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ORIGINAL ARTICLE

Health care for border residents: Construction of a reality based on ethical values

Atendimento de saúde a residentes fronteiriços: construção de uma realidade a partir de valores éticos

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DOI: 10.1590/2358-289820241439301I

ABSTRACT This study sought to explain how interactions between health actors on the triple border of Brazil, Colombia and Peru influence the provision of care to border residents in that location. As a method, a single, explanatory, integrated, qualitative case was carried out in a municipality on the triple border of Brazil, Colombia, and Peru. The sources of evidence used were: documentary data, interviews, and direct observations. MaxQDA12® software was used to organize the data and for analysis, theoretical propositions, and construction of explanations as an analytical strategy and analysis technique. The data collected showed that financial issues are the main challenge in offering healthcare to border residents. However, the healthcare offered to this population is based on ethical values, such as egalitarianism; respect for individual freedom and human life; solidarity and altruism. In this context, healthcare for border residents in the studied region is recognized by local health managers as a right.

KEYWORDS Delivery of health Care. Border health. Health management. Health manager. International cooperation.

RESUMO *Este estudo buscou expor como as interações entre os atores de saúde da tríplice fronteira Brasil, Colômbia e Peru influenciam a oferta de atendimento a residentes fronteiriços daquela localidade. Como método, foi realizado um caso único, explicativo, integrado e qualitativo em município da tríplice fronteira Brasil, Colômbia e Peru. As fontes de evidências utilizadas foram: dados documentais, entrevistas e observações diretas. Para organização dos dados, análise, proposições teóricas e construção de explicações como estratégia analítica e técnica de análise foi utilizado o software MaxQDA12®. Os dados coletados evidenciaram que questões financeiras são o principal desafio para a oferta de atendimento de saúde ao residente fronteiriço. No entanto, o atendimento de saúde ofertado a esta população se baseia em valores éticos, como o igualitarismo; respeito à liberdade individual e a vida humana; solidariedade e altruísmo. Neste contexto, o atendimento de saúde de residentes fronteiriços, na região estudada, é reconhecido pelos gestores de saúde locais como um direito.*

PALAVRAS-CHAVE *Atenção à saúde. Saúde na fronteira. Gestão em saúde. Gestor de saúde. Cooperação internacional.*

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Introduction

Since the Roman Empire, borders have delimited geopolitical spaces, designating the political, social and cultural identities of a nation. Politically, the definition of border describes it as the territorial limit between two countries that constitute the political power of the National States[1].

By this definition, borders are limited to lines mapped cartographically with the purpose of separating spatial units[2]. However, social interactions play an important role in the formation and configuration of border regions, since the cultural and social diversity of border populations and their commercial, religious, family and even political interrelations constantly shape the physical and symbolic spaces of these regions[3]. From this perspective, being a border citizen means maintaining dual relations between the political and social structures of the border, one that determines the territorial spaces, with their regional norms and peculiarities, and another formed from coexistence with their neighboring peers[4].

In the triple border region of Brazil, Colombia and Peru, care for border residents influences population movements between the countries, as the health and social conditions of the region's populations, combined with the different healthcare models of the three countries that make it up, intensify the flow of users seeking healthcare on the Brazilian side[5], which is considered the most egalitarian among the three countries, due to its access based on universality and comprehensiveness[6].

Healthcare for border residents is a reality in several border municipalities in Brazil[6-8] and Latin America[9]. However, there are no international public policies that define how and when this type of care should occur in border regions. Thus, access to healthcare for these populations depends on the public health systems and policies of each country and the ethical and political positioning of local managers[10,11].

Understanding how personal and political interrelationships influence the dynamics of healthcare for residents in border territories in the Amazon region is essential for implementing public health policies that address this issue, as this region presents many significant differences in relation to other border regions in Brazil. In this context, it is worth noting that this border, being located in the Legal Amazon, has a predominance of indigenous populations and has large areas of Legal Reserve.

In addition to these conditions, factors that directly affect local health conditions also predominate in this border area, such as the disorderly immigration of populations that use the region as a gateway to Brazil, as was the case with Haitians in 2010[12], and drug trafficking, which brings with it environmental impacts caused by the deforestation of the forest for the planting of illicit drugs[13].

Given this scenario, this study was guided by the following research question: how do interactions between health actors from the Brazil, Colombia, and Peru triple border influence the provision of healthcare to border residents in Tabatinga, a municipality on the international Amazon triple border, comprising Brazil, Colombia, and Peru? Consequently, the objective of the study was to explain how interactions between health actors on the Brazilian side of the Brazil, Colombia, and Peru triple border influence the provision of care to border residents in the municipality of Tabatinga, Amazonas, Brazil.

Material and methods

This is a single, explanatory case study with a qualitative approach, with four integrated units of analysis[14]. The context of this research was the triple border between Brazil, Colombia and Peru, and the case was the municipality of Tabatinga, in the state of Amazonas, Brazil. Tabatinga was chosen as a case study because it is a municipality that is part of the international triple border in question, having a dry

border and twin city with the city of Leticia, in the department of Amazonas, in Colombia, and a wet border, across the Solimões River, with the city of Isla de Santa Rosa do Yavari, province of Mariscal Ramón Castilla, Department of Loreto, in Peru.

Three sources of evidence were used: documentary data, interviews, and direct observations. The documentary data were collected in March 2017, in physical archives of the Municipal Health Department of Tabatinga/AM and the Municipal Health Council of Tabatinga/AM, as well as on official websites of the State Health Department of Amazonas and the Brazilian Ministry of Health. The study included documents produced between 2005 and 2017. This time frame was considered based on the implementation of the Integrated Border Health System program (SIS-Fronteiras) in Brazil[15]. The following documents were considered for analysis: Administrative Acts, Decrees, Decree-Laws, Normative Instructions, Laws, Technical Standards, Ordinances, Resolutions, Meeting Minutes, and Official Letters. From this frame, a database composed of 98 documents was generated.

The interviews were conducted with health managers from the Municipal Health Department of Tabatinga/AM, the Municipal Health Council of Tabatinga/AM, and the State Health Department of Amazonas. Managers with decision-making power in processes of implementing public health policies for health integration in the triple border region of Brazil, Colombia, and Peru, or who provided services in health units serving border residents in Tabatinga, were included. Therefore, a database of 12 interviews that took place between May and November 2017 was formed.

Direct observations took place in the services that represented the integrated analysis units, consisting of two Basic Family Health Units, an Emergency Care Unit and a maternity hospital. These units were chosen due to their proximity to the borders with Peru and Colombia. The observations were previously scheduled with the managers of the establishments and took place in November and December 2017, with a total duration of 34 hours.

Data organization was performed using MaxQDA12® software, which enabled the creation of categories, codes and subcodes, thus allowing the analysis of evidence separately and recombined with each other. To analyze the evidence, theoretical propositions and the construction of explanations were adopted as analytical strategies and techniques, which indicated the relevant conditions to be described and the construction of explanations for the phenomenon studied. Document analysis, interviews and direct observations allowed the convergence of data in a triangular manner.

This study complied with the ethical precepts of Resolution No. 466/12 of the National Health Council[16], which regulates research involving human beings, and was approved by the Ethics and Research Committee of the Federal University of Santa Catarina with a Certificate of Presentation of Ethical Appreciation – CAAE No. 61426316.2.0000.0121 and Opinion No. 2,047,137.

Results

The analysis of the evidence made it possible to create two categories that explain how interactions occur between health actors in the triple border region of Brazil, Colombia and Peru and the influence of these interactions on the provision of healthcare for border residents in the municipality of Tabatinga, Amazonas, Brazil.

The challenges in providing healthcare to border residents in the triple border region of Brazil, Colombia and Peru

Most participants view healthcare for border residents as an intrinsic factor in the border region, recognizing that this phenomenon entails some

misfortunes. Among the challenges, participants emphasize mainly those related to financial and organizational management, understanding that, although managers maintain a natural attitude towards the phenomenon, they see this type of care as a challenge.

There was a consensus among participants that providing healthcare to border residents causes financial losses for the municipality and the region, since the financing of the health sector basically comes from transfers of the Fixed Primary Care Floor, which is defined based on the population recognized as residents of the municipality. The complaint of most participants is that, through the health information system, populations coming from other countries and seeking healthcare in the municipality cannot be considered as populations effectively served.

> *Of course we need more resources to manage healthcare on the border, because the resources allocated to the municipality come to registered citizens, to those who have a CPF, a fixed residence, who are either Brazilian or naturalized foreigners [...] we receive according to the population per capita, but there are many people who live here in transit, who are not regularized, in addition to those who come here just to receive care, which is the floating population.* (Manager 6).

Financial issues related to healthcare for border residents are observed at both municipal and state levels, since – as managers of specialty and emergency service – state health representatives agree that costs related to hospital admissions, as well as expenses for emergency care, provided to foreign populations burden the public health accounts of the Brazilian municipality and state.

> *There is a loss from an economic point of view, as hospitalization is not cheap and depending on the time, this ends up putting a great burden on municipal and state departments, because they have to provide care, which ranges from vaccination to hospitalization.* (Manager 8).

Linked to financial issues, organizational challenges appear, highlighting the planning of health actions and organization of services for a population that is not included in municipal records.

For the planning of health actions ony the population residing in the coverage area is considered, according to the age group corresponding to the action to be carried out. This same condition is described in relation to the infrastructure of the municipality's health institutions, which cannot support the excessive demand generated by the local population added to the foreign population, generating situations such as lack of material, human, service and hospital beds.

> *[...] this service greatly compromises our pharmacy supplies, vaccine doses, rapid testing for communicable diseases, laboratory supplies and others, because we have 62 thousand inhabitants, but the scope of service is much greater.* (Manager 4).

> *We even had moments where all the beds [...] were occupied by foreigners waiting to be transferred.* (Manager 3).

Other challenges in providing healthcare to border residents are the differences between public policies in the three triple border countries, especially those related to the control and prevention of infectious diseases.

> *[...] one of the problems is that here in Peru and there in Colombia they have to pay if they want to be cared for, unlike in Brazil where they serve anyone who knocks on the door.* (Manager 4).

Healthcare for border residents: building a reality based on interaction between agents

The inclusion of healthcare for border residents in the municipal healthcare system of Tabatinga is due to several factors, with participants unanimously agreeing that the

universal right to healthcare, guaranteed by the Brazilian Unified Health System (SUS), is what supports healthcare for the foreign population.

> *When we think about this service, we realize that there is great acceptance and a greater understanding, both among professionals and the population, that in Brazil the SUS is a right for everyone [...].* (Manager 5).

However, the research revealed that, in addition to universality, care for border residents is based on ethical values, such as egalitarianism; respect for individual freedom and human life; solidarity and altruism. Healthcare for border residents, based on such values, stands out both in the statements of the interviewees and in direct observations.

> *They are very needy, so if they have some problem they come here and no one is going to send the patient back [...] and have to go to Iguitos which is far away and expensive [...] we are not going to let a person die for a legal reason, since it is the same geographic space.* (Manager 6).

The interpersonal relationships of the border populations are the great driving force behind this reality, since, according to the participants, the territorial divisions existing in the region are purely political, with no social or cultural barriers, transforming the space of the three bordering municipalities into a single territory, which houses the border population and favors personal and institutional interrelationships.

> *There we cannot separate Brazilians and foreigners [...] What exists there, let's say, is an environment of coexistence, where people go, where people circulate [...] this has already crystallized, it will not change anymore.* (Manager 10).

Discussion

In Brazil, the interpretation of the health system, based on universality, leads to the understanding that border residents can have access to actions and services of all kinds[17]. The occurrence of healthcare for border residents in border municipalities is attributed to several factors, ranging from the low socioeconomic conditions of the border regions[6] to the political differences and health systems of the countries bordering Brazil[18,19].

This research exposes the reality in the triple border region of Brazil, Colombia and Peru, through a case study carried out in a twin city, which suffers from both inequalities and vulnerabilities[6], as well as from the unevenness of the health systems in Brazil, when compared to Colombia and Peru, countries that maintain as their main characteristic the provision of service packages to specific groups of the population[19,20]. In this context, it is worth noting that the Colombian health system is fragmented and the Peruvian health system is characterized by an indirect contributory system, financed through fiscal resources from government agencies and employers, respectively, or by a semi-contributory system, through private social insurance[4,5]. In this scenario, healthcare for border residents in the municipality of Tabatinga occurs to a greater or lesser extent in all health services, with a greater demand for care in primary care services.

The existing conditions in the municipality studied, in relation to healthcare for border residents, entail several management challenges, but the financial one was the one that received the most attention. It is known that problems arising from the financing of the health sector are faced by several Brazilian municipalities[21,22]; however, in border municipalities, this condition is added to the need to manage resources that are intended for a registered population, but that will also serve populations in neighboring countries.

In this context, one of the main aspects related to the financing of healthcare for border residents is that it can interfere with the recognition by users and managers of the universal and comprehensive right to healthcare for border residents. A Right that tends to be accepted at the political and ethical level, but which suffers strong restrictions due to the lack of financial subsidies to cover the additional care provided for the foreign population[23].

These financial issues also correspond to difficulties in planning actions and organizing health services in the municipality studied, also cited as one of the challenges in providing healthcare to border residents. It is worth noting that these activities are established based on protocols based on national public health policies and aimed at the population registered in Brazilian territory. As determined by these policies, the planning of actions and the organization of services must serve specific population groups established territorially by collectives of registered families.

Following this model, the needs felt by populations from neighboring countries who seek healthcare in Brazil are disregarded, which leads to increased inequity in care. Thus, even if the actions seem efficient in terms of normative needs, the results will not be satisfactory for the entire foreign population who use the services in Brazil[24].

Despite these findings, it was shown that financial and planning challenges do not limit the provision of healthcare for foreign populations[5,20] and that this is based on social, humanitarian conditions and the interrelationships of the local population.

In border regions, social conditions are almost always precarious, with few profitable economic activities and often lacking in health infrastructure, which consequently results in the only viable alternative for accessing healthcare being to cross the border, to the other side of the street, bridge or river, in search of solutions for their health needs[23].

Given this finding, we recall that health is a fundamental right of the human person and that its realization requires the action of other social and economic sectors, in addition to the health sector[25], therefore, it is the duty of all health managers to protect human life, regardless of the political space from which that life came.

Furthermore, in border cities there are interpersonal relationships that favor the understanding that health services on either side of the border should and can be shared by all border residents of that territory[4]. In these locations, there is a natural integration, which creates a kind of third space, in which a new society is generated, with values and cultural, ethnic traits, peculiar and unique languages and that presents an identity different from the rest of the country[26].

Corroborating this thought, Nogueira et al.[27] emphasize that border regions do not begin or end with the demarcation of countries' territorial limits, since, in practice, urban mobility, trade dynamics, capital movement and internal factors directly influence the policies that apply to the neighboring country and that all of this is determined based on relationships established between actors and agents.

In the triple border region of Brazil, Colombia and Peru, this human mobility is consolidated in a culture and collective identity anchored in mutual solidarity, which was formed as a result of the distance and isolation from large urban centers. This, combined with the geographical situation facilitated by the conurbation between Brazil and Colombia and the short distance between Brazil and Peru, provides and consolidates bonds that are revealed in different levels of kinship between people, who move freely between the three countries, and also through relations of trade, leisure and use of goods and services[5].

The formation of collective identities is different for each border region, as it depends on the existence or not of interaction between border societies, as well as

the historical result and porosity of these relationships[27].

The formation of collective identities based on social interrelations is considered from human interactions that fundamentally consist of ideas, thoughts and beliefs that are constructed based on people's interests[28-30]. Thus, healthcare for border residents in the triple border region of Brazil, Colombia and Peru is directly influenced by the social, economic, cultural and geographic conditions established in the region.

Given the collective and individual interrelations presented in the region[5], the existence of a collective identity that allows the reception of border residents who seek healthcare on the Brazilian side of the border is identified. Thus, in the region studied, the provision of healthcare for border residents goes far beyond the application of the rights established by the SUS, as the concern of local health managers in finding ways to offer care that meets the felt and expressed needs of this population is evident.

Final considerations

The border region studied suffers from the typical geographic characteristics of the Amazon region, such as climate, great distance from major centers and difficulty in accessing services, which consequently hinder the resolution of health problems and increase social inequities and vulnerabilities. In this context, the provision of healthcare to border residents is a reality guided by the principles of universality, equity and comprehensiveness of the Brazilian health system.

In this space, the border population has the freedom to seek healthcare on the Brazilian side, but this freedom depends on the political will of the managers. Currently, the local management recognizes, despite the difficulties, that the health of border residents is a right that must be respected and included in local public health policies, but this position may change as new government political relations are established in the region. In order to overcome this weakness, it is necessary to institutionalize strong public policies that remain independent of the discretion of the political actors who regulate them.

Acknowledgements

Thanks to the Coordination for the Improvement of Higher Education Personnel (CAPES).

Collaborators

Santos-Melo GZ (0000-0003-1161-8677)* and Andrade SR (0000-0001-7449-6860)* contributed equally to conception, analysis and interpretation of data, preparation of the work, final approval of the version to be published, having final responsibility for all aspects of the manuscript. Coelho JIM (0009-0005-3284-4480)*, Fuza RL (0009-0007-2505-1778)*, Silva AMI (0009-0004-2581-3814)*, Nogueira VMR (0000-0003-4158-1510)* and Monteiro AX (0000-0002-5175-4537)* contributed equally to intellectual property review and approval of the final version of the manuscript. ■

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References

1. Ferrari M. As Noções de Fronteira em Geografia. Rev. Persp. Geografica. 2014;9(10):1-24.

2. Silva ML, Tourinho HLZ. Território, territorialidade e fronteira: O problema dos limites municipais e seus desdobramentos em Belém/PA. Rev Bras Gest Urbana. 2017;9(1):96-109. DOI: https://doi.org/10.1590/2175-3369.009.001.AO09

3. Andrade MAP. Espacios fronterizos e identidad: tensiones y estrategias politico-culturales en la ciudad de Concordia. Runa [Internet]. 2010 [acesso em 2024 jan 12];31(2):175-190. Disponível em: https://www.redalyc.org/articulo.oa?id=180819162003

4. Santos-Melo GZ, Andrade SR, Ruoff AB. A integração de saúde entre fronteiras internacionais: uma revisão integrativa TT. Acta Paul Enferm. 2018;31(1):102-7. DOI: https://doi.org/10.1590/1982-0194201800015

5. Santos-Melo GZ, Andrade SR, Lemos SM, et al. A mobilidade humana e o atendimento de saúde a estrangeiros em um município de fronteira internacional da Amazônia Legal Brasileira. Socdeb [Internet]. 2019 [acesso em 2024 jan 12];25(esp):158-169. Disponível: https://revistas.ucpel.edu.br/rsd/article/view/2503

6. Peiter PC, Franco VC, Gracie R, et al. Situação da malária na tríplice fronteira entre Brasil, Colômbia e Peru. Cad Saúde Pública. 2013;29(12):2497-2512. DOI: https://doi.org/10.1590/0102-311X00042213

7. Giovanella L, Guimarães L, Nogueira VMR, et al. Saúde nas fronteiras: acesso e demandas de estrangeiros e brasileiros não residentes ao SUS nas cidades de fronteira com países do MERCOSUL na perspectiva dos secretários municipais de saúde. Cad Saúde Pública. 2007;23:S251-S266. DOI: https://doi.org/10.1590/S0102-311X2007001400014

8. Ferreira CMPG, Mariani MAP, Braticevic SI. As múltiplas fronteiras presentes no atendimento à saúde do estrangeiro em Corumbá, Brasil. Saúde Soc. 2015;24(4):1137-1150. DOI: https://doi.org/10.1590/S0104-12902015137475

9. Corbinos LA, Delgado I, Oyarte M, et al. Salud y migración: análisis descriptivo comparativo de los egresos hospitalarios de la población extranjera y chilena. Oasis. 2017;(25):95. DOI: http://doi.org/10.18601/16577558.n25.06

10. Azzopardi-Muscat N, Baeten R, Clemens T, et al. The role of the 2011 patients' rights in cross-border health care directive in shaping seven national health systems: Looking beyond patient mobility. Health Policy. 2018;122(3):279-283. DOI: https://doi.org/10.1016/j.healthpol.2017.12.010

11. Kato Y. "Irregular foreigners" right to health in Japan: an analysis from the perspectives of international covenant on economic, social and cultural rights [tese na Internet]. Nakhon Pathom: Mahidol University; 2016 [acesso em 24 jan 12]. Disponível em: https://graduate.mahidol.ac.th/engine/current-students/detail/abstract_view.php?id=5337380&fac=77&prg=7702M&gp=4

12. Silva JA, Neto AFO, Mariani MAP. Reflexões sobre o acesso à saúde na fronteira Corumbá (BR) e Puerto Quijarro (BO). Rev GeoPantanal [Internet]. 2017 [acesso em 2024 jan 12];(esp):79-95. Disponível em: https://periodicos.ufms.br/index.php/revgeo/article/view/4107

13. United Nations Office on Drugs and Crime, Division for Treaty Affairs. World Drug Report 2022 [Internet]. Vienna: United Nations; 2022 [acesso em 2024 jan 30]. Disponível em: https://www.unodc.org/res/wdr2022/MS/WDR22_Booklet_5.pdf

14. Yin RK. Estudo de caso: planejamento e método [Internet]. 5. ed. Porto Alegre: Bookman; 2015 [acesso em 2024 jan 12]. Disponível em: https://edisciplinas.usp.br/pluginfile.php/6598416/mod_resource/content/1/Livro%20Robert%20Yin.pdf

15. Ministério da Sáude (BR). Portaria nº 1.120 de 6 de julho de 2005. Institui o Sistema Integrado de Saúde das Fronteiras – SIS FRONTEIRAS. Diário Oficial da União [Internet], Brasília, DF; 2005 Jul 7 [aces-

so em 2024 jan 12]; Edição 129; Seção I:47. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2005/prt1120_06_07_2005.html

16. Ministério da Saúde (BR); Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos e revoga as Resoluções CNS nos. 196/96, 303/2000 e 404/2008. Diário Oficial da União [Internet], Brasília, DF. 2013 jun 13 [acesso em 2024 jan 12]; Edição 112; Seção I:59-62. Disponível em: https://www.gov.br/conselho-nacional-de-saude/pt-br/acesso-a-informacao/legislacao/resolucoes/2012/resolucao-no-466.pdf/view

17. Hahn TM. O direito à saúde dos estrangeiros que necessitam de proteção: a aplicação jurisprudencial na legislação brasileira e na convenção europeia de direitos humanos [Internet]. Brasília, DF: Publicações da Escola da Advocacia Geral da União; 2009 [acesso em 2024 jan 12]. Disponível em: https://www.lexml.gov.br/urn/urn:lex:br:rede.virtual.bibliotecas:revista:2009;001020649

18. Nogueira VMR, Fagundes HS, Alonso CB, et al. Políticas de saúde nos países do Mercosul: um retorno à universalidade? Rev Pol Públ. 2016;19(1):145-56. DOI: https://doi.org/10.18764/2178-2865.v19n1p145-156

19. Giovanella L, Almeida PF. Comprehensive primary care and segmented health systems in South America. Cad Saúde Pública. 2017;33(supl2):e00118816. DOI: https://doi.org/10.1590/0102-311x00118816

20. Santos-Melo GZ, Andrade SR, Meirelles BHS, et al. Integration in health: cooperation at triple international border Amazon. Rev Saúde Pública. 2020;54:5. DOI: https://doi.org/10.11606/s1518-8787.2020054001306

21. Levino A, Carvalho EF. Comparative analysis of health systems on the triple border between Brazil, Colombia, and Peru. Rev Panam Salud Publica. 2011;30(5):490-500. DOI: https://doi.org/10.1590/s1020-49892011001100013

22. Morosini MVGC, Fonseca AF, Lima LD. Política Nacional de Atenção Básica 2017: retrocessos e riscos para o Sistema Único de Saúde. Saúde debate. 2018;42(116):11-24. DOI: https://doi.org/10.1590/0103-1104201811601

23. Fagundes HS, Kreutz IT, Nogueira VMR, et al. Saúde na linha de fronteira Brasil-Uruguai: pactos e protagonismos dos atores locais. Rev Katálysis. 2018;21(2):293-304. DOI: https://doi.org/10.1590/1982-02592018v21n2p293

24. Miclos PV, Calvo MCM, Colussi CF. Avaliação do desempenho das ações e resultados em saúde da atenção básica. Rev Saúde Pública. 2017;51:86. DOI: https://doi.org/10.11606/S1518-8787.2017051006831

25. Ministério da Saúde (BR). Declaração de Alma-Ata sobre Cuidados Primários. Conferência Internacional sobre Cuidados Primários de Saúde [Internet]. Alma-Ata, Cazaquistão: OMS; 1978 [acesso em 2024 jan 12]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/declaracao_alma_ata.pdf

26. Ocampo AHT. Saúde nas fronteiras: uma proposta de bem-estar e desenvolvimento. In: Souza ML, Ferreira LAP, Rezende VM, et al., organizadores. A saúde e a inclusão social nas fronteiras [Internet]. Florianópolis: Fundação Boiteux; 2008 [acesso em 2024 jan 12]. p. 149-154. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/saude_inclusao_social_fronteiras.pdf

27. Nogueira JRB. Fronteira: espaço de referência identitária. Atelie Geogr. 2007;2(1):27-41. DOI: https://doi.org/10.5216/ag.v1i2.3013

28. Adler E. O construtivismo no estudo das relações internacionais. Lua Nova. 1999;(47):201-246. DOI: https://doi.org/10.1590/S0102-64451999000200011

29. Wendt A. Anarchy is what states make of it: The social construction of power politics. Inter Organ [Internet]. 1992 [acesso em 2024 jan 12];46(2):391-425. Disponível em: https://edisciplinas.usp.br/pluginfile.php/7945535/course/section/6553729/WENDT%20A.%20%281992%29.%20Anarchy%20is%20what%20states%20make%20of%20it%20the%20social%20construction%20of%20power%20politics.pdf

30. Wendt A. Social Theory of International Politics [Internet]. Cambridge: Cambridge University Press; 1999 [acesso em 2024 jan 12]. 462 p. Disponível em: https://www.guillaumenicaise.com/wp-content/uploads/2013/10/Wendt-Social-Theory-of-International-Politics.pdf

Received on 02/18/2024
Approved on 08/05/2024
Conflict of interests: non-existent
Financial support: Coordination for the Improvement of Higher Education Personnel (CAPES). Process Number: 88881.695908/2022-01

Editor in charge: Raquel Abrantes Pêgo