RESEARCH ARTICLE OPEN ACCESS

Challenges of Primary Care in Health Care for Individuals Deprived of Liberty

Sirlei Favero Cetolin[1], Camila Amthauer[2], Joéli Cristiane Petry[3] , Júlia Cristina Trevisol[4] ,Luana Patrícia Marmitt[5], Vilma Beltrame[6]

[1]*PhD in Social Work. Graduation in Psychology and Social Work. Teacher in the Master's Course in Biosciences and Health at the University of the West of Santa Catarina-Unoesc. São Miguel do Oeste / SC - Brazil.*

[2]*Master in Nursing. Graduation in Nursing. Teacher in the Nursing Course at the University of the West of Santa Catarina – Unoesc - São Miguel do Oeste / SC - Brazil.*

[3]*Nurse graduated from the University of the West of Santa Catarina - Unoesc - São Miguel do Oeste / SC – Brazil.*

[4]*Nurse graduated from the University of the West of Santa Catarina - Unoesc - São Miguel do Oeste / SC – Brazil.*

[5]*PhD in Health Sciences. Graduation in Nutrition. Teacher in the Master's Course in Biosciences and Health at the University of the West of Santa Catarina-Unoesc - Joaçaba / SC - Brazil.*

[6]*PhD in Biomedical Gerontology. Graduation in Nursing. Teacher in the Master's Course in Biosciences and Health at the University of the West of Santa Catarina-Unoesc – Joaçaba / SC - Brazil.*

ABSTRACT
This article aims to identify challenges in the performance of Primary Care professionals in health care for the person deprived of liberty. It is a qualitative, descriptive-exploratory research, carried out with eight health professionals who provide assistance in an Advanced Prison Unit, located in a municipality in the interior of Santa Catarina. Data collection took place during September 2020, through an individual interview. For the interpretation of the information collected, Minayo thematic content analysis was used. The study showed that health professionals face many obstacles in ensuring access to quality health care for people deprived of their liberty. Among the challenges to be overcome, there is the precariousness of the system, the lack of adequate physical structure for health care, the difficulty in providing continuity of care, the lack of investments in Permanent Health Education for professionals, the absence of promotion and prevention actions and a lack of studies related to the performance of Primary Care teams in assisting individuals deprived of their liberty. It is necessary to expand knowledge, seeking to demystify the judgments of value about the prison reality and, in this aspect, the professionals who work in Primary Care are essential for humanized care, based on ethical principles, with equity and integrality in attending to Cheers.

Keywords— Primary Health Care, Public Policies, Prisoners, Health Promotion, Public Health.

Date of Submission: 04-01-2021 Date of Acceptance: 19-01-2021

I. INTRODUCTION

The Brazilian prison population, historically marginalized by the citizen versus state relationship, by the punitive view of the institutions and by the difficulty of social reintegration, seeks in public policies a way to ensure that the prisoner has his dignity and rights exercised by law (Soares Filho & Bueno, 2016).

Prison institutions sought to replace the inhuman and degrading practices used for centuries, with more humane means of recovering those who break the laws. In this way, deprivation of liberty has become a new form of punishment. Prison is a disciplinary device built, according to Foucault cited by Barreto Neto, with a view to exercising the power to punish by alienating freedom (Barreto Neto, 2019).

This way of punishing, prisons had to be careful not to violate the human rights of individuals. Regardless of the crime committed, deprivation of liberty does not exempt the right to a dignified life, with access to health goods and services. Criminal institutions are responsible for guaranteeing access to health actions and services legally guaranteed by the Federal Constitution of 1988, by laws No. 7,210 of July 11, 1984, which establishes the Criminal Execution Law (LEP); Law

8,080 of 1990, which regulates the Unified Health System (SUS) and Law 8,142 of 1990, which provides for community participation in the management of SUS (Silva, Nascimento, Aoyama & Lemos, 2020).

Brazil is in 3rd place in the ranking of countries with the largest prison population in the world, behind only the United States of America and China (Vasconcelos, Souza, Lima, Silva & Vasconcelos, 2019). According to the National Penitentiary Department (DEPEN), the last national survey of Penitentiary Information (Infopen), linked to the Ministry of Justice, in Brazil, between the months of January to June 2019, there were 766,752 people deprived of their liberty. Considering that the total number of vacancies is 460,750, it is possible to observe a total deficit of 306,002 vacancies, totaling a rate of imprisonment of 364.86% (National Penitentiary Department [DEPEN], 2019).

In the State of Santa Catarina, there are about 20,000 vacancies in the prison system. DEPEN data (2019) recorded that there are 25,203 persons deprived of their liberty in the State, generating a deficit of about 5,203 vacancies (DEPEN, 2019). Given the above, it is clear that there is a deficiency of vacancies available in relation to the existing prison population, raising a reason for concern and discussion in the most diverse spheres, especially with regard to the difficulty in planning and executing a health program. suitable for these prison populations (DEPEN, 2019).

These data point to the reality of Brazilian penal institutions, where there is a lack of vacancies to house all inmates, associated with difficulties in operationalization, very precarious sanitary conditions, physical inactivity, low quality food, use of legal and illegal drugs, lack of access public health services, deficit of professionals among other factors (Vasconcelos *et al.*, 2019).

Overcrowding of cells, seclusion in a physical structure without ventilation, long periods of confinement and the intense flow of visitors generates an environment conducive to the development of infectious and high morbidity diseases, such as respiratory diseases, tuberculosis, leprosy, Immunodeficiency Syndrome Acquired (AIDS) and other Sexually Transmitted Infections (STIs), in addition to enhancing comorbidities, generating the impediment to a minimally dignified life (Vasconcelos *et al.*, 2019).

Consequently, these situations violate human rights, which are fundamental rights of the human person, with the rights to life, food, health, housing, education, affection and the free expression of sexuality in which individuals deprived of liberty are also part. According to Art. V § 1 c / c 6 of the 1988 Federal Constitution, all persons have the right to respect for their physical, mental and moral integrity. The deprivation of liberty must be aimed at the reform and social rehabilitation of convicts (Favilli & Amarante, 2017).

The daily life of those who attend the prison system is sometimes marked by physical and psychological violence and aggression. Although security is a priority in prison institutions, this fact can become an obstacle to health care (Barbosa, Celino, Oliveira, Pedraza & Costa, 2014; Silva *et al.*, 2020).

II. METHODS

It is a descriptive-exploratory research, based on the qualitative approach. Descriptive-exploratory research aims to describe the characteristics of a given population or phenomenon. It seeks greater familiarity with the object of the study, aiming at clarifying or constituting hypotheses (Gil, 2010). Qualitative research is the one that applies to the study of history, relationships, representations, beliefs, perceptions and opinions, the product of the interpretations that humans make about how they live, build their artifacts and themselves, feel and think. It is characterized by empiricism and the progressive systematization of knowledge until an understanding of the internal logic of the group or process under study (Minayo, 2014).

The study was conducted with eight health professionals, responsible for assisting the individual deprived of liberty in an Advanced Prison Unit, in the municipality of São José do Cedro in the state of Santa Catarina.

Among the inclusion criteria of the participants, the following were considered: being of legal age, having higher education in the health area and being part of a Primary Care team, which provides assistance to people deprived of their liberty. As for the exclusion criteria, professionals who were in some type of leave due to vacation, special leave, health or maternity treatment were excluded from the study.

The study was not concerned with the sample size, since it had a qualitative approach and, in this type of study, the researcher should have less concern with the generalization of the findings and seek to deepen them and the scope and diversity in the process of understanding of the phenomenon. The criterion, therefore, is not numerical. Thus, an ideal qualitative sample is the one that reflects the multiple dimensions of the object of study (Minayo, 2014).

First, contact was made with the Municipal Health Secretariat of the municipality, in order to request permission to carry out the research. After

acceptance, the project was sent for evaluation and approval by the Ethics and Research Committee (CEP). After approval, a visit was made to the study site, in order to present the project to potential participants. With the professionals who agreed to be part of the study, a day, time and place was scheduled. The interviews took place during the month of September 2020, at the Basic Health Unit (UBS), on days and times scheduled according to the availability of the participants. For data collection, a semi-structured interview was used. The semi-structured interview is considered to be one that uses a script that is physically appropriate and used by the researcher. By having clear support on issues, it facilitates the approach (Minayo, 2014). The interviews were individual and conducted in a reserved space, ensuring the privacy of the participants. The interviews were recorded on a digital device with the consent of all respondents in order to fully record the statements, ensuring authentic material for analysis. Therefore, in addition to the Free and Informed Consent Term (ICF), the Authorization Term for Voice Recording was also made available to the participant. Due to the pandemic moment in progress in Brazil and worldwide, and aiming at the safety of researchers and interviewees, during data collection, biosafety measures were used as recommended by the Ministry of Health to contain Covid-19. For the recording of the interviews, masks, alcohol gel for antisepsis of the hands and a distance of two meters between the interviewee and the interviewer were used.

Data collection followed the thematic saturation criterion, which interrupts the inclusion of new participants when the data obtained starts to present, in the researcher's evaluation, a certain redundancy or repetition, and it is not considered relevant to persist in data collection (Minayo, 2014). Afterwards, there was a transcription of the data obtained through the recordings of the speeches of the participants literally in a text editor, constituting the corpus of the research.

To analyze the collected information, thematic content analysis was used. A thematic analysis consists of discovering the nuclei of meaning that make up a communication, whose presence or frequency means something to the analytical object in question. Thematic analysis is carried out in three stages: pre-analysis, exploration of the material and treatment of the results obtained and interpretation (Minayo, 2014).

The pre-analysis corresponds to the organization of the material for further analysis, based on the guiding question and the objectives of the study. This stage was carried out by listening to the recordings and floating reading, which consisted of the researcher's first contact with the interview material. From the exhaustive reading and the first impressions of the research, the excerpts of the speeches of the participants were highlighted, according to similar ideas, allowing a more in-depth analysis.

The exploration phase of the material was carried out by clipping common information found in the content of the transcribed speeches, which supported the constitution of categories. In this way, the registration units were listed, which refer to words, phrases and expressions that give meaning to the content of the statements and support the definition of the categories. In this phase, the first step involved the search for the themes that made up the registration units. After finding these units, it became possible to define thematic categories. Thus, the categorization was through a process of reducing the text to the most significant words and expressions within the corpus of analysis.

Finally, the last phase consisted of the treatment of the results obtained and the interpretation based on the theoretical references that supported the analyzes.

It should be noted that the research project was approved by means of the Consubstantiated Opinion issued by the Research Ethics Committee, under CAAE number 31646120.4.0000.5367 and Opinion number 4.067.759.

III. RESULTS AND DISCUSSION

When addressing the feelings experienced by health professionals during visits to individuals deprived of their liberty, the manifestations were of fear, embarrassment and difficulties in accepting and understanding the patients' life history. Let's look at some expressions:

It is always a challenge, because they are people with a very complex, delicate history [...] It is not that simple, right? Because in society it is necessary to obey the rules, to work, to study, to have discipline. And, generally speaking, what led these patients to the prison was because they were at odds with moral and social values. So, seeing and having to attend, assailants, traffickers, murderers, has an impact, even as a health professional and trying to understand the dynamics of human beings. (E1)

In fact, I am afraid when answering, when providing assistance, even when receiving protection from the guards, [...] I am afraid when I have to use a dangerous perforating instrument, this material can be used against my integrity. [...] I get very close, I have to have physical contact with the person, so this generates anxiety [...]. (E2)

"I answer with fear, maybe I didn't need to, but I always have a feeling that some life-threatening situation may occur". (E4)

"At first I even felt a little apprehensive, but I adapted to the service. They are always handcuffed and a prison guard always accompanies the consultation". (E5)

I do not feel comfortable with the activities when they arrive. For example, I already see if there is scissors, if there is a sharp hole nearby, to try to avoid any situation, I already try to remove everything close up, which may be sharp. So, it shows that I'm afraid (E8).

Human beings do not have feelings as a constituent part of nature. They are produced according to the socio-historical context of each era, being susceptible to change. Soon, fears would also be formed historically, which explains the transformations in the behavior of societies in relation to certain stereotypes and expressive dangerous situations (Moreira, Figueiredo, Uziel & Bicalho, 2010).

As a correspondent of solid and inherent aspects of any reality of life and work, fear is established from elements external to the subjects, and can be of different orders and origins: those related to the fear of wear and tear of mental functioning and psycho-affective balance determined by disruption of ties with colleagues, resulting from streams of suspicion, discrimination and various forms of violence and aggression, fear of mental disorganization due to extreme psychic repression, the effort to preserve constant highly recurrent behaviors, apprehension in the face of possibility of fragmentation and deterioration of the physical body due to unhealthy working conditions (Santiago, Zanola, Hisamura Jr, Shoiti & Silva, 2016).

Society is unaware of the reality of penitentiaries and through the media, which provide a collective and generalist view without considering their particularities, a negative opinion was built, fueled by stigma and prejudice. Therefore, the professional who fits this description, when in contact with the prisoner, tends to be afraid of the weight of the stigmas that this population carries with them (Rocha, 2018).

It was noticed in the study that, fear manifests itself for several reasons, in particular, it is revealed by the inmates to be always handcuffed and accompanied by a prison officer, which ends up generating some anxiety to the professionals for not knowing the real risk that these inmates feature. Also, knowing the history of these patients ends up stimulating in the professional the need to understand the reasons for the crimes committed and the reality that led them to commit. This scenario ends up raising moments of tension, insecurity and psychological stress in the health team, direct influencers in the assistance provided.

The professionals reported the difficulty in providing continuity of care to the detainees, especially as they are from other municipalities and are constantly transferred to other units, often without completing the treatments initiated at the places, which makes access to previous examinations and treatments limited.

It is difficult to provide continuous assistance, as they cannot come frequently to the UBS for consultations, which also makes the creation of a bond a challenge for us [...]. (E1)

The biggest difficulty is not being able to guide or explain the correct use of the medication and due to the amount of medication we receive for the disposal that comes from the Prison Unit, we realize the waste due to the lack of completion of the prescribed treatments. (E6)

We tried to rescue the medical records of patients who had been seen in other places and generally, we were unable to [...] try to contact them, but they are patients who come from repeated arrests, different units [...] then we start all over again, ultrasounds start, referrals for tomography, resonance, and when we start to close a diagnosis, the patient went to house arrest, or was transferred to another UPA and this makes it very difficult for us to care for inmates. (E8)

In Brazil, the reforms that resulted in the implantation of the Unified Health System sought to strengthen Primary Health Care and expand its coverage. However, although data show the gradual increase in the offer of actions and services at this level of care, the results found are not always satisfactory (Cunha & Giovanella, 2011).

The coordination of care by Primary Care comes from the integration between health services of different technological densities and must be ensured by means of assistance flows, information continuity, the gateway to Primary Care with timely and resolute access, welcoming strategies, comprehensive offer of services. actions and matrix support for health teams (Almeida, Marin & Casotti, 2017).

Longitudinality is a central and exclusive characteristic of Primary Health Care (PHC). It is the monitoring of the patient over time by a general practitioner or PHC team, for the various episodes of illness and preventive care. This monitoring includes a therapeutic relationship characterized by

responsibility on the part of the health professional and trust on the part of the patient. Attending to this attribute aims to produce more accurate diagnoses and treatments, in addition to reducing unnecessary referrals to specialists and to perform more complex procedures (Cunha & Giovanella, 2011).

The continuity of care in Primary Care is essential in the path taken by professional and patient during treatment. However, what was observed is a great difficulty in accessing information from previous appointments, either in electronic medical records or directly with the health teams responsible for these appointments, in the places where they occurred previously, which ends up requiring professionals to start all diagnostic searches again, generating costs for the sector and, delaying more reliable treatments for prisoners.

Still, another difficulty pointed out by the interviewees and which directly interferes in the service provided is related to the creation of bonds. The bond has been used as a tool to establish the relationship between health teams and the user population, however, it is clear that private prison directly interferes in team-patient care, often presenting itself as an obstacle in the care of private individuals. of freedom.

In view of this, when questioning the health team about the creation of a bond with people deprived of their liberty, it was evident that most of the participants found it difficult to create any bond with the detainees, especially because it required a more punctual work by the team and by virtue of the fact that prison officers are always present during the appointments made.

[...] I did not create a bond with any of the assisted patients, I provide care and they return to the Prison Unit. I don't exchange a lot of information and I don't talk too much. (E2)

It is very difficult to create bonds, until today I have not succeeded, they have a very large form of defense, this is the greatest difficulty. And, many times, I realize that they come to psychological care in view of some secondary gain. (E3)

It depends on how dangerous the prisoner is, he needs to be accompanied by a penitentiary agent, our room has no protection, no security, [...] there is no structure to serve this population, to provide confidentiality and professional security. The penitentiary agent has to stay together in the service or the door has to stay open. This is also a difficulty in establishing a bond. (E4)

As the care of these users is carried out through consultations and treatment of the complaint, it ends up not being a long treatment, with continuous contact, so hardly a bond is formed. (E5)

In the same way that we do not have contact with family members, we are not able to maintain any kind of bond here [...] because, many times, individuals have their backs to the health professional and, facing the wall, without looking or talk to the professional. (E6)

[...] it is difficult to create a bond with them, because as they always come with prison officers, I do not know what is the real expression of their expressions, their feelings as well. [...] I have already had the experience of some inmates who, when they came with the prison officers, manifested a type of behavior, when they came without the agents, the form was rougher, more rigid. (E8)

The bond is based on the construction of relationships of affection and trust between the user and the health worker, enabling the deepening of the process of co-responsibility for health, built over time, in addition to carrying, in itself, a therapeutic potential (Ministério da Saúde [MS], 2012).

Some participants refer that despite the difficulties, it is possible to have a bond as in any professional-patient relationship.

It is possible to create bonds, as in any relationship. Some kind of link exists, but it is quite complex, in the daily dynamics that we have here. We don't have much time at UBS to dedicate to them, they don't have the availability to come to UBS often. (E1)

[...] One of the exceptions was a patient who treated tuberculosis, was from a nearby municipality and when he was discharged for house arrest, he came here at the UBS to thank the care that was given and say he was going to thank God for home, and hoped never to return to the Prison Unit. (E8).

The creation of bonds allows the deconstruction of the professional's hierarchy over the user by bringing about a closer relationship between them through moments of conversation, listening and exchange of knowledge. Any assistance approach between health professional and user takes place through live work, in which several relational processes cohabit from the encounter between two people who act on each other, generating moments of listening, exchanges, conflicts, accountability, commitment, trust and subsequently bond (Santos & Miranda, 2016).

In this context, the bond can be considered as a "light technology" of care, as it allows professionals to know the users and the priorities and singularities of each one, giving rise to the understanding of the problems, the follow-up and the best form of intervention and treatment of these users. Still, the bond can be explored as a therapeutic resource, inserted in a new way of doing health by overcoming the biologicist model for a more humanized and responsible look at the individual, family and community. However, it is necessary to win the community's trust in the health team. Conversely, the team must believe that, supported, users will feel they are protagonists in overcoming their adverse conditions (Santos & Miranda, 2016).

The bond does not guarantee a service that envisions integrality in the relationship between team and user assistance, much less taking into account the satisfaction of health needs, possible only in a complex network that exceeds the health system. However, without the relationship of mutual recognition of individuals in their subject positions, it is not possible to think of integrality. For there to be comprehensiveness, the needs of the subject must be understood in their varieties, and, for this to occur, the combination made possible by the bond is fundamental (Storino, Souza & Silva, 2013).

Another circumstance evidenced in the study, which makes it difficult for the health team to provide comprehensive and humanized care, occurs from the moment the patient arrives at the UBS, hampered by the presence of other patients living in the community who feel uncomfortable, physical structure offered, it is not private and the reception process ends up suffering interference. For Junges et al. (2015), user embracement is an essential step in the health work process, and it is through it that the bond between user, professional and service is formed, thus taking responsibility and subsequently resolving health production processes . In this welcoming scenario, the privacy of user information, shared with the health team, is defined as a confidentiality "pact".

Privacy is considered an individual right that covers situations related to the protection of the subjects' privacy, respect for dignity, limited access to the body, intimate objects, family and social relationships. Health professionals face the challenge of ethical reflection on the responsibility and commitment of their actions in this area (Soares e Dall'Agnol, 2011).

The preservation of the privacy and confidentiality of information about the other is an ethical virtue. Our ethical virtues, as well as our values, are not natural gifts, in reality, they are inclinations that we possess and that only constitute themselves as such, that is, they are no longer a possibility to be fact, as we adopt them in our daily acts. Therefore, for respect for patient privacy as an ethical virtue in the primary care setting to be consolidated, it depends on the conscious effort and dedication of the subjects involved in the care process. The problematizing education, which includes critical reflection on everyday action, is considered indispensable for the realization of this possibility; the transcendence of acts over customs, through the belief in the supremacy of conscious action over habitual action; and, indispensably, the phenomenal expression of the final product of this process in action (Soares & Dall'Agnol, 2011).

However, the presence of prison staff during the service directly influences the dialogue between professional-patient, affecting the expression of desires, complaints and / or afflictions of the detainee. As there is no physical structure in the Prison Unit that allows the health professional to serve only individuals deprived of their liberty in a private and secure way, they need to be referred to the UBS, where care is performed quickly so that the detainee can return to the UPA as soon as possible. These are situations that hinder the care provided, the creation of bonds, the holistic view of each case and assistance with interdisciplinary characteristics.

Still in relation to the difficulties and challenges encountered in assisting individuals deprived of their liberty, there was a lack of investments in Permanent Education, with no training for professionals.

It is important to always train yourself, perhaps to open my horizons and make this population see differently, understand them differently [...], I would be willing to do something to improve my performance in relation to them. (E1)

"Many times, I don't feel prepared, I didn't do any training. I believe that training would add to the assistance [...]". (E3)

I didn't have any training aimed at serving people deprived of their liberty, but I think it is important and that it would make a difference to improve our assistance. (E6)

[...]Training would help to expand the knowledge of the entire team involved. We need Permanent Education to add to our profession formation. (E7)

"[...]we were not offered training to [...] work with inmate patients". (E8)

The professionals started the services without training and / or preparation to provide assistance to the detainees. In view of this, they base

their practices on the biomedical model, punctual, on the complaints of each individual and always cautious about what to do or how to do it. It is noticed that the lack of investments in Permanent Education directly influences the quality of assistance provided to detainees. SUS, due to its size and breadth, appears in the arena of educational health processes as a privileged space for teaching and learning, especially in places of health care. Educating "in" and "for" work is the premise of the proposal for Permanent Education in Health (EPS).

From the perspective of micropolitics, education needs to be a permanent instrument, which influences workers to new attitudes towards better health care (Lemos, 2016). In all areas of health, the EPS process goes beyond technical improvement, by enabling the subject-workers to seek their autonomy, citizenship, as well as recovering their multidimensionality, which could constitute a basis for disalienation. Still, it is essential that education is conducted according to the reality of work situations, that it is developed collectively, according to social needs and anchored in the precepts of transforming praxis (Silva, Ferraz, Lino, Backes, & Schmidt, 2010).

IV. FINAL CONSIDERATIONS

The study showed that health professionals face many obstacles in ensuring access to quality health care for people deprived of their liberty. Among the challenges to be overcome, there is the precariousness of the system, the lack of resources, the difficulty in providing continuity of care, the lack of investments in EPS, the absence of health promotion and prevention actions and a lack of studies. related to the performance of Primary Care teams in assisting individuals deprived of their liberty.

There is a need for actions to promote and prevent health problems for people deprived of their liberty, with an emphasis on the rights guaranteed by the Unified Health System. It is necessary to expand knowledge, seeking to demystify the value judgments about health. prison reality and, in this regard, professionals working in primary care are essential for humanized care, based on ethical principles with equity and integrality in health care.

REFERENCES

[1]. Soares Filho, M. M., & Bueno, P. M. M. G. (2016, July). Demografia, vulnerabilidades e direito à saúde da população prisional brasileira. Ciênc. Saúde Colet., *21*(7), 1999-2010. Recovered in 30 March, 2020, from https://www.scielosp.org/article/csc/2016.v21n7/1999-2010/pt/.

[2]. Barreto Neto, A. de P. (2019). O atendimento dos usuários nas unidades de saúde do sistema prisional brasileiro. Trabalho de Conclusão de Curso (Especialização em Gestão em Saúde) - Instituto de Ciências da Saúde, Universidade da Integração Internacional da Lusofonia Afro-Brasileira, Redenção-CE, 2019. Recovered in 31 March, 2020, from http://repositorio.unilab.edu.br/jspui/handle/123456789/1306.

[3]. Silva, J. M. da, Nascimento, M. C. do, Aoyama, E. de A., & Lemos, L. R. (2020, February). A atuação da equipe de saúde na assistência prestada ao sistema prisional brasileiro. Rebis - Rev. Bras Interdisc. Saúde, *2*(2), 70-74. Recovered in 31 March, 2020, from http://revista.rebis.com.br/index.php/rebis/article/view/355.

[4]. Vasconcelos, A. C. C. G., Souza, M. de, Lima, K. R., Silva, B. A. K. da, & Vasconcelos, D. F. P. (2019, October). Atenção à saúde de indivíduos privados de liberdade no sistema prisional brasileiro: revisão integrativa. Revista Ciênc. Saúde, Piauí, *9*(4), 28-36. Recovered in 31 March, 2020, from http://186.225.220.186:7474/ojs/index.php/rcsfmit_zero/article/view/847.

[5]. Departamento Penitenciário Nacional. Ministério da Justiça (org.) (2019). Levantamento Nacional do Sistema Penitenciário Brasileiro. Brasília. Recovered in 01 April, 2020, from http://depen.gov.br/DEPEN/depen/sisdepen/infopen.

[6]. Favilli, F., & Amarante, P. (2017, dezembro). Direitos humanos e saúde mental nas instituições totais punitivas: um estado da arte Itália-Brasil sobre a determinação de mecanismos alternativos à prisão decorrentes às situações de doença mental ou enfermidade. Cad. Bras. Saúde Mental, Florianópolis, *10*(25), 151-193. Recovered in 30 March, 2020, from http://stat.ijkem.incubadora.ufsc.br/index.php/cbsm/article/view/5184.

[7]. Barbosa, M. L., Celino, S. D. de M., Oliveira, L. V., Pedraza, D. F., & Costa, G. M. C. (2018). Qualidade de vida no trabalho dos profissionais de saúde no sistema prisional. Ciênc. Saúde Colet., *23*(4), 1293-1302. Recovered in 13 April, 2020, from http://www.scielo.br/pdf/csc/v23n4/1413-8123-csc-23-04-1293.pdf.

[8]. Gil, A. C. (2010). Como elaborar projetos de pesquisa. São Paulo: Atlas.
[9]. Minayo, M. C. de S. (2014). O desafio do conhecimento: pesquisa qualitativa em saúde (14a ed.). São Paulo: Hucitec.
[10]. Moreira, L. R., Figueiredo, T. F. de, Uziel, A. P., & Bicalho, P. P. G. de. (2010). A construção da psicopatia no contexto da cultura do medo. Revista de Psicologia da IMED, *2*(1), 297-306. Recovered in 21 October, 2020, from https://dialnet.unirioja.es/servlet/articulo?codigo=5155009.
[11]. Santiago, E., Zanola, P. C., Hisamura Jr, R. S., & Silva, I. Y. M. da. (2016). O sentimento de medo no cotidiano de trabalho na vigilância prisional e seus impactos sobre a subjetividade dos agentes penitenciários. Cadernos de Psicologia Social do Trabalho, *19*(2), 161-175, 2016. Recovered in 21 October, 2020, from https://www.revistas.usp.br/cpst/article/view/140594/135576.
[12]. Rocha, J. M. (2018). Atenção à saúde das pessoas privadas de liberdade em uma emergência a partir do discurso dos enfermeiros. TCC (Graduação), Centro de Ciências da Saúde, Universidade Federal de Santa Catarina, Florianópolis, SC, Brasil. Recovered in 14 October, 2020, from https://repositorio.ufsc.br/handle/123456789/191412.
[13]. Cunha, E. M. da, & Giovanella, L. (2011). Longitudinalidade/continuidade do cuidado: identificando dimensões e variáveis para a avaliação da Atenção Primária no contexto do sistema público de saúde brasileiro. Ciência & saúde coletiva, *16*, 1029-1042. Recovered in 21 October, 2020, from https://www.scielosp.org/article/csc/2011.v16suppl1/1029-1042/.
[14]. Almeida, P. F. de; Marin, J., & Casotti, E. (2017). Estratégias para consolidação da coordenação do cuidado pela atenção básica. Trabalho, Educação e Saúde, *15*(2), 373-398. Recovered in 21 October, 2020, from https://www.scielo.br/scielo.php?pid=S1981-77462017000200373&script=sci_arttext.
[15]. Ministério da Saúde. (2012). Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica / Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Brasília: Ministério da Saúde, (Série E. Legislação em Saúde). Recovered in 17 October, 2020, from http://189.28.128.100/dab/docs/publicacoes/geral/pnab.pdf.
[16]. Santos, R., & Miranda, F. (2016). Importância do vínculo entre profissional-usuário na estratégia de saúde da família. Revista de Enfermagem da UFSM, *6*(3), 350-359. Recovered in 21 October, 2020, from https://periodicos.ufsm.br/reufsm/article/view/17313/pdf.. https://doi.org/10.5902/2179769217313.
[17]. Storino, L. P., Souza, K. V. de, & Silva, K. L. (2013, Dezembro). Necessidades de saúde de homens na atenção básica: acolhimento e vínculo como potencializadores da integralidade. Esc. Anna Nery, *17*(4), 638-645. Recovered in 21 October, 2020, from https://www.scielo.br/scielo.php?pid=S1414-81452013000400638&script=sci_arttext&tlng=pt.
[18]. Junges, J. R., Recktenwald, M., Herbert, N. D. R., Moretti, A. W., Tomasini, F., & Pereira, B. N. K. (2015). Sigilo e privacidade das informações sobre usuário nas equipes de atenção básica à saúde: revisão. Revista Bioética, *23*(1), 200-206. Recovered in 17 October, 2020, from https://www.redalyc.org/pdf/3615/361535344021.pdf
[19]. Soares, N. V., & Dall'Agnol, C. M. (2011). Privacidade dos pacientes: uma questão ética para a gerência do cuidado em enfermagem. Acta paul. enferm., *24*(5), 683-688. Recovered in 17 October, 2020, from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0103-21002011000500014&lng=en&nrm=iso. https://doi.org/10.1590/S0103-21002011000500014.
[20]. Lemos, C. L. S. (2016). Educação Permanente em Saúde no Brasil: educação ou gerenciamento permanente? Ciência & saúde coletiva, *21*, 913-922, 2016. Recovered in 17 October, 2020, from https://www.scielosp.org/article/csc/2016.v21n3/913-922/pt/.
[21]. Silva, L. A. A. da, Ferraz, F., Lino, M. M., Backes, V. M. S., & Schmidt, S. M. S. (2010, September). Educação permanente em saúde e no trabalho de enfermagem: perspectiva de uma práxis transformadora. Rev. Gaúcha Enferm., *31*(3), 557-561. Recovered in 17 October, 2020, from http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1983-14472010000300021&lng=en&nrm=iso. https://doi.org/10.1590/S1983-14472010000300021.