







Profile of Renal Transplant Patients Associated with Social Security or Continuous Cash Benefit and Labor Status

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Abstract: Chronic kidney disease consists of kidney damage and the progressive and irreversible loss of kidney function. Thus, when the kidneys are no longer able to maintain their functions, it is imperative that the individual access some benefit to facilitate treatment. Thus, the objective of this article was to analyze the social security or welfare and labor situation of the patient transplanted by a renal transplant unit. The research was carried out by means of a questionnaire with patients who attended the specialties outpatient clinic in October and November 2021. The project was approved by the Research Ethics Committee of the Faculdade de Medicina de São José do Rio Preto, Brazil, and the patients who agreed to participate in the research signed the informed consent form, complying with the ethical principles of the National Health Council and the Ethics Code of the Social Worker. For analysis purposes, after data collection, the variables age, gender and education made up the social profile of the interviewees (n = 20) with the distribution of the variables of social security status and work status, associated with the surveyed profile. In the social profile of the group studied, the female gender contrasted with the literature researched. The variation in the frequency detected of patients in social security or welfare assistance status confirms the impossibility of resuming conditions for professional exercise and, unfortunately, although small, it is an expressive portion of patients with no income or away from the labor market.

Descriptors: Analysis of Situation; Social Security; Social Support; Job Market; Kidney Transplantation; Social Work.

INTRODUCTION

Chronic kidney disease impacts the lives of thousands of individuals and families, consisting of a public health problem. It is in this scenario that kidney transplantation appears as a treatment option with the goal of improving quality of life.¹ Kidney transplantation, in 2020, reached the number of 7,127 procedures performed throughout the country,² supporting the treatment of thousands of people. Brazil has the largest public program for organ, cell, and tissue transplantation in the world, ensured through the Unified Health System (UHS), responsible for funding about 95% of transplants in the country.³

Despite all the challenges in the phase prior to transplantation, such as the stress of pretransplant dialysis treatment, social isolation, inability to move, lack of leisure, loss of physical autonomy and work activity, after the procedure a new reality emerges with the maintenance of treatment, dietary and physical restrictions, and the permanent dependence on immunosuppressants, in addition to the periodic returns.¹ At the same time, there are structural challenges, such as 14.4 million unemployed,⁴ 13.2% unemployment rate,⁵ insufficient benefits and programs,⁶

precarious working conditions, and many other expressions of the social issue arising from capitalism that condition the health process in its entirety.⁷⁻⁹

Among so many issues for survival in capitalism and in what directs this article, it is worth highlighting a special challenge: The arduous trajectory that takes place for those who need to access the benefits for labor disability from social security or the Continuous Cash Benefit from social assistance,^{10,11} as well as the other social policies that, when accessed, strengthen the principle of universality of the UHS and facilitate treatment.¹² The arduous and tortuous path to access social rights is no exception. On the contrary, it is common to observe such difficulty, even in some outcomes whose families face the availability of the benefit after the death of the person who sought it.¹³

It is in this scenario that the social service of a teaching hospital, fulfilling its ethical-political project, works in the development of strategies, aiming at the defense and conveyance of rights as a professional duty,¹⁴ performance that contributes to the access and exercise of citizenship in the production of health.¹² Thus, to have an increasingly deeper dimension of the social reality of renal transplant patients in relation to access to social security policy and welfare benefits is an analysis that represents not only an advance for the renal transplant unit, but for the entire category of transplanted patients, since it brings to light the dialectical particularities of this group, which for several times is socially and historically invisible.

METHODS

This is a cross-sectional quantitative study^{15,16} by means of field research, which project was approved by the Ethics Committee on Research Involving Human Beings of the Faculdade de Medicina de São José do Rio Preto (Opinion no. 5,022,577; Certificate of Ethical Appreciation Submission 50527821.6.0000.5415). It was carried out in the General and Specialty Outpatient Clinic of Hospital de Base de São José do Rio Preto (Nephrology) and was conducted in October and November 2021, with a sample of 20 transplant patients, limited by the COVID-19 pandemic phase. The inclusion criteria were age over 18 years and that the patients had undergone deceased donor kidney transplantation. Regarding exclusion, patients who were not clinically able to participate in the interview were not included in the study.

Subsequently, the data collected was presented in tables and analyzed through participant observation of the authors as to the social situation of the patients in the sample regarding the type of social security benefits or Continuous Cash Benefit and the labor situation in which they were inserted.¹⁷ The search for bibliographic material and legislation was carried out in databases such as Google Scholar, Scientific Electronic Library Online (SciELO), the federal government platform and the Federal Council of Social Service. The discussion of the results was based on the dialectical perspective.¹⁸

RESULTS

Table 1 presents the social profile of the respondents, a total of 20, with a prevalence of females (n = 13, 65%), a mean age of 49.7 years, and ranges of 31 to 50 years (n = 10, 50%) and 51 to 63 years (n = 10, 50%).

Table 2 indicates the social security status indicated by the interviewees, according to the variation of the social profile. Patients without social security (n = 4, 20%) were aged between 31 and 50 years. The predominance of patients aged between 51 to 63 years who were receiving disability retirement (n = 5, 25%) was in the male gender (n = 4, 20%) and among those with incomplete elementary school education (n = 5, 25%). The total group regarding education consisted of 7 (7, 35%) disability retirees.

Table 1. Social profile of the group of interviewees (n = 20).

Variables	N	%	
Age (mean = 49.7) (years)	31-50	10	50
	51-63	10	50
Gender	Female	13	65
	Male	7	35
Education level	Incomplete elementary school	9	45
	Complete elementary school	1	5
	Incomplete high school	2	10
	Complete high school	5	25
	Complete higher education	2	10
Without schooling	1	5	

Table 2. Distribution of social security status variables associated with the social profile of the respondents (n = 20).

Variables		Sick pay	Disability retirement	Welfare aid	Pension	Retirement due to contribution time	No bonding	Total
Age (years)	31–50	2 (10%)	2 (10%)	2 (10%)	0	0	4 (20%)	10 (50%)
	51–63	0	5 (25%)	0	2 (10%)	1 (5%)	2 (10%)	10 (50%)
Total		2 (10%)	7 (35%)	2 (10%)	2 (10%)	1 (5%)	6 (30%)	20 (100%)
Gender	Female	2 (10%)	3 (15%)	2 (10%)	2 (10%)	0	4 (20%)	13 (65%)
	Male	0	4 (20%)	0	0	1 (5%)	2 (10%)	7 (35%)
Total		2 (10%)	7 (35%)	2 (10%)	2 (10%)	1 (5%)	6 (30%)	20 (100%)
Education level	Incomplete elementary school	1 (5%)	5 (25%)	2 (10%)	1 (5%)	0	0	9 (45%)
	Complete elementary school	0	1 (5%)	0	0	0	0	1 (5%)
	Incomplete high school	0	1 (5%)	0	0	0	1 (5%)	2 (10%)
	Complete high school	0	0	0	0	1 (5%)	4 (20%)	5 (25%)
	Complete higher education	1 (5%)	0	0	0	0	1 (5%)	2 (10%)
	Nonliterate	0	0	0	1 (5%)	0	0	1 (5%)
Total		2 (10%)	7 (35%)	2 (10%)	2 (10%)	1 (5%)	6 (30%)	20 (100%)

Table 3 shows the data concerning the labor situation after undergoing renal transplantation, brought by the interviewees according to the variation of the social profile. Four (20%) patients aged between 31 and 50 years were unemployed and 4 (20%) in the condition of beneficiaries of social security or on welfare assistance. In the range of 51–63 years old, 8 (40%) were receiving some kind of benefit. The female gender (n = 7, 35%) was predominant in this variable, and 8 (40%) had incomplete elementary school education. The group, regarding schooling, was made up of 12 (60%) beneficiaries of welfare or social assistance.

Table 3. Distribution of the labor status variables associated with the social profile of the respondents (n = 20).

Variables		Consolidation of Labor Laws	Self-employed	Unemployed	Social security benefit or welfare assistance	Total
Age (years)	31–50	1 (5%)	1 (5%)	4 (20%)	4 (20%)	10 (50%)
	51–63	1 (5%)	0	1 (5%)	8 (40%)	10 (50%)
Total		2 (10%)	1 (5%)	5 (25%)	12 (60%)	20 (100%)
Gender	Female	1 (5%)	1 (5%)	4 (20%)	7 (35%)	13 (65%)
	Male	1 (5%)	0	1 (5%)	5 (25%)	7 (35%)
Total		2 (10%)	1 (5%)	5 (25%)	12 (60%)	20 (100%)
Education level	Incomplete elementary school	1 (5%)	0	0	8 (40%)	9 (45%)
	Complete elementary school	0	0	0	1 (5%)	1 (5%)
	Incomplete high school	0	0	1 (5%)	1 (5%)	2 (10%)
	Complete high school	0	0	4 (20%)	1 (5%)	5 (25%)
	Complete higher education	1 (5%)	1 (5%)	0	0	2 (10%)
	Nonliterate	0	0	0	1 (5%)	1 (5%)
Total		2 (10%)	1 (5%)	5 (25%)	12 (60%)	20 (100%)

DISCUSSION

Social profile of the interviewees

The mean age of the participating patients (49.7), is similar to the information presented in a study on kidney transplant recipients (47.6) and transplant candidates of another modality (48.11 and 47.14).^{19,20} The minimum and maximum ages in this study (19–73) were similar to those of Ribeiro et al. (17–74) and Serrano et al. (19–70 and 20–73).^{19,20} The higher prevalence of the female gender

(n = 13, 65%) contrasts with the findings of articles of various transplant modalities that found the male gender above 60%.^{19,20} The predominance of the mentioned studies contrasts with the fact that the Brazilian population as a whole is predominantly female (48.2% men and 51.8% women), as demonstrated in a recent survey by the Brazilian Institute of Geography and Statistics (IBGE).²¹ Such identification is relevant, since the gender category impacts on the life of the subject, since it actively conditions their insertion and participation in life in society.²²

It is noteworthy that the adult population transplanted in 2021 (n = 66, 100%) by the kidney transplant unit was mostly male (n = 40, 66.7%), minimum age was 18 and maximum 66, and mean age was 46.6 years, according to the discussions. The finding of this study regarding the predominance of females (n = 13, 65%) may be associated with sample limitation, whose probable justification is the occurrence of the study in the context of the COVID-19 pandemic, with drastic reduction of on-site assistance in the specialties outpatient clinic of the base hospital.

The incomplete elementary school education (n = 9, 45%) presented by the interviewees is in agreement with IBGE data, whose majority of people (32.2%) also reported the same educational level,²³ as well as in the frequencies (42 and 35%, respectively) of the two groups studied in Serrano et al.²⁰ In Silva and Araújo,²⁴ most of the group interviewed had finished high school. In any case, access to education, as well as health as a right of all and duty of the State,²⁵ according to the Organic Health Law, aims to guarantee access to other social policies that determine the levels of health in society, expressing the political and social organization of the country,¹² which in our conjuncture demonstrates the need for greater investment and expansion of democratic access, although the advances in the area are undeniable.

Social security information associated with the respondents' social profile

The group of patients aged between 31–50 years with no social security (n = 4, 20%), made up of noncontributors, without the status of insured or awaiting administrative positioning from the National Institute of Social Security (INSS) or judicial, corresponds to similar results (17.70 and 28.19%) of a detailed study of social profiles.²⁰ In the 51–62 age range, the higher frequency of disability retirement (n = 5, 25%) can be justified by the right to the benefit when the inability to work is characterized, access generally granted in the phase prior to transplantation, due to severe disease and renal replacement therapy,²⁶ not excluding the possibility of later access, i.e., occurring after undergoing renal transplantation.²⁷

In total, the group was mostly composed of disability retirees (n = 7, 35%), which is understandable, as it is a severe disease, which can present ill-effects that compromise the functional capacity of the individual.²⁷ Moreover, the benefit in question may also have been granted before transplantation.²⁶ In a study by Silva and Araújo, there was a similar expressive quantity of patients receiving sickness benefit (33%) and Continuous Cash Benefit (40%).²⁴

The absence of employment in female patients (n = 4, 20%) may reflect the inequalities in gender relations, whose precariousness and sexual division of labor severely impact women.²⁸ The notorious predominance of male access to disability retirement (n = 4, 20%) verifies the surveys of social security statistical data on benefits granted in July 2021,²⁹ since the number of male deferrals is also predominant (5,186 male beneficiaries and 3,761 female ones). When it comes to both genders, most were receiving disability retirement (n = 7, 35%), reinforcing the probable continuity of functional disability. It is evident the lack of employment relationship (n = 6, 30%).

The relation of findings regarding disability retirement and incomplete primary education (n = 5, 25%) is justified by the predominance of people with this same level of education in the national scenario and contrasts with the data from the Ministry of Health, because among all retirements accessed in July 2021, the disability retirement was the one with the lowest number of deferrals (8,947).^{23,30} It is important to consider the likelihood that the patients in question had accessed this benefit before being transplanted and that, after the social security reform, the daily professional life shows greater difficulty in accessing the benefits of this policy.

The correlation between a complete high school education and no social security bond (n = 4, 20%) contrasts with some studies that have shown good results regarding the employability of people with this education.²⁶ It is imperative to have a social security bond in order to access the benefits of this policy.³¹ On the other hand, to be working, depending on the condition (informal or not), does not necessarily mean social security, especially after transplantation, a period in which the patient and the family face several hospitalizations and recurrent returns to the unit. When there is absence of bonding, it becomes an arduous challenge for survival.

All in all, the equalization of the data disability retirement (n = 7, 35%) and no social security (n = 6, 30%) presented the harsh Brazilian reality, pointed out in the previous discussions. This data was contrary to the findings of a 2017 study, the phase before the COVID-19 pandemic, which showed that kidney transplant recipients return to productive activity after transplantation.²⁶ In these terms, it is worth reflecting how much welfare and labor policies currently lack a more humane, comprehensive, welcoming review that, in its elaboration and operationalization, is defined in a network. It is worth emphasizing the importance of dialogue between them (intersectoriality), because individuals must be rethought in totality, as a human being, and not in a fragmented way.

Labor information associated with the respondents' social profile

Patients aged 31 to 50 years unemployed (n = 4, 20%) correspond to statistical surveys that point to high rates of unemployment,⁴ besides reaffirming the highly inhumane and competitive character of the capitalist labor market. It is worth remembering the importance of income for the maintenance of treatment, even though the UHS legally has the role of providing all subsidies for the integral access to health. With the same frequency (n = 4, 20%), the beneficiaries of social security or in welfare assistance—absent from work activities—also present substantial losses, especially after the social security reform,³² due to the reduction of income and loss of benefits of formal employees, such as food or meal vouchers. This also impacts on the treatment. It is at the time when the person most needs the income that it is scarce.

The age group 51 to 62 of the beneficiaries of social security or welfare assistance (n = 8, 40%) is justified by the social security indicators, since most retirements are accessed (July 2021 survey) by individuals over 50 years of age.³⁰ Considering the access criteria for welfare assistance (Continuous Cash Benefit),¹¹ it is important to note that this group of people accessed this benefit upon the characterization of their inability to work and the verification that they had not contributed to the social security system. Thus, it is very likely that the benefit has been accessed prior to transplantation, due to the issue of the chronic kidney disease, listed by the Ministry of Health and by social security as a serious disease.³⁰

The two genders with majority frequencies in the perceived benefits—social security benefit (n = 7, 35%) and welfare assistance (n = 5, 25%)—are important data from the point of view of the maintenance of the patient, the family and the treatment, although it would be more financially advantageous if the individual were inserted in the formal labor market. It is known that the formal labor market does not include people undergoing health treatment, even after undergoing transplantation. On the other hand, to what extent can we say that transplanted people fully resume their working capacity and,³³ if they do, how prepared are the companies to receive employees who, in most cases, need to be absent from work to attend the outpatient visits and the hospitalizations that complement the proposed treatment or follow-up and remain with them?

With the exception of unemployment among people with complete high school education (n = 4, 20%), an issue discussed earlier, those with incomplete elementary school education also continued to receive some benefit (n = 8, 40%), besides the other schooling levels presenting a higher frequency in the totality of this item (n = 12, 60%).

Thus, we noticed that few people in the group studied were inserted in the formal labor market (range 5 to 10%), a small portion was unemployed (range 5 to 25%), and most were still on benefit maintenance (range 5 to 60%). These data were contrary to the findings of a 2017 study, the phase prior to the COVID-19 pandemic, which showed that the majority of kidney transplant recipients (52.76%) returned to paid productive activity after transplantation.²⁶ It is worth noting that, despite this counterpoint, transplant recipients still express their difficulties against prejudice and political struggles to be able to return to the labor market, claiming a more humanized look that considers their life story as a source of inspiration.³³

CONCLUSION

The social profile of the interviewees was not very different from that found in the literature, but the gender findings were quite contrary, probably due to the sample size of this study, which is justified by the pandemic phase. As for the association between the social profile variables and age, the younger the age, the greater was the lack of bonding detected. The older age group, as expected, was inserted in the benefits for productive disability.

With regard to labor issues, the youngest age group was outside the formal labor market, and the oldest group had some type of benefit, regardless of gender. The social security data are articulated with the labor data, to the extent that the person who is undergoing treatment or health monitoring as a beneficiary of social security through sickness benefit, disability retirement, or even social assistance cannot take a position in the formal labor market, for legal reasons.

Despite the frequencies found (between 5 and 60%) in maintaining the condition of being insured by the social security system or by the welfare assistance (Continuous Cash Benefit), it is noticeable in the social service appointments the financial difficulty presented by the patients and their families—sometimes the benefit amounts to only one minimum wage—besides being expected that the social policies would be able to offer full coverage, as recommended in the legislation and according to the social and subjective needs of each individual.

Given the labor and social security conjuncture in the context of the last two years and the several particularities of the treatment phases in pre- and post-kidney transplantation, the importance of the professional performance of the social worker and the work team is remarkable. The articulated and directed activities towards a common goal favor the development of strategies that aim at the access of patients both to benefits and to the labor market itself, even if with several deficiencies.

Such coverage impacts the multiple dimensions of the social being—emotional, physical, social—in its entirety, leading to improvements in the health production process. In this context, it can be inferred that the social service in the unit, relying on protocols, flows, and routines, as well as with the ethical-political, theoretical-methodological, and technical-operational grounds of the profession's ethical-political project, has been contributing to facilitate access to social policies and that, by operationalizing its professional practice oriented to the uncompromising defense of human rights and, by extension, the rights of patients in treatment for chronic disease, it fulfills its social role.

We suggest that further studies with a larger sample size be conducted in order to fill gaps or broaden the discussions that have been developed.

AUTHORS' CONTRIBUTION

Substantive scientific and intellectual contributions to the study: Colombo DMQ, Serrano LCA, Silva ACP and Pereira VA; **Conception and design:** Colombo DMQ, Serrano LCA and Silva ACP; **Data collection, analysis and interpretation:** Colombo DMQ, Serrano LCA and Pereira VA; **Article writing:** Colombo DMQ, Serrano LCA, Silva ACP and Pereira VA; **Critical revision:** Serrano LCA, Silva ACP, and Pereira VA; **Final approval:** Colombo DMQ, Serrano LCA, Silva ACP, and Pereira VA.

AVAILABILITY OF RESEARCH DATA

Data will be made available upon request.

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REFERENCES

1. Santos LF, Prado BC, Castro FPS, Brito RF, Maciel SC, Avelar TC. Qualidade de vida em transplantados renais. *Psico-USF*. 2018;23(1):163-72. <https://doi.org/10.1590/1413-82712018230114>
2. Associação Brasileira de Transplantes de Órgãos (ABTO). Dimensionamento dos transplantes no Brasil e em cada estado: 2013-2020. São Paulo: Registro Brasileiro de Transplantes; 2020 [acessado 20 nov. 2021]. Disponível em: https://site.abto.org.br/wp-content/uploads/2021/03/rbt_2020_populacao-1-1.pdf
3. Brasil. Ministério da Saúde. O Sistema Nacional de Transplantes (SNT) [Internet]. Brasil: Ministério da Saúde; 2021 [acessado em 31 ago. 2021]. Disponível em: <https://www.gov.br/saude/pt-br/composicao/saes/snt>
4. Instituto Brasileiro de Geografia e Estatística (IBGE). Desemprego [Internet]. Brasil: IBGE; 2021 [acessado em 20 nov. 2021]. Disponível em: <https://www.ibge.gov.br/explica/desemprego.php>
5. Instituto Brasileiro de Geografia e Estatística (IBGE). Desocupação [Internet]. Brasil: IBGE; 2021. [acessado em 20 nov. 2021]. Disponível em: <https://www.ibge.gov.br/busca.html?searchword=desocupa%C3%A7%C3%A3o>
6. Aldeonato AI, Rolim GN, Andrade MD. Determinantes sociais da saúde como desdobramentos da questão social: análise da entrevista social no transplante hepático. *Qualitas*. 2019;20(2):157-79. <https://doi.org/10.18391/req.v20i2.5396>
7. Fávero AA, Bechi D. A subjetivação capitalista enquanto mecanismo de precarização do trabalho docente na educação superior. *Educ Policy Anal Arch*. 2020;28(13):1-23. <https://doi.org/10.14507/epaa.28.4891>
8. Yazbek MC. Serviço social, questão social e políticas sociais em tempos de degradação do trabalho humano, sob o domínio do capital financeiro. *Serv Soc Rev*. 2018;21(1):183-94. <http://dx.doi.org/10.5433/1679-4842.2018v21n1p183>

9. Souza DO. O caráter ontológico da determinação social da saúde. *Serv Soc Soc.* 2020;(137):174-91. <https://doi.org/10.1590/0101-6628.207>
10. Bittencourt ALM. Da dignidade da pessoa humana. In: Bittencourt ALM. *Manual dos benefícios por incapacidade laboral e deficiência*. 4ª ed. Curitiba: Alteridade; 2021. p. 2-34.
11. Brasil. Ministério do Desenvolvimento Social. O Benefício de Prestação Continuada - BPC. Guia para técnico e gestores da assistência social [Internet]. Brasília: Ministério do Desenvolvimento Social, 2018 [acessado em 18 out. 2022]. Disponível em: http://www.mds.gov.br/webarquivos/publicacao/assistencia_social/Guia/Guia_BPC_2018.pdf
12. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências [Internet]. Brasil; 1990 [acessado em 25 set. 2021]. Disponível em: http://www.planalto.gov.br/ccivil_03/leis/L8080.htm
13. Severiano EMO, Macedo AC. Previdência social: a saga entre trabalho e adocimento. *Katálysis.* 2015;18(2):172-81. <https://doi.org/10.1590/1414-49802015180200004>
14. Bisco GCB, Sarreta FO. Atuação profissional do serviço social na saúde para efetivação de direitos. *REFACS.* 2020;8(3):1009-18. <https://doi.org/10.18554/refacs.v8i0.5018>
15. Freire MCM, Parrussi MP. Tipos de estudos. In: Estrela C, ed. *Metodologia científica: ciência, ensino e pesquisa*. 3ª ed. Porto Alegre: Artes Médicas; 2018. p. 109-27.
16. Souza KR, Kerbauy MTM. Abordagem quanti-qualitativa: superação da dicotomia quantitativa-qualitativa na pesquisa em educação. *Educ Filos.* 2017;31(61):21-44. <https://doi.org/10.14393/REVEDFIL.issn.0102-6801.v31n61a2017-p21a44>
17. Marietto ML. Observação participante e não participante: contextualização teórica e sugestão de roteiro para aplicação dos métodos. *Rev Ibero Am Estrat.* 2018;17(4):5-18. <https://doi.org/10.5585/riae.v17i4.2717>
18. Masson G, Falch SF. O materialismo histórico-dialético nas pesquisas em políticas educacionais. *Rev Estud Teóricos Epistemol Polít Educ.* 2018;3:1-15. <https://doi.org/10.5212/retepe.v3.011>
19. Ribeiro MVG, Zanesco C, Berlezi GF, Silva DTR. Perfil e desfecho clínico de pacientes transplantados renais em um serviço especializado: desfechos de um projeto de extensão. *Cidadania Ação.* 2018;2(2):19-30. <https://doi.org/10.5965/259464122219>
20. Serrano LCA, Rondina AMF, Duca WJ, Silva RF, Silva RCMA, Arroyo Júnior PC, et al. Perfis sociais dos candidatos a transplante de fígado em um hospital-escola no interior paulista. *Rev Cient Integrada* [Internet]. 2019 [acessado em 25 set. 2021]. Disponível em: <https://www.unaerp.br/documentos/3361-rci-perfis-sociais-dos-candidatos-a-transplante-de-figado-em-um-hospital-escola-no-interior-paulista-06-2019/file>
21. Instituto Brasileiro de Geografia e Estatística (IBGE). Conheça o Brasil - população: quantidade de homens e mulheres [Internet]. Brasil: IBGE; 2019 [acessado em 28 set. 2021]. Disponível em: <https://educa.ibge.gov.br/jovens/conheca-o-brasil/populacao/18320-quantidade-de-homensmulheres.html#:~:text=Segundo%20dados%20da%20PNAD%20Cont%C3%ADnu,51%2C8%25%20de%20mulheres>
22. Alves AM. Pensar o gênero: diálogos com o Serviço Social. *Serv Soc Soc.* 2018;(132):268-286. <https://doi.org/10.1590/0101-6628.141>
23. Instituto Brasileiro de Geografia e Estatística (IBGE). Conheça o Brasil - população: educação [Internet]. Brasil: IBGE; 2019 [acessado 28 set. 2021]. Disponível em: <https://educa.ibge.gov.br/jovens/conheca-o-brasil/populacao/18317-educacao.html>
24. Silva EMS, Araújo MSS. Perfil socioeconômico dos usuários do serviço de transplante renal do Huufma. *Braz J Develop.* 2020;6(4):19047-59. <https://doi.org/10.34117/bjdv6n4-173>
25. Brasil. Constituição da República Federativa do Brasil de 1988 [Internet]. Brasil; 1988 [acessado em 19 set. 2021]. Disponível em: http://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm
26. Pereira NCS, Cardoso JS. O retorno do paciente renal crônico às atividades produtivas após o transplante renal. *Rev Ter Ocup Univers São Paulo.* 2017;28(2):221-9. <https://doi.org/10.11606/issn.2238-6149.v28i2p221-229>
27. Zerbini T, Araki MMP. Benefício de aposentadoria por invalidez previdenciária em portadores de doença renal crônica submetidos a transplante renal. *Saúde Ética Justiça.* 2014;19(2):86-9. <https://doi.org/10.11606/issn.2317-2770.v19i2p86-89>
28. Braga NL, Araújo NM, Maciel RH. Condições do trabalho da mulher: uma revisão integrativa da literatura brasileira. *Psicol Teoria Prática.* 2019;21(2):232-51. <https://doi.org/10.5935/1980-6906/psicologia.v21n2p232-251>
29. Brasil. Ministério da Economia. Instituto Nacional de Seguro Social – INSS. Benefícios. Aposentadoria [Internet]. Brasil: Ministério da Economia; 2021 [acessado em 18 out. 2021]. Disponível em: <https://www.inss.gov.br/beneficios/>
30. Brasil. Ministério da Saúde. Boletim estatístico da previdência social [Internet]. Brasília: Ministério da Saúde; 2021 [acessado em 22 set. 2021]. v. 26(7). Disponível em: https://www.gov.br/trabalho-e-previdencia/pt-br/acao-a-informacao/dados-abertos/dados-abertos-previdencia/previdencia-social-regime-geral-inss/arquivos/beps072021_final-1.pdf
31. Brasil. Lei nº 8.213, de 24 de julho de 1991. Dispõe sobre os planos de benefícios da previdência social e dá outras providências. Brasília: Presidência da República; 1991 [acessado em 4 maio 2021]. Disponível em: http://www.planalto.gov.br/ccivil_03/LEIS/L8213cons.htm
32. Silva MA. Análise crítica da proposta de reforma da previdência social no Brasil entre os anos 2016 e 2018. *Serv Soc Soc.* 2019;(135):213-30. <https://doi.org/10.1590/0101-6628.175>
33. Mugnatto S. Pacientes transplantados relatam dificuldade de reinserção no mercado de trabalho [Internet]. Brasil: Câmara dos Deputados; 2021 [acessado em 7 jan. 2022]. Disponível em: <https://www.camara.leg.br/noticias/810429-pacientes-transplantados-relatam-dificuldade-de-reinsercao-no-mercado-de-trabalho/>