law No. 10,216/2001, thus avoiding the maintenance of segregation approach standards, imprisonment, psychosocial institutionalization in its punitive character and potentiating marginalization. In the actions carried out, the discussions of complex cases asylum in the institutions were framed, on a regular basis, making the individual care network of each person responsible, deconstructing practices of segregation, marginalization and institutionalization, in an attempt to increase visibility to the outside, with the intermediation between the inside and outside scenarios. Bonds were also rescued, working on the power of interpersonal and affective relationships, patient support, understanding biographies, histories and relationships between person, family and communities, with the mobilization of substitute mental health services along with social equipment and interprofessionality, highlighting education, culture and work initiatives. In this way, a transformation of attitudes was sought and a change was sought from the view of stigma and enclosure to that of the development of full citizenship and the guarantee of human rights, with health as a priority issue in a perspective of quality of life and biopsychosocial well-being. Among the results of the intervention carried out, the contribution to the elaboration of public policies that seek to reduce the time of asylum in the prison regime, the attitude of combating a prison career, as well as an expansion of the network in an active and participatory behavior in the face of the collective collaboration of care in an expanded view of the offender with mental disorders, factors that aggravate the condition of marginalization and the threats to the quality of life and comprehensive care of these populations. (KEMPER, 2022)

In this perspective of studying complex cases with interconnected mental and social multimorbidity, in which the situation of deprivation of liberty is added to the context of a person with a mental disorder, with insertion in a Custody and Psychiatric Treatment

Hospital, the analysis of existing relationships in a hybrid environment between justice and health is understood. In this way, we strengthen ties and the need to dialogue together with the findings of the Psychiatric Reform with the context of the Health Reform in a broad view of territorial, social and family issues linked to the maintenance and enhancement of mental health needs, understanding the individual as a community being who needs the reduction of segregation for the maintenance of citizenship and the guarantee of rights inherent to the human person. Thus, it is essential to care for and cope with cases of human rights violations, commonly found in these scenarios of amplified burden of conditions of segregation and marginalization, potentiated by the idea of dangerousness of the associated madness and criminality, such as the historical construction of asylums and the objectives of the exclusion of the target population institutionalized in them. (OLIVEIRA et al, 2022)

Visualizing the structural construction of this scenario of double marginalization, we highlight the factor of theorization of the anti-asylum struggle, with a difficulty in operationalizing the actions present in the Psychiatric Reform in favor of guaranteeing comprehensive health care and articulated with the network, promoting the protection of basic rights of the citizen, dignity, and the protagonism of the person in mental suffering and under a situation of isolation in penal service, excluding family and community environments. The stagnation and lack of progress in this debate perpetuates the difficulty in creating practical planning, directed to the main needs to be overcome in the precariousness of comprehensive care in these scenarios, based on evidence, integrating care, management, families and territory. Such prioritization of the agenda for collective debate enables the consolidation of strategies in the deconstruction of a historical stigma and in the creation of practical forms in the light of current legislation and dialogue with effective public policies, enabling ways of applying strategic plans that expand access and quality of health care, in an integral view of the human being. These actions should be thought of in an integrated perception from the point of view of the health network, of support and centered on the person from the perspective of a global understanding of the health needs of this neglected segment, seeking to understand the person as a whole and encouraging the citizen protagonism of these populations. (OLIVEIRA et al, 2022)

## THE PRISON SYSTEM AND THE PROCESS OF ILLNESS

The prison population, upon entering the prison system, goes through a process of segregation and depersonalization, which alienates them from their own citizenship and, consequently, from many of their basic rights. Guaranteeing the right to health for people

deprived of liberty has always been and continues to be a challenge, since convicts are strongly stigmatized and often seen as "non-citizens", therefore, not being seen as deserving of health care. Thus, large gaps related to health care were established in the prison system, in order to generate a profile of illness among the re-educated, more commonly called prisoners, which reflects the conditions in which these individuals are inserted. (PINHEIRO et al, 2015; BAHIANO; TURRI; FARO, 2021)

Given this scenario, the shortcomings in the prison system become evident in the precariousness of the provision of health services for the re-educated. From this perspective, overcrowding, lack of structure, scarcity of human and material resources and other factors culminate in the lack of assistance to inmates, despite mobilizations and the emergence of policies to ensure better living conditions in the prison environment. In this sense, prison, by providing a scenario of social exclusion and unhealthy conditions, enhances physical and mental illness. Thus, imprisonment compromises the health-disease process and the inmates start to present different demands from the extra-prison population, which makes evident the need to effectively include these people in the health system and to bring a look directed to their specific demands. (PINHEIRO et al, 2015)

A study sought to understand the phenomenon of imprisonment from the perspective of the individual who experiences the deprivation of liberty in the prison system. He visualized and perceived patterns of adaptation behaviors that were initiated by the existence of a trigger scenario, a stressor point contributing to the condition of suffering and the impact of social determinants on human behavior. The perception collected from the word prison brings the idea on the part of the individual of an environment of difficulties, compromising life and leading to health threats to the point of triggering illness of the body and mind, identifying a correlation and potentiation of physical and mental multimorbidity, aggravated by the traumatic social condition of interruption of activities of the life cycle, caused by the deprivation of liberty and its psychological consequences. Among the protective factors identified was the emphasis on the idea of hope in the face of building a future, even in the face of adversity, with an idealization for the reconstruction of a life based on opportunities for social reintegration after liberation. However, the expectation and the idea of hope for improvements in the future do not dialogue with the conditions of protective factors existing in the territory and in the same environment that promoted the development and maintenance of the condition of marginalization and that contribute to the deprivation of liberty, as well as the label of ex-prisoner, helping to aggravate the negligence and segregation of this population when returning home. This conjuncture highlights the importance of prioritizing re-education actions and planning how reintegration will occur, in

order to empower the person and motivate the creation of a life plan beyond bars, without allowing the social pressure of judgment and marginalization to break the perspective of the future and the search for changes in living conditions. (BAHIANO; TURRI; FARO, 2021)

In an attempt to ensure the rights of people deprived of liberty, the National Health Plan for the Penitentiary System (PNSSP) was created in 2003, later replaced by the National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (PNAISP) in 2014. However, the implementation and reach of these policies are limited and the prison population remains unassisted. Therefore, the relevance of ensuring mechanisms for the implementation of these measures is highlighted and, thus, allowing health care, as well as interventions for the prevention of diseases and for the promotion of health in prisons, involving, in addition to the prisoners, those who relate to them, including their families and prison system workers. (PINHEIRO et al, 2015)

In semi-structured interviews carried out in a Regional Penal Complex in Rio Grande do Norte, the perception of illness by the inmates was identified, in which some of them refer to the process as something sudden, sudden and without knowing how to relate exactly the causes. However, many point to the circumstances of incarceration as a determining factor in illness, mentioning the poor hygiene conditions, poor diet and unhealthy environment. Mental illness was also prevalent in the prisoners' reports, in which it was reported that the hostility of the prison provided the emergence or worsening of psychological symptoms. Therefore, the mishaps imposed by the prison environment on the health-disease process are observed. (PINHEIRO et al, 2015)

With regard to perceptions about health care, conformism is observed on the part of the prisoners, which may indicate a process of alienation in which not even the individual himself sees health as his right, but rather a privilege, therefore being satisfied when some care is provided, regardless of the effectiveness and quality of this service. In addition, these people relate good care to the speed of the process and the prescription of medications, which reveals the lack of holistic care that contemplates the individual and brings to light the understanding of their role in their own health. On the other hand, others express dissatisfaction with the precariousness of the health service in the penitentiary system, whether due to the insufficiency of the service to offer comprehensive care, the lack of transportation to take to care centers, the lack of structure and personnel, or the biological assistance employed in the care, in which the patient was little heard and reduced to a "sick body". Regarding oral health, treatments were limited only to tooth extraction, without adequate dental care being promoted. (PINHEIRO et al, 2015)

With regard to health education, this practice was understood by the inmates as important, although all of them reported the absence of these actions during their stay in the prison environment. In this aspect, people deprived of liberty showed interest in participating in health education actions and projects, even as a way to fill gaps left by the lack of health care in prison. (PINHEIRO et al, 2015)

In view of the above, the health needs of this population require interventions with a directed look, as the re-educated, despite being part of a heterogeneous social group, have a similar disease profile, resulting from the precarious conditions of the environment in which they are inserted. In addition, it is important to implement health education programs as tools to provide the understanding of prisoners about the conditioning factors in their health-disease process and to enable self-care practices and mental health promotion, one of the aspects most affected by the hostility of the prison environment. Thus, Family and Community Medicine, in working with the team, can, through these measures, corroborate the abolition of the merely punitive character of the prison system, enabling a resocializing look, in order to promote the right to health and dignity of the prisoner. (PINHEIRO et al, 2015; BAHIANO; TURRI; FARO, 2021)

## GENDER PERSPECTIVE FOR WOMEN IN DEPRIVATION OF LIBERTY

The increase in the number of women in the prison system has not been accompanied by the expansion of effective strategies aimed at improving access and longitudinal quality health care in this neglected segment, with a priority focus on the social reintegration of women, and despite an increase in recent public policies aimed at women, the need to highlight and consider their specificities is still a problem. In a documentary analysis of the periods of 2020 and 2021, including non-governmental and governmental actions and strategies, it is observed that in Brazil there are few programs with a gender focus aimed at the social reintegration of women in situations of deprivation of liberty, who have left the prison system. Thus, the priority look at the vulnerable follow-up of women in situations of double marginalization in the prison system is a challenging theme that encompasses the need for this deepening in the approach to citizenship, human rights, health and dignity with a focus on the gender issue. (SCHULTZ et al., 2020; MIRANDA; GOLDBERG; BERMUDEZ, 2022; CARVALHO et al., 2024)

A quantitative cross-sectional study carried out in Ceará sought to analyze access to health from a perspective of care for women deprived of liberty, associated with the screening of common mental disorders, with the participation of 90 women inserted in the penitentiary system with health needs in the area of hypertension, diabetes, tuberculosis,

syphilis, hepatitis B, HIV/AIDS, puerperal or pregnant women. In its results, it obtained the visualization of the limitations of access to the health needs of these women, amplifying the state of violation of basic human rights in health, also encompassing barriers to the tests available to this population. It was evidenced that 68.24% of the women in deprivation of liberty participating in the study had a risk of common mental disorder, identified after the application of the Self-Reporting Questionnaire (SRQ) to screen for factors associated with common mental disorders. (CAMPELO et al., 2024)

A study carried out in the interior of São Paulo worked on the analysis of women ex-prisoners, with a discussion of the technical feasibility of the Ethnographic Clinical Narrative Interview, based on the perceptions of this group in relation to threatening and stressing factors existing in the period of deprivation of liberty, in how such factors impacted the individual biography. In the discourses on the trajectories in the prison system, the psychological and social barriers that preceded the situation of deprivation of liberty were exposed, leading to the difficulties existing in the prison environment, the conflicting and overcrowded conditions, as well as the existing climate of hostility. The fragility of social and family support, with precarious social ties, helplessness and distancing from children, negativity and somatization linked to the trauma of this break in linearity in the life cycle, were consequences of the deprivation of freedom present in the women's narratives, but the presence of resilience was also observed with the hope of new opportunities for changes in future living conditions. (ALVES et al., 2023)

Physical violence against women in situations of deprivation of liberty is also a problem addressed within the environment, acting as a stressor and trigger for the worsening of mental suffering conditions. Such a scenario contributed to the worsening of the situation of extreme human rights violations, with violence in prisons being a factor of stress and trauma prevalent around the world, compromising physical and mental health in association. Among the actions that consist of violence against women, acts that lead to physical, mental, sexual impairment or suffering are included, also considering coercion and the threat of aggression. (GAMA-ARAUJO et al., 2020)

## FINAL CONSIDERATIONS

Looking at the care of marginalized populations from a perspective of needs, opportunities and fragilities is looking at collective health and the studies of prison health policies, and it is essential to immerse FCM in teaching, research, extension, assistance and studies of strategies to operationalize, in a practical way, measures that allow an effective and dignified social reintegration, prioritizing a neglected segment within this

group of criminals: women in deprivation of liberty. (MIRANDA; GOLDBERG; BERMUDEZ, 2022) Thus, the struggle for health as a human right must occur in its full concept of absence of discrimination based on gender or social class, with an emphasis on the equity of care for marginalized populations in Brazil. To this end, it is necessary to structure specific measures that allow the prioritization of access and longitudinal follow-up for those inserted in a neglected group, the most vulnerable groups in the context of marginalization: young people, migrants and women, thus preparing health systems for problem-solving assistance and full compliance with the health needs of these populations in the prison environment.  in a view with a broad understanding of the impact of the social determinants of health on the amplification and worsening of the health conditions of this population, thus preventing an imprisonment of the body, in line with the imprisonment of the meaning of human dignity, from enhancing the preconditions that led to the prison situation. Such a view of the problem in its complexity reinforces the concept that all incarceration, institutionalization and imprisonment do not consist of treatment, recovery or reeducation, breaking the meaning of the act of immersion of the person in a prison system that is not prepared for the reintegration of the citizen in the territory.


## ACKNOWLEDGMENTS

To CAPES – the present work was carried out with the support of the Coordination for the Improvement of Higher Education Personnel – Brazil (CAPES) – Financing Code 001

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