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Representations and care practices of professionals regarding indigenous use of alcohol

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Abstract *Indigenous people's health in Brazil is organized by the indigenous health subsystem, structured according to that of SUS, and described in the National Policy for Health Care of Indigenous Peoples. Alcohol consumption has been regarded as a health issue among indigenous peoples. In this paper, we describe the representations attributed by health professionals concerning alcohol use among indigenous peoples, and how these influence care practices. This is a descriptive ethnographic study based on interviews and participant observation. Analysis and interpretation were made with the support of Software Atlas TI 8.0. Excessive consumption occurs in specific contexts, and professionals view alcohol use as a problem. Drinking patterns vary with ethnicity, religion, and location, thus resulting in the need to develop cultural competencies that support implementation of effective actions and that also allow for collective construction, as stipulated in the policies. A network of supporters is described, among which are indigenous leaders, traditional healers, and the Evangelical Church. The study shows the difficulties of both carrying out policies and implementing actions which correspond to the indigenous peoples' expectations, recognizing the cultural and social rationale related to alcohol use.*
Key words *Health of indigenous people, Alcoholism, Health Policy*

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Introduction

Indigenous health in Brazil is organized by the indigenous health subsystem, structured according to the Unified Health System, and guided by the National Policy for Health Care of Indigenous People (PNASPI). The policy proposes differentiated care based on guidelines that aim to introduce primary care in their territories that respects the specificities of each group, including their perceptions about the health and disease process, their knowledge and medical practices, and also provides for autonomy through social oversight and the training of its human resources[1-3].

Since the psychiatric reform movement, Brazilian Mental Health Policy builds upon practices that focus on user care and harm reduction, especially among consumers of alcohol and other drugs.[4] In the case of indigenous health, in 2007 a specific Mental Health Policy proposal providing guidelines that promote mental health care for these people was presented. This policy covers alcohol and drug consumption and considers the situation of alcohol use and suicide among some indigenous peoples as critical[5]. It calls for ongoing training and the creation of a management committee.

Alcohol use among indigenous peoples has, therefore, been presented as an important health problem. However, Ghiggi Jr and Langdon[6] and Langdon[7] describe the difficulty in establishing a consensus as to what can be characterized as true alcoholism, given the variation of consumption patterns exhibited by the different indigenous groups. These differences do not allow us to generalize or associate these ways of drinking with that which is standard for non-indigenous society. In our view, this perception is the center of the guidelines proposed by the specific policy of the Ministry of Health that centers on the protagonism of indigenous peoples in the process of planning, execution and evaluation of actions related to the theme.

Many studies carried out among indigenous people have built on the concept of alcoholization, proposed by Menéndez[8], who addresses this "problem" more contextually and allows us to observe the different ways of drinking of each social and cultural group, as well as to understand the positive and negative repercussions and consequences concerning the use of alcoholic beverages[8]. This concept considers the full spectrum of consumption, rather than only examining it as a health problem with focus on the so-called "alcohol-dependent" subjects, regardless of whether they are considered excessive, moderate or abstainers. Thus, alcohol use can also be analyzed in its context, not only as a problem but also as a social and cultural practice[8-10].

Reflecting on the concept of alcoholization, Souza and Garnelo[11] indicate that the analysis of alcohol consumption must take into consideration the relevant contexts of the subjects, their culture, and their history and look for the significance of drinking rather than only its "problematic use". Langdon[7] reinforces this view by saying that we need a more "cultural/collective/multifactorial" approach that broadens focus on the situation and allows us to create strategies that have a more significant impact on the situation.

It is known that the different groups possess a multiplicity of representations for psychoactive substances, including alcoholic beverages. We need to understand the different ways of drinking manifested in indigenous societies and what meanings they convey. This is of fundamental importance in order to understand the "how and why of drinking" in these diverse contexts, as well as to understand how rituals and rules established by indigenous peoples carry "symbolic and socio-political regulatory implications" that must be considered when health teams plan their actions[7,11,12].

This paper aims to describe the representations and meanings attributed by health professionals to alcohol use in indigenous communities, as well how these perceptions influence the development of care practices among indigenous peoples in the northern part of the state of Amapá. With focus on the expanded concept of alcoholization, we also examine relations with the guidelines of the specific policies.

Methodological aspects

This is an ethnography conducted among professionals employed in indigenous health services in the municipality of Oiapoque, Amapá. About 30% of the State's population is indigenous, numbering approximately 7,000 individuals. They are members of the Galibi Marworno, Karipuna, Galibi Kali'na, and Palikur indigenous groups and are distributed in three indigenous territories.

The ethnography was based on participant observation carried out during the provision of assistance activities. Research was combined with activities of health education and registered through videos and a fieldwork diary. The

research project initiated in 2016, when the first author was invited to develop actions related to alcohol consumption in a meeting of the Indigenous District Council.

Beginning with this request, research was developed and conducted from 2017 to 2018 with the incorporation of the researcher into meetings, health education, and extension activities. Besides discussion on the theme, these activities included health education, theater of the oppressed sessions, lectures, conversation groups and work in conjunction with the health team.

Semi-structured interviews were also conducted with 11 professionals (Table 1), out of a total of approximately 20 workers. Not counted in this number are those Indigenous Health Workers who were not part of this stage due to logistical and administrative problems of entry into the villages. The participants were interviewed in locations outside the villages during their time off.

Selection was made through a formal face-to-face or phone/e-mail invitation. After the professional's acceptance by signing the Informed Consent Form, a location and time were scheduled for the interviews, which were recorded.

Table 1. Profile of the professionals interviewed by age, gender, ethnicity, profession, and length of service in the Indigenous Health Sub-System.

Profile	Number
Profession	
Nurses	02
Social Worker	01
Pharmacist	01
Nursing Technician	07
Gender	
F	05
M	06
Age group (years)	
20-29 anos	04
30-39	03
40-49	01
≥ 50	03
Ethnicity	
Brown	05
Indigenous	06
Length of service in IH	
≤ 5 years	03
6-9 years	05
≥10 years	03

Source: Interviews' records, 2018.

Analysis and interpretation were performed according to the logic of dialectical hermeneutics that proposes to understand how praxis occurs in relation to the subjects' statements. As outlined in the theoretical references, analysis seeks to interpret verbalized meanings as well as dialogue critically with what was observed during fieldwork and taking into consideration the larger context surrounding the practices of the professionals and Indigenous peoples[13-15].

Data was organized with the support of the Software ATLAS TI 8.0, described by Forte et al.[16] and Martorell-Poveda et al.[17] as potential support in organization and reading of data collected in conjunction with analysis based on the practice of dialectical hermeneutics. The documents were transcribed, read and organized, together with the videos in the software where re-readings and ordering of the citations through assignment of codes or primary categories created inductively from with the initial readings and triangulated according to observations made during fieldwork according to the proposed object and objectives.

After organizing the data, we sought to understand the different meanings and symbols present in the different forms of language presented by professionals through developing a network of relationships. Four categories emerged from this data organization: representations and meanings, cultural competence, a network of supporters, and professional attitudes and practices. The last three were grouped in the description because they were present and understood as complementary when the statements and observations were analyzed.

Representations and meanings assigned to alcohol use among indigenous people

In general, professionals observe exaggerated consumption in the territories where they work. Words like "much" and "excessive" emerge as expressing how they represent the ways of drinking of the indigenous peoples with whom they work. The situation is perceived as problematic in general, based on the characterization of excessiveness, which does not appear to be directly related to a pattern or quantity, but to the consequences resulting from abusive consumption:

[...] *it is almost always problematic because they start by having fun, but in this drinking fun, they lose control,* [they] *start drinking, and drinking, and then lose control.*

Some consumption contexts are highlighted as determinants of this pattern of abuse. Among

them are the saints' festivals associated with the Catholic Church and historically present in indigenous territories since the colonization process. Professionals state that these events stimulate the unbridled consumption of alcoholic beverages, that is, without control and lasting over many days or weeks:

And whenever there is a celebration in the village, we know that they drink [...] *in holy festivals. During São João, they always party. They consume a lot of alcohol, from the fermented to the distilled.*

Alcohol use also differs by location or ethnic group with whom they work. Villages in which the residents are mostly evangelicals are characterized as less problematic with respect to the consumption of alcoholic beverages, given that alcohol is prohibited to converts of this religion. This tendency has also been observed among other ethnic groups in other territories where the Evangelical Church is also present:

[...] *it was a village that didn't have it, that didn't make much use of alcohol. People said that this was almost entirely due to the evangelization efforts.*

An important change is observed in consumption patterns that developed previously in relation to *caxiri* – a traditional drink produced by the people of the region – and that currently drive the consumption of industrialized beverages such as beer and *cachaça*, the latter being more present in places where there is still no electricity. In this context, who drinks is also different; previously it was young adults, today the consumption of industrialized alcohol is observed among those of a much younger age, which is a concern for professionals:

Their drink (caxiri) *was less of a problem because it is not as strong as that which comes from the outside.*

They used to drink more caxiri before, which was only what they drank in the past, what adults used to do... children didn't drink. Nowadays, we see a child around 10-11 years old already drinking. In the past, it wasn't this way; there was great respect among the families.

[...] *their traditional drinks - they are using with less frequency for parties, celebrations, the Turé dance, among others. But the majority of the drinks present are industrialized drinks.*

Problematic use is also associated with transgressions of the rules and social norms established by indigenous people that generate conflicts that cannot always be resolved by the professionals whose efforts include involving a network of supporters present in different ways in the territory. Forms of manual labor appear as the primary form of punishments constructed by the indigenous society itself, independent of professional conduct. The subject's wrong-doing is exposed to the indigenous community, promoting "shame" and submitting the transgressor to situations of forms of intense work, tasks that would typically be developed by a large group of people and becomes the responsibility of one:

[...] *punishing, right. There are the jobs that they give. It is their law. When someone does the wrong thing, they have their laws, such as having people do a clean-up... a punishment.*

Among the so-called problematic situations are those that generate violence (domestic or other), family conflict, absenteeism in work, school, or failure to comply with commitments; there is a strong focus on the family context, as well as on disobedience of established social norms present in the indigenous territory:

This drug problem, you know, I mean alcohol, but alcohol is also a drug, a legal drug, but a drug. To a certain extent, we have noticed a lot of family conflicts. There have been several problems here, and there was a time when we had several situations, such as wife beating...

The use of alcohol is a bit complicated, right, because it brings lots of bad consequences... among them, fighting, disagreement in the family such that they sometimes get aggressive, even among themselves. Also, besides violence, the difficulties that a family has that involves other families... social problems and sometimes young people drinking instead of attending school, doing things they shouldn't.

Establishing networks, professional skills and constructing practices

We defined "professional competence" as the development of specific capacities necessary to address topics such as the use of alcoholic beverages. It was represented in certain moments by professionals when they recognized the need to understand better the knowledge and practices involved in alcohol use and to establish actions that meet what the people with whom they work recognize as a true need, given the diversity of the region where they work:

[...] *every professional has to be trained, trained to address each situation because it is one thing to work with indigenous peoples and another with the non-indigenous.*

It has to be a different effort with them, right.

We work with 3 peoples: Galibi Marworno, Palikur and Karipuna.

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The development of these skills permits the performance of culturally appropriate and well-organized care. However, many felt overworked in relation to the many actions that must be executed in the different health programs, and this influenced their representations and also the development of the planning of specific actions. Consequently, some professionals who recognized the need to establish a differentiated care practice indicated that it would be useful to have a specific team to develop efforts on this theme:

[...] *it is complicated sometimes to bring an approach to them and to demonstrate the harm alcohol brings.*

Basic to the development of these competencies is a hierarchical network of supporters that directly influences the attitudes and practices of these professionals. Some of the supporters are important representatives of the people, such as the "leaders" identified as chiefs, councilors, healers, as well as others, such as ex-chiefs and teachers, and who are cited in reference to the structuring of the organizational models established in the indigenous context.

For the professionals, these leaders hold power and, consequently, the responsibility for the situation generated by the use of alcohol, in particular that which is problematic, since it is linked to social conflict that intrinsically breaks the rules established by these indigenous peoples. Besides these leaders, employees of FUNAI (National Indian Foundation) and the police also appear with similar attributes, as conflict mediators and regulators supported by law:

[...] *when there is much drinking, the chief has to be tough with those who don't obey, fight, commits an wrong, while drinking ... the chief has the right to punish an individual, to dispense hard labor, or do something else, call the police if there is something serious there, you know.*

The professionals understand that leaders are able to interfere in the ways of life and patterns of social organization. Generally, their actions are promoted by pre-established laws, rules and norms that regulate the introduction and sale of beverages within the territories and days and times that residents are permitted to drink. Moreover, they also establish the forms of punishments, as described above, depending upon the level of disobedience and impact generated by such action.

In this context, some workers are seen as better qualified to deal with these situations, as in the case of Indigenous Health Workers (AIS) and indigenous nursing technicians, both members of this support network. It was observed that these individuals, because of their position in the community, have much more authority to intervene in a situation that requires addressing the use of alcohol. The school and teachers were also regarded as potential supporters, particularly for actions aimed at health education practices.

For most professionals, especially the evangelicals, the church is an essential supporter for "solving the alcohol problem". The Palikur are the group identified as predominantly evangelical; although in recent years, this religion has expanded and spread to other ethnic groups studied here:

[...] *I like to talk about the gospel, sometimes the person becomes evangelical and stops drinking, because of religion.*

[...] *I think it may be the best experience I've ever had.*

In this second quote, the professional refers to the Evangelical Church and the conversion of indigenous people that resulted in abstinence. When asked about successful experiences concerning the approach of the problem, he argued that abstinence was the solution. This opinion is opposed to how they perceive the action of the Catholic Church, which is seen as stimulating uncontrolled use of alcoholic beverages among indigenous people and organizing abuse environments, such as that of the festivals of saints:

[...] *we don't see them using the indigenous beverage, but boxes and boxes of ... I'm going to name it, right…51(a popular brand of cachaça), boxes and boxes of beer ... you know, and their parties have host, and each host has to give a quantity of drinks and alcohol.*

Institutions such as Alcoholics Anonymous and a therapeutic community known as the Farm of Hope have also been viewed as members of this network, in so far as they have developed techniques promoting abstinence as the solution to problem. Some practices implemented by the professionals have been based on their models, in direct contradiction of that which is proposed by healthcare policy for alcohol and other drugs' users. In addition, this most likely introduces a bias in the attitudes of the professionals who fail to follow protocol guidelines and see these groups promoting abstinence as support for addressing the situation of alcohol consumption.

The director of the Special Indigenous Health District (DSEI) was mentioned in the discussion about the network as contradictory in terms of support; the professionals expressed a lack of support on the part of the DSEI personnel for the

development of actions, principally with respect for the instrumentation of activities to be executed and in the training of the professionals who, in accord with PNASPI, should be carried out by the DSEI. In this sense, it is understood that besides the provision of supplies and materials, as described by some professionals, guidelines for training of human resources and, consequently, the development of cultural skills necessary for care implementation, are hampered.

Based on the availability of the tools characterized as necessary for the development of actions, professionals determine which strategies and practices can be developed, highlighting activities that focus on education. Lectures, workshops, individual counseling were cited by almost all as important strategies that should be continuous, even if they are not carried out by some. According to them, the failure to occur is linked to different aspects, from limited supplies and human resources to questions related to difficulties concerning the theme and methods of approach, from lack of management support to the way in which the professional defines or limits his job responsibilities.

The latter is due to a kind of distancing of the theme as part of the job description and to limited health actions that are not articulated. Work responsibilities established by each professional is based on codes previously created by them either in the training process or in the service structure itself. For example, social workers or pharmacists do not develop activities related to the problem of alcohol abuse, but rather position themselves as having other duties and argue that specific professions, such as nursing and psychology, handle such action.

Schools are seen as potential locations for the development of these activities. According to the professionals, it is necessary to focus on children and the younger population and to show the harm caused by the use of alcoholic beverages, including possible diseases and problems attributed to abuse. In spite of the perception of the importance of education, few professionals reported the organization of continuous activities with the support of teachers within the schools.

Discussion

In relation to the excessive consumption described, previous studies attribute such episodes of excess to indigenous peoples' diversity of drinking styles. Long "binges" are not always seen as problematic by indigenous peoples, in contrast to the professionals' representations studied here[7,9,18,19]. When describing his impressions of alcohol use among the residents of the Uaçá Indigenous Territory, Dias[20] asserts that their style of drinking "is characterized by an ethics of immoderation, exaggeration, and renouncement of parsimony".

Factors that influence how, when and where one drinks are multiple and generally do not occur in isolation among indigenous peoples. Consumption is social, occurring in groups, even when the indigenous society is surrounded by contexts of interethnic contact[21]. The typical use of alcohol at parties, funerals, field work, construction of houses, healing rituals and other collective spaces presented in diverse studies do not always have the same connotations. They can be attributed to moments of diversion; to the establishment of social and political relationships; to efforts to remain attent and alert in the development of a particular activity; to celebrate or mourn for the departure of a loved one; to draw the spirits closer; to honor a specific entity; and to establish therapeutic processes, among other symbolic meanings[7,11,18,20,22].

The intervention of the Evangelical Church has altered the meaning of cultural practices and locations where alcohol and other drugs are consumed. It is recognized as a support for biomedicine, as a kind of "symbolic efficacy" attributed by indigenous people and professionals, but both maintain different perspectives and have different initiatives concerning interventions directed to minimize problems generated by alcohol use. Regarding the focus on abstinence in Pentecostal ideology, it is important to emphasize that not only abuse is stressed, but that any kind of consumption is at the core of intervention, contradicting the political guidelines established for the care of consumers of alcohol[23].

In his thesis, Rivera[23] treats the situations of cultural transformation involving religious conversion as a "new rationality" that is structured in a way that exceeds expectations concerning biomedical and traditional practices and becomes "Pentecostal medical knowledge". From this perspective, the signification and meaning attributed to the health-disease process are transformed and, thus, therapeutic processes are also modified. As Vallverdú[24] affirms, in spite of strengthening and reconfiguring the organizational, political and social models of these peoples directly, this symbolic reworking has also been a zone of

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conflict "because it challenges traditional political and economic control structures" and at the same time can be considered as an ideological basis for the reformulation of contemporary political and economic powers.

The decline of the consumption of traditional beverages in relation to industrialized alcoholic beverages, represents different cultural adaptations made over time. Concerning the transition to or incorporation of other drinks, some authors report that drinking often seems to be intensified, in the sense that *cachaça* and other industrialized beverages have a stronger effect compared to traditional fermented drinks due to a higher alcohol content. However, the motives that result in these moments of group exaggeration still have socially constructed and established meanings, even in new drinking contexts such as those described by health professionals[7,18,22,25].

Regarding the problematic situations resulting from the excessive consumption of other drinks or the substitution of traditional beverages for industrialized ones, Oliveira et al.[25] describe a similar situation among the Maxakali. Indigenous leaders' discourse recognizes the negative consequences that have come with this change in the consumption patterns of these peoples. Health professionals working among the Potiguara presented the same observations[26].

Similarly, Quiles[18] shares this view when talking about behavior exhibited in periods of alcohol abuse among the Bororo. Prolonged use of alcohol by observed for all age groups, and "generally the whole village accompanies all stages of the binge", resulting in situations of aggression and violence and usually ending with "passing out".

Dias[20] drew attention to the fact that this habit of "drinking until you fall", began with the traditional use of *caxiri* that was characterized as a form of collective drinking that lasted at times for days until the supply of the fermented beverage was exhausted. This custom has been extended to the consumption of *cachaça* or other purchased alcoholic drinks, and, as in the case of *caxiri*, excessive drinking can be followed by days, weeks, and even months of abstinence. In the same study some indigenous leaders statements indicated that the positive representations of *caxiri* were distinguished at times from excessive consumption of *cachaça* when they recognized the consequences as negative.

According to the PNASPI that establishes differentiated health attention as a goal, health workers should be trained in order to provide primary care that is culturally appropriate. Adequate training for such skills is necessary for following the guidelines proposed by the policy. However, training programs for the provision of differentiated care are not always provided, and lack of training is directly reflected by the insecurity expressed by health professionals and also by the continuing poor health situation of these peoples[3,27].

The general health policy, as well as that specifically addressing mental health for indigenous peoples, call for the collective construction and indigenous representation in planning, execution and evaluation of health programs and activities offered to them, including those related to alcohol use as mentioned above. In addition, all programs should be designed to value and respect the cultural and health particularities of each people and provide for permanent training of health professionals deployed in these diverse contexts for effective implementation of actions[1,5].

The conditions imposed by the Evangelical Church with respect to alcohol consumption in indigenous territories are based on rules contrary to traditional norms, fostering an inversion of meanings based on new interpretations and symbols related to the health-disease-care process. The meanings of what is right and ontologies of the divine argue for mandatory conversion and salvation, while at the same time, dialogue with significant conflicts regarding the organizational models that guide indigenous contexts[23,24].

According to Rivera[23] , the "symbolic structure of Pentecostal therapeutic practices generally motivate conversion", and this is reflected in the acceptance that the social production of Pentecostal knowledge is authentic and unique, which must be reproduced by all who are part of the religion. Among the most commonly reproduced blessings is that "following the path of God" makes you appear as a good person and, since drinking is not a good thing, you will not drink anymore and eventually will find salvation.

We must clarify that the religious affiliation of the professionals in this study was not identified, but it is clear that some of them are part of a group that reproduces such ecclesiastical ideology in their work, although this is not generalized. In this sense, it is necessary to establish the capacity for "relativism" among these professionals, which is also present when we speak of the development of skills and competences for the advance of their work[9,27,28].

What should be instituted as a practice, considering the political guidelines, would be pri-

marily to provide knowledge, information, and guidance about the population with whom they work, allowing the individuals, families, or society to choose and manage their relation with alcohol, as well as their health program. This is quite evident in the Mental Health Policy in Brazil that fosters. The harm reduction proposal, as a negotiation model, assigns autonomy to subjects, including their role in the construction of health programs[4,5,28].

According to Souza[9], there seems to be difficulty among health professionals in developing health prevention and promotion actions in the context of chronic non-communicable diseases, especially because they require behavioral changes that are autonomous and cannot be directly managed. This situation is also reflected in the difficulty of working in diverse cultural and ethnic contexts when the academic training processes are hegemonically medical-centered.

Starting from discussions by other authors, Souza and Garnelo[29] describe the difficulty of health professionals employed in different contexts, especially among those groups that reproduce specific cultural patterns, as in the case of indigenous peoples. Even more challenging is the development of work related to mental health within the context of primary care, when the focus on care for alcohol users "is constructed as an important obstacle to be addressed by professionals".

Conclusion

The professional representations described here seem to be focused on a single dimension and direction, where the workers assume a position that only considers the biological and biomedical concepts that were acquired during training. In this case, there is greater difficulty in carrying out genuinely effective actions and dialoguing with the expectations of indigenous people as a group, especially when the performance of these professionals is involved in moral and non-secular issues. This individualizing perspective is not the focus of the political guidelines designed for these contexts, nor is it the proposal of differentiated care.

Health professionals are employed in indigenous health without the necessary skills to plan, execute, and evaluate actions within the scope of the diverse cultural and ethnic contexts that characterize the work with these peoples in Brazil.

The consumption of alcohol is perceived by professionals without taking into consideration the social and cultural logic of consumption established by the indigenous people under their care, without understanding that the various ways of consumption are permeated by actions of reciprocity, control, and regulation that go beyond control on quantity and also have ritual and symbolic connotations. The limited understanding of these behaviors and practices has led these professionals to focus on an individualizing model, which is contradictory to the rationale of indigenous societies in general and indigenous mental health policies in Brazil.

The recognition of these socio-cultural dimensions of indigenous drinking patterns must be the basis for construction of alcohol harm-reduction policies. The dialogical methodologies of listening and recognizing the other would guarantee greater capacity for the implementation of these policies. In other words, the real interests of the indigenous people and the social capital generated by them must be considered, as well as the community dimensions of drinking expressed by consumption rituals.

However, we have observed that health professionals do not base their actions on local symbolism nor on the changes that truly interest this population the process of planning, evaluation and implementation of practices focused on this theme, contradicting, therefore, the regulatory frameworks provided for in the specific policies discussed here and reducing the likelihood of success in the development of their actions.

Collaborations

AM Mendes: elaboration and development of the project, data collection, and analysis of results, drafting and structuring of the paper. M Grisotti and EJ Langdon: support in the development and structuring of the project, data analysis, drafting and structuring the paper. JOR Alfonso and A Martínez-Hernáez: support in data analysis, drafting, and structuring of the paper.

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