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Challenges and perspectives of nursing care to vulnerable populations

Desafios e perspectivas do cuidado em enfermagem a populações em situação de vulnerabilidade

Desafíos y perspectivas del cuidado en Enfermería a poblaciones en situación de vulnerabilidad

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ABSTRACT

Objective: Analyze perspectives of nursing care provided to vulnerable populations.
Method: This is a theoretical-reflective study based on the Vulnerability and Human Rights framework.
Results: The psychosocial approach to vulnerability has allowed the resignification of the notion of the health needs of vulnerable populations through a position that favors addressing right violations that mark the life of these people. It has also allowed to develop a discussion on the use of the expression 'key populations' to prioritize these groups in health actions and their normative and moralizing developments contrary to right protection and the humanistic foundations of care.
Conclusion: When developing these arguments, this study concluded that, in order to overcome the challenges of providing nursing care to these populations, new perspectives about the human existence should be considered starting from the defense of their diversity and equal rights.
Keywords: Nursing care. Health vulnerability. Human rights.

RESUMO

Objetivo: Refletir sobre o cuidado em Enfermagem a populações em situação de vulnerabilidade.
Método: Ensaio teórico-reflexivo, embasado no referencial da Vulnerabilidade e Direitos Humanos.
Resultados: A abordagem psicossocial da vulnerabilidade permitiu ressignificar a noção de necessidades de saúde de populações em situação de vulnerabilidade a partir de um posicionamento favorável ao enfrentamento das violações de direitos que marcam o viver dessas pessoas. Também permitiu problematizar a utilização da expressão "populações-chave" para priorizar esses grupos em ações de saúde e seus desdobramentos normativos e moralizantes contrários à proteção de direitos e aos fundamentos humanistas do cuidado.
Conclusão: Ao desenvolver esses argumentos, concluiu-se que, para superar os desafios do cuidado em Enfermagem a essas populações, é imprescindível assimilar novas perspectivas sobre a existência humana a partir da defesa de sua diversidade e da igualdade de direitos.
Palavras-chave: Cuidados de enfermagem. Vulnerabilidade em saúde. Direitos humanos.

RESUMEN

Objetivo: Reflexionar sobre el cuidado en Enfermería a poblaciones en situación de vulnerabilidade.
Método: Ensayo teórico-reflexivo, basado en el referencial de la Vulnerabilidad y Derechos Humanos.
Resultados: El abordaje psicosocial de la vulnerabilidad permitió resignificar la noción de necesidades de salud de poblaciones en situación de vulnerabilid a partir de un posicionamiento favorable al enfrentamiento de las violaciones de derechos que marcan el vivir de esas personas. También permitió problematizar la utilización de la expresión "poblaciones clave" para priorizar esos grupos en acciones de salud y sus desdoblamientos normativos y moralizantes contrarios a la protección de derechos ya los fundamentos humanistas del cuidado.
Conclusión: Al desarrollar estos argumentos, se concluyó que, para superar los desafíos del cuidado en Enfermería a esas poblaciones, es imprescindible asimilar nuevas perspectiva sobre la existencia humana a partir de la defensa de su diversidade y de la igualdad de derechos.
Palabras clave: Atención de enfermería. Vulnerabilidad en salud. Derechos humanos.

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INTRODUCTION

The implementation of care practices that fulfill the needs of vulnerable populations is a major challenge for health care. In order to support innovation in these practices, strong interest in increasing the knowledge on social inequalities, its relationship to the precariousness of living conditions and the constitution of vulnerabilities in health has been observed, especially in the last three decades. In this context, the analytical innovation proposed by the concept of vulnerability broadens the understanding of the situations that cause the worst outcomes in health in scenarios of social inequities (inequalities resulting from injustice and social exclusion)[1-2].

In recent history, the complexity of these scenarios and their consequences for health had its greatest expression during the AIDS pandemic. In the 1990s, the disease progressed among low-income populations with low purchasing power, poor access to goods and services that are essential for health maintenance and who were undervalued due to their gender, race, and sexuality. Since then, vulnerability has become a conceptual category that can encompass the effects of a cultural and political scenario that reproduces injustice and human rights violations[1].

The concept of vulnerability linked to human rights knowledge has changed the programmatic response to AIDS, especially in Brazil where, since the 1990s, the Unified Health System (SUS), governed by the principles of universality, comprehensiveness and equity, provides health care to minimize the deleterious effects of these social inequities[1].

With an expressive workforce in SUS, nursing can help consolidate these transformations. However, it requires expanded knowledge of health vulnerabilities to understand the challenges imposed by contexts of social inequities on the work of these professionals. Several national and international publications have disseminated such knowledge. In Brazil, some publications discuss the binary explanations about the causes of the problems, the underappreciation of individual subjectivity and the difficulties of interpersonal relationship with so-called morally deviant groups. International publications on this theme highlight the importance of considering the social position and cultural insertion of people receiving care, adopting an empathic professional position that promotes social justice and offering care from a psychosocial perspective of the conditions of these populations[3-8].

Based on the Vulnerability and Human Rights framework, this study seeks to contribute to a debate that is still incipient in the nursing field. The objective was to analyze nursing care to vulnerable populations in the context of the human rights violations that mark the life of these people.

Challenges of nursing care to vulnerable populations

Considered a reference for the qualification of technical skills and scientific knowledge, care is a structuring concept for nursing, with empathy, collaboration and solidarity highlighted among its humanist foundations[9]. Guided by solidary actions, nursing respects the sociocultural reasons of each citizen, assimilating painful and joyful experiences promoted by interactions, which results in symmetry and balance in its multiple activities[10].

Although the act of caring and its humanistic prerogatives include the activities conducted by nursing professionals since remote times, this theme remains widely debated in the scope of Brazilian health. The implementation of the National Humanization Policy in 2003 is one of the developments of such debate as it consolidated a movement to promote the rights of users and workers. It aimed to reinvent the practice, management and traditional systems of health care[11].

In Brazil, the representative insertion of nursing professionals in the health sector shows the recognition of their importance for the quality of care. In this sense, and considering the urgency to meet the health needs of vulnerable populations, two questions have emerged. What challenges have to be addressed to ensure care for these populations? How do these challenges place us closer to or more distant from the practice of humanized care?

To answer these questions, it is important to understand that the range of individual and social situations and conditions required in the analysis of vulnerability demands an evaluation that shows concrete vulnerabilities in people's daily lives. The perspective that has highlighted the role of human rights violations can help fulfill this demand, as it suggests that personal and psychosocial trajectories depend on relations of power that can only be understood in terms of their local meanings and structural context. In this perspective, contexts where relationships of power structure inequalities in social class, race, gender, and sexuality define personal trajectories of vulnerability[1]. This conception leads to questions about the extent of meanings associated with the term 'vulnerable populations,' especially regarding their use to designate a generic group of people affected by similar health and socioeconomic problems. Our experience in tuberculosis research has encouraged us to formulate this criticism, as it shows

that the worst outcomes of illness are related to negative stereotypes associated with poverty, AIDS, and illicit drug use; the moral rejection in veiled experiences with racism and homophobia; and the submission and oppression of women exposed to HIV infection[12].

These experiences have also helped to improve the knowledge about the needs involved in the illness processes of these people. This should certainly impact the care plans developed for every person. In this sense, identifying and classifying needs (such as those related to housing, social bonds, income, safety, and food) are not as important as understanding their meanings and implications in everyday life. It is a reflexive exercise that is not successful when the relational dynamics, which brings health professionals and patients together, disregard an attentive, sensitive and powerful listening when producing shared responses that are consistent with the demands of the environment where life happens[2]. In line with the standpoints about vulnerable populations presented in this study, assuming a position that is consistent with this relational dynamics requires dealing with a paradox. It refers to the awareness of humanized care as a presupposition for the quality of health practices in comparison with the identity discrepancies between health professionals and patients involved in care provision.

The social differences emphasized in this study refer to the symbolic and material marks in people who live in situation of vulnerability in relation to people with diametrically diverse identity experiences. It is noteworthy that difference[13], as a sociological category, helps explain that social differentiation is a process to categorize people who belong to certain groups or adopt certain practices, and can deepen social inequalities, depending on how these discourses operate in every analyzed context. This debate also addresses the relationships between different people to understand how challenging it is to promote a solidarity action and a care practice in terms of humanization, among asymmetries and imbalances in social relationships. Another challenge refers to judging whether, in the relationships built with people in contexts of social inequality, efforts are made to reveal oppression, violence, exploration and other manifestations of human rights violations considered as sources of suffering and illness. The section below discusses these ideas based on presuppositions of human rights in their relationship to health. With such analytical approach, this study proposes a debate on perspectives that can produce care practices aiming to promote improvements in the health of vulnerable populations.

The practice of care in contexts of vulnerability and violation of human rights

Non-discrimination, equality and community participation in decisions about how to address the problems that affect people are core principles of human rights when responding to situations of vulnerability. These principles have represented the insertion of innovations by promoting new ways to deal with health needs in national political agendas and in the provision of programmatic guidelines at a global level[14].

In Brazil, scientific studies that incorporate this reference are still incipient[1], but this interest tends to increase, especially in areas such as nursing, given the challenges in the practice of humanized and resolute care.

An appealing source of knowledge has been the production of Brazilian researchers in the Vulnerability and Human Rights framework, as they propose new prevention and healthcare technologies with greater sensitivity to the needs, values and concrete intersubjective relationships between the actors involved in care provision. A constant element in these propositions is the undeniable rejection of universalism and essentialism of very abstract or stereotyped identities, raised by the idea of 'target population'[2]. This term is widely used in health programs to refer to groups affected by similar conditions regarding social disadvantages. In this sense, 'vulnerable populations,' as discussed here, would be the term that most effectively represents these groups.

This position, based on a psychosocial analysis of vulnerability, seeks to show dystopias generated in generic representations of people, for example, 'non-adherent to treatment,' 'drug user,' 'illiterate.' In the health field, the consequences of these dystopias are behaviors that 'moralize or standardize any practice or conception of what is good,' supported by highly persuasive scientific knowledge in prescribing 'healthy' behaviors[2]. This criticism facilitates the understanding of historical processes in which violations of human rights play a critical role in the trajectories of people, as opposed to the tendency to the moral judgment of their behavior. It also rejects the idea that, while belonging to one group, the other is naturally undisciplined, threatening, unable or possessing other qualities that do not ensure their social acceptance. The historical and social processes related to the deterioration of the identity of certain groups have been widely studied in sociology[15]. So they are considered here as central knowledge in understanding the discriminatory behaviors adopted in many manifestations of social life, also in the context of institutional relations in

the health field. Finding out, in fact, who the people we have relationships with are, respected in their undeniable dignity as human beings, increases the chances of recognizing their emotional, intellectual and cultural singularities expressed in their daily life that produce the meanings in their stories. Assimilating the diversity of human existence is, therefore, part of a proposal for changes in socialization patterns for health care.

In proposals of care for vulnerable populations, human diversity should be understood beyond the stereotypes of a cultural scenario characterized by social exclusion. In the health field, this scenario has even more specific lines with the reproduction of a reductionist view of the reality, which should be broken down into objects to be better understood and handled by health professionals[16].

An inspiring narrative on health care has made us recognize the importance of considering humanistic assumptions in technical actions, so as not to reproduce such reductionism. In this narrative, the story of an interrupted 'project of happiness' is rescued when responding to the unfavorable clinical condition of 'Mrs. Violeta,' who, when losing the perspective of living in the planned house with her companion, also loses the references of her existence. Not supporting the care practice on rigid technical principles of health sciences was critical to relieving the 'pain of missing someone or something' that she felt in her heart[12].

In sociocultural scenarios of human rights violation and, consequently, of reduced chances to perform 'projects of happiness,' what health actions would be effective in extinguishing the pain of someone daily affected by racism and social class discrimination? Likewise, how to eliminate the pain in women who have to give up their freedom and play a role that is pre-determined for them even before they are born? For those who decide to have homosexual experiences or adopt a gender identity without heterosexual and sexist standards, what are their pains and which interventions could mitigate them? Would the health system be able to eliminate the consequences of stigmatization among drug users and people living with HIV? We believe that when trying to find the answers to these questions, nursing can acquire new knowledge that helps conduct care practices based on humanistic principles in contexts of vulnerability and violation of human rights.

FINAL CONSIDERATIONS

The reflections presented above allowed us to conclude that the challenges in nursing care for vulnerable populations can be overcome by broadening our perspectives on human existence through an ethical position that is consistent with support to freedom, diversity and non-discrimination. The scarcity of nursing studies on approaches that integrate human rights and health care can be a limitation to the scope of the considerations in this study. They were presented here as a call for the innovation demanded by the reality itself when considering the increasingly complex contexts of health vulnerability. As one of the most present professional areas in the health sector in Brazil, nursing benefits from such knowledge. It helps to improve its practices and contributes significantly to the achievement of SUS proposals, particularly those related to the right to comprehensive and humanized health care. This study recommends expanding the opportunities to analyze these practices and consolidate knowledge about vulnerability and human rights in nursing.

REFERENCES

1. Ayres JR, Paiva V, França Junior IF. Conceitos e práticas de prevenção: da história natural da doença ao quadro da Vulnerabilidade e Direitos Humanos. In: Paiva V, Ayres JR, Buchalla CM, organizadores. Vulnerabilidade e direitos humanos: prevenção e promoção da saúde: da doença à cidadania. Curitiba: Juruá; 2012. p. 71-94.
2. Paiva V. Cenas da vida cotidiana: metodologia para compreender e reduzir a vulnerabilidade na perspectiva dos direitos humanos. In: Paiva V, Ayres JR, Buchalla CM, organizadores. Vulnerabilidade e direitos humanos: prevenção e promoção da saúde: da doença à cidadania. Curitiba: Juruá; 2012. p. 165-208.
3. Silva IR, Gomes AMT, Valadares GV, Santos NLP, Silva TP, Leite JL. Nurses' perceptions of the vulnerabilities to STD/AIDS in light of the process of adolescence. Rev Gaúcha Enferm. 2015 Sep;36(3):72-8. doi: https://doi.org/10.1590/1983-1447.2015.03.47293.
4. Zanatta EA, Motta MGC. Violência, sob o olhar de jovens, na perspectiva da corporeidade e da vulnerabilidade. Texto Contexto Enferm. 2015 June;24(2):476-85. doi: https://doi.org/10.1590/0104-07072015001302014.
5. Pedrosa SM, Reis ML, Gontijo DT, Teles SA, Medeiros M. The path to crack addiction: perceptions of people under treatment. Rev Bras Enferm. 2016;69(5):899-906. doi: https://doi.org/10.1590/0034-7167-2016-0045.
6. Sinkfield-Morey T. Diversity, inclusion, and storying: connecting across cultures to give meaning to patients' whole health. Creat Nurs. 2018;24(1):12-9. doi: https://doi.org/10.1891/1078-4535.24.1.12.
7. Hellman AN, Cass C, Cathey H, Smith SL, Hurley S. Understanding poverty: teaching social justice in undergraduate nursing education. J Forensic Nurs. 2018;14(1):11-17. doi: https://doi.org/0.1097/JFN.0000000000000182.
8. McCann E. Vulnerability and psychosocial risk factors regarding people who identify as transgender: a systematic review of the research evidence. Issues Mental Health Nurs. 2018;39(1):3-15. doi: https://doi.org/10.1080/01612840.2017.1382623.
9. Waldow VR. Cuidar: expressão humanizadora da enfermagem. 2. ed. Petrópolis: Vozes; 2007.
10. Souza ML, Sartor VVB. [Nursing care: a theoretical approcah]. Texto Contexto Enferm. 2005;14(2):266-70. doi: https://doi.org/10.1590/S0104-07072005000200015. Portuguese.
11. Martins CP, Luzio CA. Política HumanizaSUS: ancorar um navio no espaço. In-

terface (Botucatu). 2017;21(60):13-22. doi: https://doi.org/10.1590/1807-57622015.0614.

12. Maffacciolli R, Oliveira DLLC, Brand EM. Vulnerabilidade e direitos humanos: compreensão de trajetórias de internação por tuberculose. Saude Soc. 2017;26(1):286-99. doi: https://doi.org/10.1590/s0104-12902017168038.
13. Brah A. Difference, diversity, differentiation. Cadernos Pagu. 2006;(26):329-76. doi: https://doi.org/10.1590/S0104-83332006000100014.
14. Ferguson L, Tarantola D, Hoffmann M, Gruskin S. Non-communicable diseases and human rights: Global synergies, gaps and opportunities. Global Public Health. 2017;12(10):1200-27. doi: https://doi.org/10.1080/17441692.2016.1158847.
15. Goffman E. Estigma: notas sobre a manipulação da identidade deteriorada. 4. ed. Rio de Janeiro: LTC; 2008.
16. Ayres JRCM. Revisitando "D. Violeta": nos caminhos do cuidado. In: Pinheiro R, Müller Neto JS, Spinelli, MAS, Silva Júnior AG, organizadores. Construção social da demanda por cuidado: revisitando o direito à saúde, o trabalho em equipe, os espaços públicos e a participação. Rio de Janeiro: UERJ/IMS/CEPESC/LAPPIS/ABRASCO; 2013. p.15-30.

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