

Experiences of ethnic groups in a care facility in the Amazon region of Brazil

Vivências de Diferentes Etnias em Uma Casa de Saúde Indígena na Região Amazônica/Brasil

Domingas Machado da Silva¹

Eloane Hadassa de Sousa Nascimento²

Luana Almeida dos Santos³

Maria Teresa de Sousa⁴

Karina Angélica Alvarenga Ribeiro⁵

Maura Cristiane e Silva Figueira⁶

¹Nurse. Department of Health of Santarém. E-mail: domingaslegal@yahoo.com.

²Nurse. Department of Health of Santarém. E-mail: eloane.h@hotmail.com

³Nurse. Department of Health of Santarém. E-mail: luanah.orix@gmail.com

⁴Nurse. Department of Health of Santarém. E-mail: enfateresa@hotmail.com

⁵Nurse. Lecturer at Unigran Capital, Mato Grosso do Sul. E-mail: kavabana_ri@yahoo.com

⁶Nurse. PhD student in Health Sciences at the State University of Campinas - Unicamp, São Paulo. E-mail:mauracsf@gmail.com



Abstract

The National Policy on Health Care for Indigenous Peoples restructures indigenous primary health care based on the principles and guidelines of the Unified Health System. Objectives: to describe the reports of indigenous persons living in an indigenous care facility in the Amazon region. Methodology: a qualitative study based on semi-structured interviews with indigenous people from five ethnic groups was carried out with the help of a translator, and the content was analyzed. The results were grouped into themes: feelings on leaving the village, improvements experienced while staying in the facility and coexistence between ethnic groups. The authors believe that despite advances in indigenous health in Brazil, improvements are needed to meet the individual needs of different ethnicities.

Key-words: Indigenous Health; Health of Indigenous Populations; Access to Health Services.

Resumo

No Brasil, a Política Nacional de Atenção à Saúde dos Povos Indígenas reestrutura a Atenção Primária à Saúde Indígena seguindo os princípios e diretrizes do Sistema Único de Saúde. O objetivo é descrever os relatos da vivência de indígenas em uma Casa de Saúde Indígena (CASAI) na região amazônica. Trata-se de um estudo qualitativo, descritivo, cuja abordagem ocorreu por meio de entrevistas semiestruturadas, gravadas e transcritas com indígenas de cinco etnias, assistidas pela CASAI (Mawayana, Tunayana, Wai-wai, Tiriyo e Katwena), com auxílio de tradutor dos dialetos. Utilizamos a análise do conteúdo das falas dos indígenas. Como resultados emergiram 3 categorias temáticas: “o sentimento em deixar a aldeia”, “melhorias no período de permanência na CASAI” e “a convivência com outras etnias”. Consideramos que apesar das crescentes mudanças e avanços na saúde indígena no Brasil, necessita-se de melhorias que possam atender de fato as peculiaridades de saúde próprias de cada etnia.

Palavras-Chave: Saúde Indígena; Saúde de Populações indígenas; Acesso aos Serviços de Saúde.

Introduction

In Brazil, the National Policy on Attention to Health of Indigenous Peoples (PNASI) ⁽¹⁾ was established by the Ministry of Health through Administrative Rule 254, dated January 31, 2002, restructured Primary Health Care to Indigenous Health, aiming to ensure full access to comprehensive health care, following the principles and guidelines of the Unified Health System (SUS), according to the social, cultural, geographical, historical and political diversity among the ethnic groups, leading to the overcoming of factors that make populations indigenous people most vulnerable to health problems of higher prevalence in the general population, seeking the recognition of traditional medicine as the right of indigenous peoples to their culture ⁽¹⁾.

According to the Brazilian Ministry of Health, Indigenous Health Care services are organized in 34 Indigenous Special Health Districts (DSEIs), the decentralized management units of the Indigenous Health Care Subsystem (SASI), and the territorial base is defined strategically by ethnogeographic,

epidemiological and service access criteria (health, transportation, communication, administrative and economic) ⁽¹⁻²⁾.

The indigenous health centers (CASAI) are inseparable elements of the DSEI and / or regional management, being linked to their councils by territorial criteria, organizing the primary health care services within the indigenous areas, integrated and hierarchical with increasing complexity. In addition to the DSEIs, the service structure has health centers located in indigenous villages, with the base poles and CASAI, created in strategic areas of the DSEIs or in urban reference centers to receive indigenous patients referred for examination and treatment of cases of medium and high complexity ⁽¹⁻²⁻³⁾.

According to PNASI, these health centers should be able to shelter and feed patients and caregivers, provide full-time nursing care, make appointments, follow-up exams or hospitalization and should also be adequate to promote health education activities, handicraft production, leisure and other activities for patients and companions ⁽¹⁾.

Government programs make indigenous



people the same demands they make for non-indigenous organizations, not recognizing their own forms of social organization, forms of representation, ways of expressing their feelings, customs and differences among ethnic groups ⁽⁴⁾.

In the IBGE census ⁽⁵⁾, 817,963 self-declared indigenous persons were registered in Brazil. These Indians are organized in different ethnic groups and languages, among them the ethnic groups that are assisted in the CASAI Santarém-Pará-Brazil, which are: Tiriyo, Wai-Wai, Tunayana, Hiskaryana, Mawayana, Katwena, Xerew, Karyjana, Kayana, Kaxuyana, Zoé, Munduruku and Kayapó.

The Brazilian government ⁽¹⁻²⁾ recommends that reference procedures should be established, against reference and incentive to health units for the provision of differentiated services that influence the recovery process of indigenous patients (such as those related to eating habits, relatives and / or interpreter, visiting traditional village therapists, installing sleeping nets, using traditional therapy, among others) and that CASAI should be able to receive, house and feed patients referred and accompanying persons, full-time nursing, appointments, follow-up examinations or hospitalization, to provide follow-up of patients and their return to the communities of origin. However, there is no determination of the definition of places for the separation between the different ethnic groups housed in CASAI.

Given the knowledge of this context we had the following question: is there any difficulty for the indigenous people of different ethnicities who live in the Indigenous Health House of the Amazon region / Brazil?

This approach is justified by providing the report of the indigenous people, with the perspective of offering information to managers and health staff, to minimize the impacts related to the displacement of their natural environment, to occupy a different environment from that of daily life and the conviviality with other ethnicities, thus helping in the planning of action strategies that minimize possible conflicts and the long stay in the

unit of reference.

The theoretical support of this research was the National Policy on Health Care of the Indigenous Peoples of Brazil ⁽¹⁾.

The objective is to demonstrate the reports of indigenous people of different ethnicities living in an Indigenous Health House (CASAI) in Santarém - Pará / Brazil in the Amazon region about their feelings and perspectives about this moment.

Method

This research has a qualitative, exploratory and descriptive approach, since it allows to understand the characteristics of the investigated phenomena and, in doing so, sustains important articulated reasoning for political, educational and scientific research decision making ⁽⁶⁾.

The place of study was CASAI Santarém - Pará / Brazil, belonging to the Guamá-Tocantins Indigenous Sanitary District. The Santarém-Pará Pole-Base provides health assistance to ethnic groups from the Nhamundá / Mapuera and Cuminapanema indigenous reserves, as well as to the Munduruku and Kayapó ethnic groups located in the area covered by the Itaituba-Pará / Brazil Base Pole belonging to the Rio Tapajós Sanitary District.

Thus CASAI Santarém provides assistance to the following ethnic groups: Tiriyo, Wai-Wai, Tunayana, Hiskaryana, Mawayana, Katwena, Xerew, Karyjana, Kayana, Kaxuyana, Zoé, Munduruku and Kayapó. The work team consists of the director, four nurses, five nursing technicians, four administrative staff, three cooks, two drivers and one interpreter. The nursing team remains fully in CASAI, having greater knowledge of the dynamics and organization of the work process according to the health needs of the users.

The Indians were invited to participate voluntarily, confirmed by the signing of the Term of Free and Informed Consent (TCLE) written in Portuguese language and translated into the indigenous dialect of each ethnic group to facilitate understanding or recorded for the Indians with

restrictions on signing.

After the acceptance, the data collection took place in September 2014, through interviews with the participants, using a script with the guiding questions written in Portuguese. In order to reduce the linguistic barrier, we had the assistance of a translator indicated by CASAI in the approach of those indigenous people who did not understand the Portuguese language.

Protecting the identity of the participants to ensure confidentiality, the names of native plants of the Amazon region were used: Castanheira, Ipê, Cedro, Andiroba, Jatobá, Massaranduba, Seringueira, Açaí, Angelim, Buriti, Bacaba, Inajá, Pupunheira, Babaçú e Cupuaçú.

The interviews were recorded and transcribed into Portuguese with the support of the translator of the native language with an average duration of 45 minutes. Fifteen natives aged over 18 years were interviewed, for whatever reason they stayed at CASAI Santarém. This amount of indigenous was closed by the richness of the collected content.

The semistructured interview form was divided into two phases, the first being composed of: age, sex, ethnicity, occupation within the indigenous community (work activities), period of stay at CASAI Santarém until the period of return to indigenous land and the reason for the shift from Basic Attention (or from the village of origin) to Attention of Medium and High Complexity.

The second moment was composed of questions organized according to the objectives proposed by the research:

- What is the feeling of having to leave your native land, the family and come to CASAI Santarém?
- What is your opinion regarding what could be improved or modified during the period of your stay at CASAI Santarém?

In compliance with Resolution No. 466/2012 of the National Health Council, with regard to ethical

principles, a favorable opinion was required from the National Committee for Research Ethics (CONEP), Protocol No. 827,490 of September 2014 and Research Ethics Committee of the State University of Pará, Protocol No. 751.016 of August 2014 and, the authorization of the Coordination of CASAI Santarém - Pará.

For the analysis of empirical data, we used content analysis according to Minayo ⁽⁷⁾. We performed an exhaustive reading of the interviews to better interpret the content, considering the objectives and the theoretical reference, identifying the central themes and relevant aspects. Based on the objectives of the study, on the empirical material collected and on the proposed theoretical framework, three thematic categories were highlighted based on the guiding questions: the feeling of leaving the village; "Improvements in the period of stay in CASAI" and "coexistence with other ethnicities".

Results and Discussion

In this research, 15 indigenous people from six different ethnic groups were interviewed: eight were female (55%) and seven were male (45%). As for age, three were 18 to 28 years old, six from 29 to 39 years, one from 40 to 49 years and five from 50 to 60 years.

The main occupations of the subjects in the villages of origin are: fisherman, teacher, artisans, farmer, indigenous health agent and school lunch assistant.

The interviewees belong to five ethnic groups: six Wai-wai, four Kaiapós, one Mawayana, one Tiriyo, two Katwena and one Tunayna.

Regarding the reasons for the arrival of these Indians from the villages to CASAI Santarém were: specialized references to medium and high complexity services, specialized exams, hospital procedures and return for follow-up/treatment. On average the stay in CASAI varied from a minimum of three days and a maximum of 170 days.

We identified the nuclei of meaning in

speech, and the following thematic categories were organized for this study: "The feeling of leaving the village"; "Improvements in the period of stay in CASAI" and "Coexistence with other ethnicities".

The feeling when leaving their villages

The most commonly reported feelings were concern for family members, sadness about the departure of the village and the longing for family life, as can be seen in the following narratives:

" [...] I'm very sick, that's why I left my village there, I left my family, I want to go back there as fast as I can, because I've been here a long time, far from the village" (Ipê).

"The feeling is why I am far from my village, sometimes I am sad, there in the village I will be happy right? Because in my village I'm like this, happy, here in the city now I'm sad that it's far from my village" (Seringueira).

According to Becker⁽⁸⁾, health and disease processes need to be examined within their historical, economic, social, and cultural contexts, even with the advancement of medicine one cannot interfere in ethnic and cultural aspects, devaluing local knowledge and practices.

In a study⁽⁹⁾, in the CASAI space, from the point of view of the professionals, the Indians seem to accept the care they receive, expressing passivity in the biomedical network. It also reinforces that there is an impersonal look for the person, without considering the social and symbolic elements present in the process of illness. Health professionals distinguish the behavioral characteristics of the Indians from each ethnic group, but the recognition of the cultural needs of each group was little observed⁽⁹⁾.

The environments outside the village, which are home to the Indians, should be adapted to the

characteristics that do not distract from local customs, and thus Western and indigenous medicine should be articulated so that the objectives are achieved with safety and well-being, both of the patient and the family, during the treatment phase⁽¹⁰⁾.

It is noteworthy that, although there are other difficulties faced by indigenous people, as they move from their villages referenced to CASAI, they go through a phase of adjustment, adaptation and in this period, culture, their beliefs, habits and values, can be seen as hindering factors for adaptation and relationship between the indigenous people themselves and between them and health professionals⁽¹¹⁾.

According to Pontes and collaborators⁽¹²⁾, hospital admission or stay at CASAI also generates a rupture of dietary rules, quite restrictive that some indigenous groups maintain, as observed in the following speeches:

"When I live in the village I feed myself well, the food for me is healthy in my village. In Casai no, because when I stay in my village I feel good, because I have to hunt and fish myself, here in the city is all paid" (Pupunheira).

"[...] because it's different here in the city, the food, it's because I do not feed myself well, I do not like to eat meat, soup, these city things from CASAI. When I am back in my village, there are fish, I eat, I eat well, not here, because I want to go back to my village, so I can feed myself well, eat fish and food from nature" (Castanheira).

Among other aspects, the dietary habits of the indigenous people also differ between the ethnic groups and the non-indigenous, and have a link of respect and balance with nature, as they

recognize that they come from their food, medicinal herbs and even the instruments used to hunt and fish ⁽¹³⁾.

Regarding the dialect, it is observed that the linguistic barrier becomes an obstacle to a reliable understanding of what the patient refers to about their health, even though there is a translator. In his study, Pereira ⁽¹⁴⁾ recognizes the impossibility of an integral translation, in which, the processes of translation become, in something difficult to understand, that is, it is interpreted by the dialect and symbols. Among other implications, the linguistic variability of these peoples and the vitality of the native language, in the face of Portuguese majority, cause many indigenous communities to adopt Portuguese as a second language, while others remain in their convictions of transmitting the native language to their children. However, the difficulty of a translation in an integral and trustworthy way, results in misunderstandings, dubious interpretations, bumping into what is untranslatable, before the technical vocabulary of the health area and the indigenous language in question (15).

" [...] to tell what I have to the health guy is very difficult for me, his language is bad, I do not understand how to speak well" (Seringueira).

"It happens that our languages are different, do not understand what it says right, the words have different sayings that complicate what we mean to them." (Castanheira.)

Improvements in the period of stay at CASAI

Aspects related to the infrastructure and ambiance of the house are frequently mentioned, being a factor that causes distress due to the difference attributed to the environment of their hollows in the villages:

"[...] here it is different to take a shower, there is different

water, there in my village there is only river, we are going to bathe directly, it is not like that in here, it is different even if the water is out, we cannot bathe here. Also the food is different, only at the specific time in the morning there is breakfast, lunch at noon, lunch in the village we have direct food, here is different from my village" (Jatobá).

"The CASAI has to be very adequate, because when I got sick, I lay in the hammock, everyone together, it's a lot of noise too, the children, the Indians cannot stand it, CASAI has to improve (...) whoever is priority has to be alone in the room" (Bacaba).

Other prospects for improvements relate to the scheduling of consultations, and of examinations as soon as possible, as well as the acquisition of medicines necessary for treatment:

"It's difficult to make an appointment, (...) we even pay sometimes CASAI does not pay, understand? That's it, have to improve, CASAI has to give us support to do these things, exams, anyway" (Acai).

"[...] CASAI also has to buy medicine for people ... we have the right, we do not have the money to buy medicine, CASAI has to improve, the health home has to improve too, we stay all together and the bathrooms do not work well, it's just one big room, and very hot too" (Inajá).

These discourses appear in the dissatisfaction of the Indians with the physical conditions of the CASAI to accommodate them and their companions, thus understanding that the environment plays a fundamental role in the therapeutic process of this population. This aspect was observed in the study carried out by Pontes et al.⁽¹²⁾, in which CASAI conditions were inadequate for patient and family lodging, which demonstrates that it is not an exclusive reality of CASAI Santarém, but of other CASAI in Brazil, requiring this form a different look for this theme.

Living with other ethnicities

The intercultural conflict is evident in the indigenous narrative, since this process of change in the routine significantly interferes in the health-disease process making them more vulnerable to health problems.

“For CASAI to improve, it has to be bigger, because when we are here, we are not relatives, because we are different ethnicities, others are katwenos, waianos, in this case we communicate, but we live well together, so close, except that we do not like it because in our house it is different, because the others live in another village, we live in another village, CASAI would be better to have the room for each one” (Cupuaçu).

“CASAI would be even bigger, to be able to have more people, so we can be more distant from other Indians from another place, so a little more space, it is different, and because you cannot sleep because it is very hot ... sometimes the water ends, but not in my village, when I'm there, I'm fine, it's the river itself (...)” (Andiroba).

“In CASAI, all together, with Indian from another tribe, very bad. It should be separated, divided. I do not like to be together, they keep looking at us, it's not good (...)” (Açaí)

Studies highlight the need to understand the context in which this indigenous user is inserted, valuing their culture, values and beliefs, so that health care can be fully established⁽¹⁶⁾.

Pontes et al.⁽¹²⁾ also point out that the incomprehension of these cultural differences by health professionals and managers can be expressed, for example, in cultural inadequacy when organizing services offered at CASAI, such as: the mixing of people of different ethnicities, understood as a situation of risk to health as well as the disregard of traditional diets and dietary restrictions of sick families. There is also the precariousness of places of accommodation without conditions of ethnic separation and other conflicting problems in the context of indigenous health.

Conclusion

This study made it possible to identify the difficulties faced by indigenous people during their stay at CASAI and provided discussions with local coordinators and with the nursing team, and presented the results in a meeting, aiming at possible adjustments in some points reported by the indigenous people, according to with the custom of each ethnic group. These findings will promote, perhaps in the medium and long term, discussions about indigenous health policy at the various levels, as well as new approaches to the care of these clients, aiming at improving quality during their stay outside their villages.

Regarding what could be improved in CASAI/Santarém, they mentioned: a different meal plan, in relation to the traditional one; improving the linguistic and cultural barrier; of adaptation in relation to the physical structure of CASAI and the

coexistence with different ethnic groups being uncomfortable for the natives.

We realized that such difficulties were felt by the ethnicities that participated in the research, and could not be extended to other non-participating ethnic groups. Thus, we suggest to have of other studies done with the same approach that broadens and promotes debates on this theme.

They also suggested that the physical structure could be modified in CASAI to preserve the privacy of each ethnic group, so they could be in separate rooms; agility in the appointment of consultations and referrals to the specialties for a short return to the village and food according to the habit and custom of the natives.

However, in spite of the growing changes and advances in indigenous health in Brazil, there is a need for improvements that can actually meet the specific health peculiarities of each ethnic group, as well as the understanding of care professionals regarding the differences between them. Another factor to consider is the physical structure of CASAI Santarém that differs from that advocated by the National Indigenous Health Policy.

Considering the aspect of the family ties of indigenous people, it is essential to think about the inclusion of the family as a necessary and effective support in the health-disease-care process in indigenous health. No less important is the ambience and interpersonal relationships for the process of recovery of the health of the individual as a whole, evidenced by characterizing the indigenous peoples by the specific peculiarities of each ethnic group.

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