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Bertolozzi, Maria Rita; Izumi Nichiata, Lucia Yasuko; Ferreira Takahashi, Renata; Itsuko Ciosak, Sueley;
Hino, Paula; Ferreira do Val, Luciane; de La Torre Uguarte Guanillo, Mónica Cecília; Gomes Pereira,
Érica

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The vulnerability and the compliance in Collective Health

OS CONCEITOS DE VULNERABILIDADE E ADEÇÃO NA SAÚDE COLETIVA

LOS CONCEPTOS DE VULNERABILIDAD Y DE ADERENCIA EN LA SALUD COLECTIVA

Maria Rita Bertolozzi¹, Lucia Yasuko Izumi Nichiata², Renata Ferreira Takahashi³, Suely Itsuko Ciosak⁴, Paula Hino⁵, Luciane Ferreira do Val⁶, Mônica Cecília de La Torre Uguarte Guanillo⁷, Érica Gomes Pereira⁸

ABSTRACT

The Vulnerability and the Compliance are concepts that have being focus of debate in the Collective Health field. The challenge of the Collective Health is to promote technologies, and tools to support qualified actions, and to answer to the social groups' needs, looking for the innovation of the instruments to apprehend the reality and to develop interventions that could produce impacts: attending these social groups who needs support to conquer autonomy in the self-care. This article presents aspects of the analytic categories Compliance and Vulnerability, proposing indicators for monitoring it, in order to contribute to the development of the concepts as to the health production process.

RESUMO

Os conceitos de Vulnerabilidade e Adesão têm sido foco de debate na Saúde Coletiva. É desafio posto pela Saúde Coletiva, propiciar tecnologias, dispositivos e instrumentos que apoiem a construção de práticas qualificadas, para responder às necessidades dos grupos sociais. Na produção do conhecimento, tem buscado inovar no desenvolvimento de instrumentos que apoiem a captação da realidade de vida e saúde e que auxiliem na leitura das necessidades e no desencadeamento e sustentação de projetos de intervenção que produzam o impacto desejado: atender os grupos sociais que mais carecem de apoio para conquistar autonomia para viver a vida com qualidade e a consecução do auto-cuidado, no cenário da equidade e da justiça social. O artigo apresenta aspectos das categorias analíticas Adesão e Vulnerabilidade, quanto à proposição de marcadores/ indicadores para o seu monitoramento, o que pode contribuir para o adensamento do conceito e para a prática do processo de produção à saúde.

RESUMEN

Los conceptos de Vulnerabilidad y Adhesión han sido foco de debate en la Salud Colectiva. El desafío puesto por este campo, de propiciar tecnologías, dispositivos e instrumentos que apoyen la construcción de prácticas calificadas, para atender a las necesidades de los grupos sociales, ha constituido el terreno donde se elabora el conocimiento, buscando la innovación en el desarrollo de instrumentos que apoyen la captación de la realidad, apoyen la lectura de las necesidades y en el desencadenamiento y sustentación de proyectos de intervención que produzcan el impacto deseado: atender los grupos sociales que más carecen de apoyo para conquistar autonomía para vivir la vida con calidad y la consecución del auto-cuidado, en el escenario de la equidad y de la justicia social. El artículo presenta aspectos de las categorías analíticas Adhesión y Vulnerabilidad, en cuanto a la proposición de indicadores para su monitoreo, lo que puede contribuir para el desarrollo del concepto y para las prácticas en el proceso de producción a la salud.

KEY WORDS

Vulnerability.
Risk groups.
Public health.
Medication adherence.

DESCRIPTORES

Vulnerabilidade.
Grupos de risco.
Saúde pública.
Adesão ao medicamento.

DESCRIPTORES

Vulnerabilidad.
Grupos vulnerables.
Salud publica.
Adhesión al tratamiento.

¹ Nurse. Assistant Professor. Associate Professor of the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. mrbertol@usp.br ² Nurse. PhD, Professor of the the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. izumi@usp.br ³ Nurse. Assistant Professor. Associate Professor of the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. rtakaha@usp.br ⁴ Nurse. Assistant Professor. Associate Professor of the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. siciosak@usp.br ⁵ Nurse. Student of the Graduation Program of the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. paulahino@yahoo.com.br ⁶ Nurse. Student of the Graduation Program of the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. lucianedoval@gmail.com ⁷ Nurse. Student of the Graduation Program of School of Nursing at University of São Paulo. São Paulo, SP, Brazil. mdguanilo@usp.br ⁸ Nurse. Laboratory Technician of the the Nursing Department in Collective Health of the School of Nursing at University of São Paulo. São Paulo, SP, Brazil. egpereira@usp.br

INTRODUCTION

This article deals with two concepts that have been the object of reflection in the ambit of the *Vulnerability, Compliance and Needs in Collective Health* Research Group: vulnerability and compliance with intervention practices. Let's start with the Vulnerability Concept.

THE VULNERABILITY ANALYTICAL CATEGORY

The word *vulnerability* is generally used to designate people's susceptibility to health conditions and damages. The descriptors used by Bireme define Vulnerability as the degree of susceptibility or risk to which a population is exposed of suffering damages arising from natural disasters. It also includes the relation between the intensity of those damages and the magnitude of a threat, adverse event or accident. It also contemplates the probability of a certain community or geographic area of being affected by a threat or potential risk of disaster.

Those definitions are rather comprehensive and, despite including the idea of *risk*, a distinction between vulnerability and risk should be made. The sense of risk is a core issue in epidemiologic studies: it is related to the idea of identifying people and characteristics able to expose people to a greater or smaller risk of exposure to health conditions able to compromise them physically, psychologically and/or socially. Therefore, it includes the probabilities of groups of population to get sick and die as a result of a health condition⁽¹⁾.

The objective of the vulnerability concept, on the other hand, is to bring abstract elements associated and associable to the processes of getting ill to planes of more concrete and particularized theoretical elaboration where the nexus and mediations among these processes are object of knowledge. Differently from risk studies, the investigations conducted in the theoretical landmark of vulnerability look for universality instead of an increase in the reproduction potential of its phenomenology and inference. Thus, the vulnerability expresses potentialities of getting sick, of not getting sick, and of facing health conditions related to *each and every individual*⁽¹⁾.

Under the perspective of vulnerability, exposure to health conditions results from individual aspects and collective contexts or from conditions able to produce higher susceptibility to health conditions and death and, simultaneously, to the possibility and resources to face said conditions. Therefore, to interpret the health-disease process we consider that risk indicates probabilities, and vulnerability indicates social iniquity and lack of equality. Vulnerability precedes risk and determines

the different risks of one getting infected, getting sick and dying⁽²⁾.

When the AIDS epidemic started it unleashed a movement among researchers and healthcare providers to rethink the concept of risk and to move on to discussions on vulnerability. Coming originally from the area of international law for Human Rights, the word vulnerability originally designated legally or politically fragile individuals to promote, protect and/or guarantee their rights to citizenship⁽³⁾.

Within the ambit of nursing research, the concept is important because it is intrinsically related to health conditions⁽⁴⁻⁷⁾. Thus, the relevance of the knowledge of vulnerability for health conditions lays on the implications it has in the health of those who are vulnerable and, consequently, on the identification of their healthcare needs in order to ensure their protection⁽⁷⁾.

The multidisciplinary nature of the vulnerability concept is implicit. And that is essential when dealing with health conditions and needs, once the complexity of the object of healthcare requires different theoretical-methodological contributions, or else its actions will be reduced to punctual *tasks*, with an emergency nature, which do not modify the structure of the causality web⁽⁶⁾.

We have to take into account that if we adopt vulnerability as a conceptual landmark, it is important to be careful in order not to reproduce the classic naturalization of the health-disease process. Moreover, it is necessary not to emphasize the *debility* pole; instead, it is necessary to emphasize the resistance pole and individuals' creative capacity to overcome difficulties⁽¹⁾. So, the

concept includes detecting fragilities, but also the capacity of facing health conditions.

How should the vulnerability concept be used?

In this article, the vulnerability concept is tied to the AIDS issue. Inasmuch as we consider that the possibility of people's exposure to the disease results from a set of not only individual aspects, but also collective ones, and that it involves the context, operationally speaking, of interpreting AIDS based on the interaction of three dimensions: individual, programmatic and social⁽³⁾.

The *individual* dimension refers to the knowledge of a health condition and the behaviors enabling the occurrence of the infection. The behaviors are not determined just by people's voluntary actions, but particularly by their capacity to incorporate knowledge and transform their behaviors able to make them susceptible to health conditions. Vulnerability is determined by cognitive conditions (access to information, acknowledgement of susceptibility and efficacy of ways of prevention), behavioral conditions (willingness and capacity to change behaviors caus-

ing susceptibility) and social conditions (access to resources and capacity to adopt protective behaviors).

The *programmatic* dimension refers to access to healthcare services, how those services are organized, the relationship users have with healthcare providers, actions prescribed to prevent and control the disease and the social resources existing in the area encompassed by the healthcare service.

The *social* dimension refers to the social dimension of getting sick by using indicators able to reveal the profile of the population in the area it encompasses as to access to information and expenses with social and healthcare services. This dimension includes the life cycle, social mobility and social identity. It also includes the characteristics of the social space, social rules in force, institutional rules, gender relations and iniquities, among other aspects.

As previously said, on the essence of the vulnerability concept lays the individuals and social groups' capacity of fighting against health conditions and recovering from them. In this essence are located, therefore, the *entitlement*, which refers to these people's right; and *empowerment*, which refers to political and institutional participation⁽¹⁾. These should be taken into account when assessing vulnerability, and an important aspect refers to the fact that there is constant movement among the dimensions mentioned. Thus, the individual dimension includes the social trajectory, which includes subjectivities, life projects and perception related to the future, for instance. It also includes the subjective representation one has of the other and the perception of the use of healthy living practices. It includes the subjective perception of rules and personal interpretation and expectations of punishment, among other issues.

THE COMPLIANCE ANALYTICAL CATEGORY

Compliance has been mainly investigated related to chronic diseases⁽⁹⁾. The studies that have been conducted about this theme within the ambit of the Vulnerability Group, compliance and needs in Collective Health, have tried to give scientific substance to the concept and to propose indicators and technologies able to subsidize the implementation of healthcare policies and monitoring individuals and social groups targeting on watching the health, mainly for health conditions demanding long-term treatments. The first study conducted on this theme reported elements to compose a treatment compliance concept different from the one accepted in Classic Epidemiology, i.e., abandonment of the treatment⁽¹⁰⁾. The logic of the Classic Epidemiology operates based on variables that are presented as individuals' attributes in the causal frame. As a result, should the treatment be abandoned, it is usually understood as a result of the individual's be-

haviors or attributes, thus ending up by stereotyping attitudes towards treatment. Thus, it fails to consider this matter in a way articulated with the development of life in society. Therefore, some individuals' attitudes are taken as a rule, healthcare services are deemed a system limiting the practices in control programs and the interpretation of health and disease is placed mainly in the rationality of the Natural History of the Disease.

The study mentioned, conducted on the theme of compliance with treatment⁽¹⁰⁾, revealed several aspects that give peculiarity and specificity to the interpretation of this matter no more as a result of behaviors/attitude and reduced to singular behavior, but as an attempt to identify powers to do the treatment. Said powers are related to three planes composing the concept: 1. a plane related to the conception of the health-disease process of a person suffering from the disease; 2. a plane referring to the social place of the sick person; 3. a plane dealing with the healthcare production process.

So, let's detail more explicitly those elements constituting the concept and then we will move on to make a proposition of indicators able to make them operational. The first plane to be approached, which refers to the interpretation of the health-disease process, is part of an assumption that the way people understand the health-disease process will guide their daily life, either more actively or passively. A broad understanding of the health-disease process, i.e., in a way associated to life in society, enables individuals to involve themselves in order to allow the health-disease process to undergo a transformation instead of taking a stance of conformism or contemplation. It allows gathering powers to face life knowing where vulnerabilities and needs are. In this sense, therapy and compliance with practices of intervention in health are configured as the need to provide healthcare, and it is presented as a life project. Under this perspective, this is a proactive stance before the need of overcoming a moment of disease and there is responsibility and commitment with the healthcare team as to healthcare interventions. The subject is assumed as the subject of the process instead of as a follower of therapeutic projects that do not meet his living requirements.

Therefore, the more limited an individual's understanding about the health-disease process is, its being considered here the result of a linear relationship where are conjugated at the most the attributes of the etiological agent, those of the host and of the environment, the more passive his attitude will be before the need of overcoming the disease. It is clear that the representations related to the health-disease process, with magical, mythical, transcendental explanations, contribute to behaviors of abject obedience to the therapy adopted and towards life. On the other hand, the more emancipating the understanding of the health-disease process is, the broader it is in the sense of allowing people to understand that the health-disease process is fully inserted in the reality and, as such,

it depends on the structures composing the society: its economic base and its legal-political-ideological dimension. These factors determine the way of insertion in the society and the society, the life styles which, on their turn, will promote possibilities to face the disease.

This last consideration refers to the second plane composing the compliance concept: the way of insertion in the society will determine access to a dignified life and potentialities to face the processes leading to feel worn-out in life. This plane encompasses access to work and to all elements part of life in society and which are related to the most fundamental needs in life: a place to live, healthcare services, food, clothes, education, information, transportation and leisure, among others. These are the needs related to supporting life⁽¹¹⁾. Meeting them can contribute to strengthening human beings in daily life and in the health-disease process as much as in stressing situations, when the pole evidencing the disease becomes much more evident. It is important to consider that this plane referring to insertion of individuals in society also encompasses freedom, autonomy, stimuli to develop creative, shared and constructive relationships, affection and happiness, among other needs.

The third plane refers to the process of producing healthcare services. We have to notice here that we are not talking about a hermetic system, but in ways of organizing working processes of transforming an object in a given situation by adopting means and tools, always according to a certain objective that guides the whole process. Within the ambit of Collective Health, the working processes operate according to the objective of transforming epidemiological profiles focusing on leading a healthy life. To do that, it is necessary the performance of a healthcare team composed of the disciplinary knowledge of each one of its members. The health as a complex process involving the whole constitutional weave of the society, with its contradictions and constitutive tensions, requires healthcare providers working with competences and skills to share their knowledge in order to enable the people under their institutional responsibility to understand the reality of life. To do that, technologies able to collect

healthcare needs are required, which can be done through qualified listening, through the bond resulting from meetings which should contain symmetric relationships instead of dominating relationships, or relationships able to limit freedom. Relationships oriented towards the subjects' autonomy in the construction and choice for certain therapeutic project.

Such interpretation planes support the proposition of the following compliance concept:

Compliance is not just an act of personal volition. It is a process intimately associated to life, which depends on a series of intermediations involving people's daily life, on the organization of working processes in healthcare and broad accessibility [which includes processes that lead – or fail to lead – to the development of a dignified life⁽¹²⁾].

Currently the Vulnerability, Compliance and Needs in Collective Health Research Group has been working to build treatment compliance indicators able to monitor users of healthcare services properly and able to stand for a tool easily understood by healthcare providers within the ambit of the assistance at local healthcare units, always under a perspective of Health Watch, i.e., indicators allowing considering subjects' vulnerabilities and potentialities to face their daily life. Thus, the Group proposes the following indicators which will be configured as operational variables to be defined according to the scores of vulnerabilities and potentialities of healthcare services' users.

FINAL CONSIDERATIONS

Understanding the concepts of vulnerability and compliance with intervention practices is one of the most important trends of investigation in the Nursing area once it broadens the analyses that operate according to logics usually based on multi-causality. Moreover, it allows innovations in healthcare by presenting indicators/markers contemplating the health-disease process in its full dimension and, therefore, it enables understanding the meeting of the healthcare needs, which are not limited just to those with a physical, clinical and biological nature.

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