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ORIGINAL ARTICLE

Prison-territory, cell-home: Caring for People Deprived of their Liberty at the Papuda Penitentiary Complex – Federal District

Prisão-território, cela-domicílio: o cuidado de Pessoas Privadas de Liberdade no Complexo Penitenciário da Papuda – DF

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ABSTRACT This article examines prison as a health territory based on a qualitative study conducted in the Prison Primary Health Care Units of the Papuda Penitentiary Complex, in the Federal District, Brazil. The methodology articulated theoretical perspectives of health territorialization with the everyday practices of teams operating under the logic of Primary Health Care (PHC) in contexts of deprivation of liberty. Data were produced by means of participant observation, interviews, focus groups, document analysis, and field narratives. The study identified care strategies that challenge the dominant punitive logic and affirm health as a right in contexts of exception. The findings reveal that the prison territory is characterized by controlled circulation, institutional restrictions, multiple territorialities, and an intense production of subjectivity. Initiatives such as the use of written notes called 'catataus' the recognition of prison cells as a form of domicile, and practices related to mental health care are highlighted. It is concluded that, although the prison environment imposes significant challenges to the implementation of PHC, there is considerable potential in the micropolitical practices developed by health teams. Understanding prison as a health territory therefore constitutes an ethical, political, and technical proposal to strengthen care within the prison system and to expand the role of Brazil's Unified Health System (SUS) in addressing the needs of vulnerable populations.

KEYWORDS Primary Health Care. Prisons. Sociocultural territory. Social Determinants of Health. Vulnerable populations.

RESUMO *Este artigo discute a prisão como território de saúde a partir de uma pesquisa qualitativa realizada nas Unidades Básicas de Saúde Prisionais do Complexo Penitenciário da Papuda, no Distrito Federal. A metodologia articulou referenciais da territorialização em saúde às práticas cotidianas das equipes que atuam sob a lógica da Atenção Primária à Saúde (APS) em contexto de privação de liberdade. Utilizaram-se observação participante, entrevistas, grupos focais, análise documental e narrativas de campo. Identificaram-se estratégias de cuidado que tensionam a lógica punitiva predominante e afirmam a saúde como direito em contextos de exceção. Os resultados indicam que o território prisional é marcado por circulação controlada, restrições institucionais, múltiplas territorialidades e intensa produção de subjetividade. Destacam-se iniciativas como o uso de bilhetes ('catataus'), o reconhecimento da cela como domicílio e ações voltadas à saúde mental. Conclui-se que, embora o ambiente prisional imponha desafios à atuação da APS, há potência nas práticas micropolíticas desenvolvidas pelas equipes. A prisão como território de saúde configura-se, assim, como uma proposta ética, política e técnica para qualificar o cuidado no sistema prisional e ampliar a atuação do Sistema Único de Saúde (SUS) junto a populações vulnerabilizadas.*

PALAVRAS-CHAVE *Atenção Primária à Saúde. Prisões. Território sociocultural. Determinantes Sociais da Saúde. Populações vulneráveis.*

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Introduction

Brazil is among the countries with the largest populations deprived of liberty in the world, counting about 909 thousand people in state custody in the year 2024[1]. Most of this contingent is composed of young, and black or poor men, evidencing the penal selectivity and the structuring role of racism in the composition of the prison system[2]. Mass incarceration has been consolidated as a policy of social control in the face of the fragility of strategies for the protection and promotion of citizenship, revealing the punitive face of the State in the face of social conflicts[3]. In this scenario, the guarantee of the right to health for the incarcerated population is still characterized by invisibility and negligence, requiring a critical approach in the field of public health.

The Unified Health System (SUS), guided by the principles of universality, equity, and comprehensiveness, is responsible for the health care of the entire population, including those under deprivation of liberty, as provided for in the Federal Constitution and the Penal Execution Law[4,5]. The creation of the National Health Plan in the Penitentiary System (PNSSP) in 2002 and the subsequent consolidation of the National Policy for Comprehensive Health Care for Persons Deprived of Liberty in the Prison System (PNAISP) in 2014 represented advances in the institutionalization of prison care as an attribution of SUS, under the logic of Primary Health Care (PHC)[6]. Based on those policies, the presence of Basic Prison Health Units (UBSP) was consolidated as a care strategy in penal establishments.

Within the field of collective health, the concept of territory is central to the organization of health actions, especially in PHC, being understood as a lived space, loaded with meanings, characterized by material economic conditions and social relations[7]. The concept aims to overcome a mere notion of space for the look at social dynamics, interactions, and determinants, that is, the social hierarchies that define access to and quality of health services, the existing relations of violence, living conditions, and other processes that influence the health-disease-death cycle[8,9].

In this context, a reflection is proposed on the prison as a territory of health: a bounded institutional space that houses a complex dynamic of life production, suffering, care, and control. Prison, as a territory, challenges the assumptions of territorialization as conceived in traditional PHC, as it is characterized by heteronomy, enclosure, and disciplinary logic.

The compulsory territorialization imposed by the conviction contrasts to the territorial ascription based on bond and community belonging. People Deprived of Liberty (PPL) have their displacements strictly controlled, their daily lives regulated by disciplinary rules and their access to health mediated by bureaucracies and security systems. Foucault[10] described prison as one of the instruments of 'disciplining of bodies', while Goffman[11] classified it as a total institution, where the daily life of individuals is controlled by rigid and centralized rules. In that environment, health care is crossed with relations of power, control, and stigmatization.

The work of the UBSPs in the Papuda Penitentiary Complex, in the Federal District, offers a concrete opportunity to analyze PHC potentialities and limits within prison territory. Teams, composed of health professionals from different fields, face the challenge of offering comprehensive care to a population deprived of daily autonomy, difficulties in accessing the external network and under constant institutional surveillance. Requests for assistance to Prison Primary Care team are made in writing, through notes addressed to the professionals called 'catataus'. Thus, strategies such as the 'catataus', creative use of spaces and building bonds by means of qualified listening reveal inventive practices within that territory[12].

Concurrently, prison territory imposes severe limits on PHC attributes effectiveness, such as access, longitudinality,

comprehensiveness, and care coordination. Communication with Health Care Network (HCN) is fragmented, flows are unstable, and care is often restricted to the clinical containment of diseases, to the detriment of health promotion[12]. Even so, teams build micropolicies of care that strain the punitive logic and affirm health as a right, even in exception contexts.

This article proposes to discuss prison as a health territory based on the findings of qualitative research conducted in Papuda's UBSPs. To this end, we sought to articulate the theoretical references of territorialization in health with daily practices of teams working under dual membership: SUS and the penitentiary system. It is of interest to reflect on care strategies developed in that scenario and on how PHC reorganizes itself in a space crossed with multiple forms of institutional and social violence.

By recognizing prison as a health territory, we affirm the importance of overcoming the isolation of prison health actions and of more fully integrating that subsystem into the logic of equity and social justice. Health in prison is not a concession or a privilege: it is a right. And, as such, it must be ensured in its dimensions, even when the territory is hostile to life.

Material and methods

This article is a product derived from the doctoral thesis entitled 'Basic Prison Health Units: SUS strategies and practices as to PPL within Papuda Complex – DF'. The research proposed to investigate the organization of health care in prison context, focusing on UBSP performance in the light of PHC principles and on the notion of territory in collective health.

This is qualitative research of exploratory character and inspired also by health work micropolitics as by the subjects' centrality recognition and their practices during daily routine of services. The empirical field of the research was Papuda Penitentiary Complex, located in the Federal District, where five health units linked to Health Department of the Federal District (SES-DF) operate in coordination with the Penitentiary Administration Secretariat (SEAPE-DF).

Different research techniques were used to construct data: a literature review of national and international publications on prison health; PHC and health work in SciELO, PubMed, Google Scholar, and Web of Science databases; open access international documents and treaties relating prisons to living conditions and human rights.

Documentary analysis of public policies applied to health within prison system was also carried out, as were participant observation of teams and care daily life; focus groups with UBSP professionals; semi-structured interviews with members of health teams; and collection of narratives written in field diaries. The research started in 2022 and was concluded in November 2024.

Interviews and focus groups were conducted between September and October 2024, recorded and fully transcribed. The participant observations took place during working hours, under institutional authorization, verbal consent and signature of the Consent Form by the professionals involved in the research. The production of the narratives followed the perspective of listening and sensitive writing on care practices, seeking to articulate the meanings produced in the field with the theoretical references of collective health[13,14]. Documentary analysis included ministerial ordinances, local regulations, technical reports, and institutional flowcharts.

As for empirical data treatment, Content Analysis methodology was applied, as proposed by Bardin[15], through the support of Atlas.ti® software, which helped in the construction of a 'code book' and in data thematic organization. Analytical categories emerged from the floating reading and thematic coding organized into macro-themes aligned with PHC attributes – access, care coordination, comprehensiveness, longitudinality –,

in addition to cross-cutting themes such as territory, culture, community, interpersonal relationships, bonding, mental health, and family relationships. Triangulation between different data sources and retrieval techniques allowed us to enrich the analysis and confer greater interpretative density to the findings. That approach was chosen because it allows the systematization of qualitative data from multiple sources – interviews, focus groups, participant observations, and narratives – so to construct analytical categories capable of revealing meanings produced during the daily routine of health work in the prison system. Pre-analysis phase involved a floating reading and the definition of a textual *corpus* to be further analyzed.

Analytical categories emerged from the connection among PHC attributes, specific challenges of prison health, and the micropolitical elements of the work process. Macro categories were then created, such as access, care coordination, integrality, longitudinality, family, bond, territory, culture, community, and mental health. That structure made it possible to map the strain between the work prescribed by public policies and the actual work experienced by UBSP teams. It confirms Merhy's reference on 'live work in action'[13] and Cecilio's contributions on health needs as a guide for comprehensive care[14]. The analysis thus sought to understand how professionals produce care in a territory of exception, tensioned by the logic of security and the denial of rights.

Given the ethical complexity of this research, approvals were required by two Ethics and Research Committees, under codes CAAE 69755022.0.0000.5260, Opinion: 6,160,785, and CAAE 69755022.0.3001.5553, Opinion: 6,510,102, in addition also to the favorable opinions of the Public Prosecutor's Office and the Penitentiary School of the Criminal Police (Epen) as the approval by the Criminal Execution Court. All participants signed the Informed Consent Form. Following the guidelines of CNS Resolution No. 466/201216, anonymity of participants and respect for dignity of subjects involved were ensured, especially due to the context of vulnerability that characterizes the prison environment.

Papuda as a territory: Description and contextualization

Recognizing prison as a health territory requires describing and contextualizing some of its sociopolitical, institutional, and health particularities. Territorialization as an analytical category of collective health refers to spaces inhabited and used by subjects, in which bonds, conflicts, affections and health needs are created. As it occurs in communities, favelas or rural areas, the prison system needs to be understood as a territory with its own dynamics – characterized not only by physical enclosure, but also by the relational, symbolic and institutional web that shapes the daily life of prisoners and health and security professionals[7,13].

Papuda Penitentiary Complex, located in the Federal District, houses most of the incarcerated population of the federal capital, bringing together, in the same area, different prison units, with varied regimes and profiles of sentences. In 2025, PPL estimates within Federal District exceeded sixteen thousand inmates, of whom more than 85% were under Papuda custody. The occupancy rate of the complex exceeds the projected capacity, evidencing a scenario of overcrowding in units intended also for provisional as for closed and semi-open regimes[1].

Health management in DF prison system is shared between the Department of Health and the Department of Penitentiary Administration. Five UBSP operate inside the complex with multiprofessional teams linked to and responsible for the health care of about fourteen thousand inmates. Those teams work in different contexts, following various regimes and population profiles that include people in pretrial detention, in criminal execution and those who are part of the

most vulnerable social segments. Although the majority of the incarcerated population consists of young, black men, and low income and education, it is worth highlighting the plurality of that group: women, elderlies, foreigners, indigenous people, lesbians, gays, transsexuals, people with disabilities, among others.

Another aspect of this scenario concerns Papuda architectural and operational characteristics, what directly influence the organization of health care. The displacement of inmates through cells, courtyards and health units depends on the availability of escorts and prior authorization from security, constraining access, and attendance to services. Collective housing, disciplinary rigidity, and restricted displacement through cells ease micro-territorialities carrying their own identities and practices, configuring what can be called prison territoriality. In this context, care practices mold themselves to the possibilities and limits imposed by space, requiring teams to develop creative and flexible strategies for the construction of bonds, qualified listening, and effectiveness of longitudinal care.

Access to health and displacement in the prison territory

PPL access to health services within the prison system does not occur spontaneously or by direct demand, as is typical of a PHC in the free world. Within Papuda Complex, the displacement of subjects in the territory is strictly controlled by safety protocols that impose physical, bureaucratic, and symbolic barriers to access health services. The logic of 'controlled circulation' defines the prison territory as a space of supervised and selective flows, where the displacement between cells and health units depends, as mentioned, on the availability of escorts, the architectural configuration of the unit and the authorization of the penal system.

Among the most common strategies for accessing UBS stands out the use of the so-called 'catatau' – notes written by PPL themselves requesting care. That form of access is mediated by various factors, such as the literacy of the prisoner, access to pen and paper, and power relations within the cell. In some situations, a catatau is filtered by internal leadership people before reaching the health team, generating additional barriers to care: "*I think that even for the sake of organization inside the cell, it turns out that João, for example, does not have access to the catatau as Francisco does*" (GF2, P10).

Another essential way to access the services is the 'tram', which corresponds to the arrival or transfers among prison units. At the time of the tram, the initial care takes place, with active listening, clinical evaluation, and survey of immediate needs. This is a strategic opportunity to identify acute and chronic conditions, mental health problems, and epidemiological risks. One professional reports: "*The first contact with the inmate is on the tram. We welcome them and ask if they have any health complaints, if they are taking medication, if they have any chronic disease...*" (GF3, P15).

In addition to catatau and the tram, access to health can be mediated by security agents and court orders. The so-called 'official requests' come from requests made by defenders, lawyers or family members to the criminal execution courts, and are often prioritized due to the obligation of a formal response. One interviewee states: "*I mix, I put 70% judicial and 30% catatau*" (ESE, P7). That prioritization is not always aligned with clinical criteria, because it generates the risk of an inverse logic of care, favoring those with a larger legal support network to the detriment of more urgent demands from the point of view of care.

PPL displacement within health units also obeys strict rules. Each internal displacement – from the waiting cell to the office, from the service room to the medication room – requires a police escort. Consultation time includes not only clinical care, but also waiting for corridors to be cleared, doors opening and escort availability. Thus, an agenda set up for appointments

every 15 or 30 minutes, for example, should consider that part of this time is used with the logistics within the prison itinerary.

The special organization of prison territory, therefore, radically alters the forms of access and circulation typical of PHC. The idea of territorial ascription, fundamental in the model of the Family Health Strategy outside the walls, is characterized in prison by a highly regulated system, in which the presence in the health service depends both on the subject's perceptions of demands and on the authorization of the penal institution. Prison territory is not only a place where care is offered, but a space where care must constantly compete for place with surveillance and control.

Institutional restriction in prisons and the production of health care

UBSPs operate under institutional surveillance and control, sharing the territory with prison security, interfering with the rules of circulation, scheduling, and permanence of prisoners in health services. This overlapping of logics – care and discipline – directly shapes the teamwork process, limiting clinical autonomy and requiring constant negotiation with security agents. In that territory, surveillance is both structural and symbolic, crossing the daily routine of health work with meanings and priorities that are not always aligned with the logic of care.

Planning and length of consultations and even the presence of the patient in a health unit depend also on the availability of an escort as on the logistical and operational support of the security sector. In some contexts, criminal police officers even participate informally in the creation of care plans, given their proximity to the cases and health professionals. However, that cooperation, although useful in certain circumstances, compromises confidentiality and displaces the subject centrality in the care process.

One of critical points identified by the research was the strain between judicial prescriptions and clinical demands. Part of the services is motivated by judicial requests, which sometimes arrive with strict deadlines and require a formal response to the judge or prosecutor. Those decisions, often based on requests from lawyers or family members, compete with demands identified by the teams or requested via 'catatau'. One of the professionals' reports:

> *In my view, criticism is that we end up having to review priorities concerning judicial decisions. The judicial decision with a deadline overlooks demands that are, sometimes, biologically, more important to our technical view. But, sometimes, we see lawsuits giving a deadline of 24 hours to be answered* (GF2, P10).

That priority issue can create a new form of 'law of inverse care', by which those with greater legal support have the chance of being attended more quickly, due to the strain the judicial logic exerts on the power that emerges from the territory.

The cell as a home

As for prison context, the cell imposes itself as the central space of the daily life of people deprived of liberty, where they sleep, feed, take care of personal hygiene and develop work and education activities in environments ruled by institutional norms, in which they may remain for periods ranging from days to months or even years[17]. Those spaces, despite being restrictive and shared, end up being the temporary home throughout the fulfilment of the sentence. Although that space was not idealized as a place of residence, it attains, in practice, the status of compulsory domicile. Such reading is supported by the Brazilian Institute of Geography and Statistics (IBGE), which recognizes the collective domicile as one in which coexistence takes place under rules of administrative subordination, as occurs in prisons and detention houses[18]. Thus, the cell can and should be considered as a territory of

temporary residence, an understanding that has direct implications in the formulation of health care practices.

The cell as a home is not a gesture of understanding prison as natural, but of visibility and responsibility in the face of the concrete reality experienced by PPL. By understanding the cell as a home, it is possible to apply home care tools – such as on-site visits, extended listening, and direct observation of living conditions – in care planning and implementations. Such approach allows the technical gaze to shift from the isolated clinic to an expanded reading of the territory, including factors such as overcrowding, ventilation, food, sanitation and support network among inmates, all fundamental determinants of the health-disease process. During this work, as there were no visits inside the cells, it was decided to call 'territorial visits' a series of those actions *in loco*.

As observed by Santos et al.[17(14)], when inhabiting the cell, the person needs to reorganize himself psychologically and socially so to share the space with strangers, follow rules of coexistence and create new forms of protection and solidarity. The cell not only houses but also disciplines and transforms. It is a space of vulnerability and, at the same time, of resistance and life living. In many cases, bonds formed between inmates in that space become close to the notions of 'extended family' or 'circumstantial community', making home perspective even more pertinent.

Examples are relationships of 'camaraderie' that become a condition for survival due to the need to establish bonds in an environment where the relation with the outside world is limited. On the other hand, these relationships can also be characterized by violence, domination, and coercion, reproducing and perpetuating cycles of aggression. Cells that shelter the same inmates for long periods of time tend to develop beliefs and identity values among their members, such as the creation of religious rituals, exemplified by prayers or collective readings of the Bible.

The document 'Home Care in Primary Health Care'[19] stands out the relevance of home care within PHC, detailing attributions, challenges, and specificities for different population groups. However, despite addressing homeless populations and rural areas, the text does not detail the approach on the population deprived of liberty, evidencing a gap in the protocols and guidelines from the health system authorities towards care in prison homes.

Health teams territorial visits to the blocks, wards, and cells – a practice that presupposes the activation of various security devices – are important strategies to recognize the specificities of the territory, helping the observation of determinants of health-illness processes and the lifestyles of that population. Those incursions make professionals able to perceive aspects such as the absence of adequate mattresses, the presence of vectors, environment stuffiness and precarious access to water and food, decisive factors in maintaining health and preventing diseases[11,20]. Direct observation allows the identification of possible neglected conditions and the recognition of priorities and therapeutic possibilities based on the daily life experienced, not only on the referred complaint.

By conceiving the cell as a home, PHC work legitimacy within prison units is expanded. The blocks, wards, and cells thus become the locus of individual and collective interventions, such as mass vaccination, active search for individuals with respiratory symptoms, distribution of educational material, and guidance on oral or mental health. As for Goffman[11], total institutions like prisons cause a kind of 'civil death' in the subjects, who lose autonomy over their bodies and routines. By recognizing the cell as a home, health teams resist such logic, reaffirming care as a right and presence.

That perspective requires a shift from the technical-centered perspective to the intersectional and territorialized approach. Home-cell evidences the social determinants of illness, allows preventive interventions, and

values the bond between team and population served. Care starts to be built within and with the territory, revealing cells not as obstacles, but as spaces for listening, welcoming and health promotion, even amid the brutality of incarceration.

Territory, culture, and community

The prison territory is not homogeneous. On the contrary, it is characterized by multiple territorialities that intersect and impose each other: gender, ethnicity, religiosity, social support networks, time spent serving the sentence and internal power structure. Each cell, ward or gallery carries its own symbolic structure, where hierarchies, alliances and conflicts are daily updated. For this reason, the authors suggest the use of the term territory-prison, which can be understood as

> The one where people live compulsorily, for a defined time, under rigid rules, legitimized by laws, norms, and guidelines, totally under the tutelage and responsibility of the State[12].

Health teams, when working in those spaces, need to decipher such codes and build forms of care that take those dynamics into account. One interviewee reports:

> *This thing about culture and territory is very crazy. Because there is not anything like it out there. [...] The feeling I have is the top of the iceberg of vulnerability* (ESE, P8).

Those territorialities are crossed by social determinants that enhance psychic suffering. Overcrowding, lack of privacy, institutional violence, idleness, and precarious material conditions directly impact mental health of people deprived of liberty. In addition, the compulsory masculinity in force in prisons acts as an inhibitor of emotional expression, transforming crying into taboo and anger into the sole escape valve. The expression of emotions such as crying and anger becomes an act of resistance in a place where rigid masculinity and discipline seem to override basic human needs.

Faced with that scenario, health teams develop creative and inventive practices to stop the medicalizing and punitive logic. An example is the 'Reflect' project, which emerged in the research field, in which books on mental health, spirituality and thinking are 'prescribed' to people with psychic suffering. The reading circles emphasize listening, dialogue and collective elaboration of incarceration pains: a UBSP organized a small library with self-help and mental health books, acquired with its own resources, for people suffering from insomnia, grief, lack of perspective or rupture of bonds.

Another example of micropolitical resistance is the LGBTQIAPN+ population, who discuss topics such as gender identity, hormone therapy, pride, religiosity, sexually transmitted diseases, and violence. One of the teams even organized a seminar on LGBTphobia together with penal police officers and health and education professionals from the prison. Those initiatives strain institutional norms and affirm care as a practice of recognition and listening.

Cultural, spiritual, and integrative health practices are also part of teams' repertoire in coping with pain and hopelessness. Projects with medicinal gardens, therapeutic practices based on Traditional Chinese Medicine, such as Lian Gong and auriculotherapy, meditation and art therapy were found in some units. Such practices not only alleviate symptoms but also create gaps of subjectivation, allowing life to find meaning again even in territories of exception.

Understanding prison system as a lived territory – and not just as a space of confinement – is central for the construction of more comprehensive and powerful care practices. By recognizing multiple territorialities, health teams exercise a clinic committed to the culture, dignity, and life of incarcerated people, even if under surveillance and in

environments marked by pain and stigma. Thus, prison-territory is also a potential place of community, resistance and care.

Conclusions

The recognition of prison as a health territory represents a conceptual and political advance necessary for SUS consolidation as a universal and equitable system. This study revealed that, even in a context characterized by surveillance, discipline, and systematic denial of rights, it is possible to build care practices guided by PHC principles, mainly as for territorial perspective. By considering the cell as a compulsory domicile and the prison space as a sanitary territory, possibilities of health intervention are expanded while SUS presence is qualified within exceptional territories.

UBSP functions as central devices in that process, operating between the limits of institutional control and the micropolitical power of care. Teams' creative strategies – such as books' prescription, LGBTQIA+ population groups, visits to cells and creative use of 'catataus' – show that health care rendering goes beyond protocol and technical prescription, being deeply crossed by relationships, territory, and qualified listening. Those practices not only respond to health problems but also allow other incentives to subjectivity in spaces distinguished by containment.

Structural challenges remain as constraints to PHC effectiveness in the prison system. Challenges of joint work between health and security, consolidation of practices aimed at shared multiprofessional work, adoption of singular therapeutic projects and matrix support, expansion of the use of Integrative and Complementary Practices, communication fragmenting due to RAS and the quantity of legal demands addressed to health teams are expressions of an incarceration policy that weakens care. In addition to local initiatives, an institutional and intersectoral agreement is needed to strengthen PNAISP, ensure adequate funding and promote continuing education of the professionals involved.

Prison, as a territory of multiple territorialities, requires an approach based on comprehensiveness with regards to social determinants of health-illness processes, cultural plurality of incarcerated population and the complexity of institutional relations. Health care is not limited to absence of disease, but involves acknowledging, listening, and respecting the dignity of people deprived of liberty. That is how affirming prison as a health territory is also an ethical-political act of delivering equity and human rights.

The findings of this research contribute to the broadening of the debate on prison health in the field of collective health by proposing the articulation between territory, micropolitics and care. By making visible the practices of health teams within the prison system, the study highlighted the need to overcome institutional fragmentation and to ensure that health, as a right, is effectively universal – even in spaces historically relegated to exclusion.

Finally, we reaffirm that health care in Brazilian prisons cannot depend on individual creativity or on silent militancy of few professionals. It urges to consolidate the presence of the SUS in prisons as an integrated public policy guided by social justice. Therefore, prison as a health territory is both a diagnosis and an ethical and institutional proposal to confront reproducing inequalities in spaces of liberty deprivation.

Authorship contributions

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