

Difficulties faced by indigenous people during the stay in an Indigenous Health Center in the Amazon region/Brazil

Dificuldades enfrentadas pelos indígenas durante a permanência em uma Casa de Saúde Indígena na região Amazônica/Brasil

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Abstract

The National Policy of Health Care to the Indigenous Peoples (PNASI) was established by the Ministry of Health restructuring the Primary Care to Indigenous Health, following the principles and guidelines from the Unified Health System (SUS). This study aims to identify the difficulties faced by the indigenous peoples during the stay in the Indigenous Health Center (Casai) in Santarém (PA), in the Amazon region. It is an exploratory qualitative study, whose approach was through semi-structured interviews, recorded and transcribed, with 15 indigenous people from five ethnic groups, assisted by the Casai (Mawayana, Tunayana, Wai-wai, Tiriyo and Katwena), with help from a translator acquainted with the dialects. We used the content analysis arising from thematic categories: the difficulties faced during the adaptation period in the Casai/Santarém, the feeling about leaving the indigenous land and the perspectives regarding the improvements during the stay. We consider that, despite the increasing changes and advances in indigenous health in Brazil, improvements that can truly meet the health peculiarities of each ethnic group are necessary.

Keywords: Indigenous Health; Access to Health Services; Unified Health System.

Resumo

A Política Nacional de Atenção à Saúde dos Povos Indígenas (PNASI) foi instituída pelo Ministério da Saúde reestruturando a Atenção Básica à Saúde Indígena, seguindo os princípios e diretrizes do Sistema Único de Saúde (SUS). Este estudo visa identificar as dificuldades enfrentadas pelos indígenas durante o período de permanência na Casa de Saúde Indígena (Casai) em Santarém (PA), na região amazônica. Trata-se de um estudo qualitativo exploratório, cuja abordagem ocorreu por meio de entrevistas semiestruturadas, gravadas e transcritas com 15 indígenas de cinco etnias, assistidas pela Casai (Mawayana, Tunayana, Wai-wai, Tiriyó e Katwena), com auxílio de um tradutor que dominava os dialetos. Utilizamos a análise de conteúdo emergindo em categorias temáticas: as dificuldades enfrentadas durante o período de adaptação na Casai/Santarém, o sentimento em deixar a terra indígena e as perspectivas quanto às melhorias no período de permanência. Consideramos que, apesar das crescentes mudanças e avanços na saúde indígena no Brasil, necessita-se de melhorias que possam atender de fato às peculiaridades de saúde próprias de cada etnia.

Palavras-chave: Saúde Indígena; Acesso aos Serviços de Saúde; Sistema Único de Saúde

Introduction

The National Policy of Health Care to the Indigenous Peoples (PNASI) was established by the Ministry of Health through Ordinance 254, dated January 30, 2002, restructuring the Primary Care to the Indigenous Health, having as objective to assure the access to integral health care, following the principles and guidelines from the Unified Health System (SUS), being in conformity with the social, cultural, geographic, historic and political diversity, providing the overcoming of factors that make the indigenous populations more vulnerable to health deterioration of higher prevalence in the population in general, seeking the acknowledgment of the traditional medicine as indigenous peoples' right to their culture. (Brasil, 2002a).

With the creation of this specific policy, the indigenous population should be assisted in an integral and hierarchical way within the principles that rule the Unified Health System, having access to the health services, since the primary care level up to the tertiary care level.

According to the Ministry of Health (Brasil, 2012), the services of Care to Indigenous Health are organized into 34 Special Indigenous Sanitary Districts (DSEIs) - decentralized management unities of the Indigenous Health Care Subsystem (Sasi) -, which are divided strategically by territorial criteria, organizing the health primary care within the indigenous areas, integrated and hierarchical, with increasing complexity and articulated with the Unified Health System's net. Besides the DSEIs, the service structure has health unities located in the villages, with the base poles and the Indigenous Health Center (Casai), created in strategic areas of the DSEIs or in reference urban centers to receive indigenous patients sent for examinations and treatments of medium and high complexity cases (Brasil, 2002a, 2012; Cardoso, 2014).

According to the PNASI, these Indigenous Health Centers should be in conditions to receive, accommodate and feed the patients and companions sent, give full time nursing assistance, book appointments, complementary examinations or hospitalization and should even be adequate to

promote activities of health education, artisanal production, leisure and other activities for patients and companions (Brasil, 2002a).

Following Popyguá (2007), the public authorities in Brazil have difficulty to dialog with indigenous peoples and to acknowledge their differences in practice. The government programs make the indigenous people the same demands they make to the non-indigenous organizations, not acknowledging their ways of social organization, the ways of representations, the way of expressing their feelings and the customs.

As per the census carried out by IBGE¹ one registered 817,963 self-declared indigenous people, being present in the five Brazil's regions; the North region concentrates the highest number of individuals, 342,8 thousand, and the lowest number, 78,8 thousand, is in the South. They are organized into distinct ethnic groups and languages, among which the ethnic groups that are assisted in the Casai Santarém (PA), central point of this study. They are: Tiriyo, Wai-wai, Tunayana, Hiskaryana, Mawayana, Katwena, Xerew, Karyjana, Kayana, Kaxuyana, Zoé, Munduruku e Kayapó.

The Ministry of Health (Brasil, 2002a, 2012) preconizes that one should define reference, contra reference and incentive procedures to the health unities by offering differentiated services, with influence on the recovering and cure process of the indigenous patients (as the ones related to food restrictions/prescriptions, accompaniment by relatives and/or interpreter, traditional therapist visit, hammocks installation, among others) and that the Casai shall be in conditions to receive, accommodate and feed the patients and companions sent, give 24/7 nursing assistance, book appointments, complementary examinations or hospitalization, provide the patients' accompaniment on these occasions and their return to the native communities, along with the information on the case.

In the Mundurukus' letter sent to the Brazilian government on June 8, 2013 (Brasil, 2013), the indigenous leaderships emphasize, among other

subjects, the value of the family context for the construction of the indigenous people's character, as well as teaching them the importance of preserving nature, of the cultural practices, and preparing them to live in the world.

All Mundurukus have the knowledge inside themselves. Knowledge orally transmitted by the ancestors in order the cultural value and millenarian knowledge not to disappear. All elderlies have knowledge. We, Mundurukus, are like this, valorize what surrounds us. (Brasil, 2013).

Considering the aspects of the family bonds, evidenced in the letter, it becomes necessary to think about the inclusion of the family as necessary and efficient support in the health-sickness process of the care in indigenous health. Not less important, one points to the ambiance and the interpersonal relations for the process of the individual's health recovering as a whole, which is evidenced for characterizing the indigenous peoples by the peculiarity of each ethnic group.

In this context, we asked the following question: which are the difficulties faced by indigenous people during the stay in the Casai/Santarém?

This approach is justified because provides the report of the difficulties faced by the indigenous people, with the perspective of offering information to the managers in order to minimize the impacts related to the displacement of the indigenous people from their natural environment to occupy another environment different from the daily one. Thus, it helps in the planning of action strategies that minimize the impacts on the displacement from the villages and the stay in the reference unity.

Brazil's PNASI provided the theoretical support for the research.

Objective

The study aims to identify the difficulties faced by the indigenous people during the stay in the Casai/Santarém (PA).

¹ Available from: <<http://indigenas.ibge.gov.br/>>. Accessed on: 7 Dec. 2016.

Method

This research is characterized as qualitative, exploratory and descriptive, once, according to Bicudo (2011), it allows understanding the characteristics of the phenomena investigated. Proceeding this way, it supports articulated considerations important for political, educational and scientific research decision-making. Such researches analyze people's subjective comprehension regarding their daily life (Pope; Mays, 2009).

The assistance model of care to Brazil's indigenous peoples is based on the DSEIs, formed via projects elaborated with the communities, under the supervision of the Interinstitutional Nucleus for Indigenous Health (Nisi) and other professionals specialized in indigenous health. Thus, the DSEIs should be characterized in: territorial base defined by ethnogeographic and epidemiological criteria, access to services (health, transportation, communication, administrative and economic). It is worth mentioning that the Casais are elements inseparable from DSEI and/or regional management, being connected to their councils and/or to the Nisi (Brasil, 1993).

According to Oliveira e Rosa (2014), there are certain instability and intermittence in the conduction of the indigenous health policies, with the frequent changes of bodies, associated to the institutional limitations, besides the challenge in the context State-society in the socioeconomic and cultural component. Despite the decentralization in the indigenous health via the DSEIs, the policies destined to this population are still a vertical strategy that, sometimes, does not consider the local peculiarities; as the case of the Special Indigenous Sanitary District of Maranhão (DSEI-MA).

The local of study was the Casai/Santarém, belonging to the Indigenous Sanitary District of Guamá - Tocantins (DSEI Guatoc). The Santarém-Pará base pole provides health care to the ethnic groups from the Nhamundá/Mapuera and Cuminapanema indigenous reservations and also to the munduruku and kayapó ethnic groups, located in the areas of scope of the Itaituba base pole - Pará, belonging to the Rio Tapajós Sanitary District.

The work team of the Casai/Santarém is composed of the following members: one director, four nurses, five nursing technicians, four administrative agents, three cooks, two drivers and one interpreter.

The subjects of the research were invited to participate voluntarily, confirmed through the Free Prior Informed Consent (FPIC), written in Portuguese and translated into the indigenous dialect of each ethnic group, to facilitate the understanding and avoid any kind of tendentious manipulation for acquisition of the acceptance to participate of the study.

After the acceptance, the data collection was carried out in September, 2014, via interviews performed directly with the participants, using a script written in Portuguese with the guiding questions. In order to decrease the language barrier, we had help from a translator appointed by the Casai when approaching those indigenous people who would not understand Portuguese.

Protecting the research participants' identity, one used the popular names of the region typical fish: *pirarucu*, *tucunaré*, *tambaqui*, *pescada*, *filhote*, *lambari*, *pirapitinga*, *mapará*, *dourada*, *curimatã*, *caratinga*, *acarí*, *surubim*, *matrichã* and *aruanã*, preserving the information confidentiality.

The interviews were recorded and transcribed into Portuguese with support from the native language translator. Fifteen indigenous people were interviewed, regardless of their diagnostics and/or reason for the stay in the Casai/Santarém. The number of subjects of the research was determined by the richness of the collected content.

The interview semi structured form was divided into two moments, being the first composed by closed questions: age, sex, occupation within the indigenous community (work activity), period of stay in the Casai/Santarém up to the return to the indigenous land and the reason of the displacement from primary Care (or from the native village) to Medium or High Complexity Care (Casai/Santarém).

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

- (1) There were difficulties during the stay in the Casai/Santarém? If yes, which were the difficulties faced?
- (2) Which is the feeling about having to leave your indigenous land, the family and come to the Casai/Santarém?
- (3) Which is your opinion in relation to what could be improved or changed so that there is not difficulty during the stay in the Casai/Santarém?

Meeting the deliberation 466/2012 of the National Health Council in what refers to ethical principles, it was necessary the favorable opinion from the National Commission for Research Ethics (Conep), Registry 827.490 dated September, 2014, and from the Commission for Research Ethics of the State of Paraná, Registry 751.016 dated August, 2014, besides the authorization from the Casai Coordination/Santarém.

For the empiric data analysis we used the content analysis, according to Minayo (2014). Exhaustive reading of the interviews was performed, and we let ourselves be impregnated by the content, considering the objectives and the theoretical references, identifying the central themes and relevant aspects. Based on the study objectives, on the empiric material collected and on the theoretical reference, we highlight three thematic categories: **Category 1** - the difficulties faced during the stay in the Casai/Santarém; **Category 2** - The feeling about leaving the indigenous land; and **Category 3** - the perspectives regarding the improvements during the stay in the Casai.

Results and discussion

In this research, fifteen indigenous people were interviewed, being 8 females (55%) and seven males (45%). In relation to the age, three were in the age range of 18 to 28, six were in the age range of 29 to 39, one was in the age range of 40 to 49, and five were in the age range of 50 to 60.

The main subjects' occupations in the native villages are: fisherman, teacher, artisans, farmer, health indigenous agent (AIS) and school cook.

The interviewees are from the following ethnic groups: ten Wai-wai, one Mawayana, one Tiriyó, two Katwena and one Tunayna.

The reasons for these indigenous people to come from the villages and be received in the Casai/Santarém were: specialized references to the medium and high complexity services, specialized examinations, hospital procedures and return for monitoring/treatment. The stay period of the interviewees in the Casai varied from, in the minimum 3 days to, in the maximum, 170 days.

Category 1 – The difficulties faced during the stay in the CASAI Santarém – Pará, Brazil

The main difficulties reported by the indigenous people during the stay were: to book appointments; long wait for hospital procedures; financial difficulty to buy medicines; nourishment different from the traditional indigenous one; language barrier; Casai's physical structure, as expressed in the following opinions:

I waited too much to undergo surgery (Pescada).

I went for treatment but even so we buy medicine, the Casai does not give us medicine. They give prescription, the doctor gives prescription but we have to buy; where is the health insurance? (Pirarucu).

I am undergoing examination. [...] it is very difficult for me to stay in the Casai because I pay for the appointment myself; it is very expensive (Surubin).

As it can be observed in the indigenous speech, despite the Unified Health System's health insurance, from the Primary Care to the Tertiary Care, and, yet, specifically in relation to the Sasi, there are still difficulties regarding the health integral access as per what was set forth by Law 8.080, dated September 19, 1990. There is still the situation in which the users do not find room for their demands referral in moments of severe pain and suffering (Azevedo; Costa, 2010).

In a study performed by Marinelli et al. (2012) on the assistance to the indigenous population and the difficulties found by nurses, one verified, among

the difficulties, the lack of specific training for the work with indigenous people, communication difficulty, geographic barrier, professional acceptance by the indigenous people and not satisfactory work conditions.

It is worth mentioning that the difficulties faced by nurses may also be faced by the indigenous people once, when they get referrals to the Casais, undergo an adaptation period. In this period, the indigenous culture, with its customs and values, may be seen as a barrier for the adaptation and relationship among the indigenous people and the health professionals (Teixeira, 2008).

In survey on the indigenous people's situation in the Brazilian states performed by Conass (2014) for the construction of a proposal of integration between the care with this population group and the attention to health priority nets, including the optimization of the management tools, regulation and planning in special, one presented reports on the specialized ambulatory and hospital care, such as the access difficulty and, in situations where the patient is admitted, it is necessary to face the lack of transportation due to the fact that when in treatment outside the domicile, the indigenous person takes the whole family along, what demands accommodation and food for everybody, overloading the Casais.

According to Pontes, Garnelo and Rego (2014), either the hospitalizations or the stay in the Casai provokes rupture of very restrictive dietary rules that some indigenous groups are used to, according to the following speeches:

When I live in the village I eat well, the food for me is healthy in my village. In the Casai, it is not, because when I am in my village I feel good, because I myself have to hunt and fish, here in the city everything is paid (Surubim).

[...] it is different here in the city, the food, because I do not eat well, I do not like eating meat, soup, those city's stuff, Casai's stuff. When I am in my village, there's fish, I eat well, not here, because I want to come back to my village, and then I can eat well, eat fish and food from the woods (Pirarucu).

Among other aspects, the indigenous people's eating habits also differ from the non-indigenous ones. Those have a respect and equilibrium link with the nature, because they acknowledge their food, medicinal herbs and even the tools used to hunt come from it. However, as Geniole, Kodjaoglanian and Vieira (2011) emphasize, the cultural identity is constantly elaborated, through a dynamic process of change.

According to the *Manual of action in indigenous health* (Brasil, 2008), the indigenous people have changed their way of life drastically in the last years, either by the territory limitation, sedentary life, decrease of natural resources, or by the introduction of new customs, nourishment, medicines, change in the family structure, breaking of food taboos and rites of passage.

The changes interfere significantly with the indigenous people's health, regarding mainly the illnesses related to food changes, with industrialized food being introduced, besides the decrease of physical activity, resulting in chronic degenerative illnesses and other comorbidity.

On the dialect, one observes that the language barrier turns into an obstacle for the trustworthy understanding on what the patient refers to, even there being a translator. In his study, Pereira (2012) acknowledges the impossibility of an integral translation, as it demands the comprehension of dialects and symbols difficult to understand. Among other implications, the linguistic variability of these peoples and the vitality of the native language, before the majoritarian Portuguese, lead many communities to adopt Portuguese as second language, while others maintain their convictions of transmitting the native language to their children. However, the difficulty of an integral translation results in mistakes, coming up against something that is untranslatable, before the technical vocabulary from the health field and the language in question.

[...] to tell the technician what I have is very difficult for me, Portuguese (Pirapitinga).

Regarding the infrastructure, the reports are as follows:

[...] *it is very crowded here, very hot as well* (Pirarucu).

Look! You can see it, here at the Casai there's no fan, the bathrooms do not work, the Casai is small, and very hot here as well, it is necessary to improve this Casai (Lambari).

In these reports, it is possible to observe the indigenous people are not satisfied with the Casai's ambiance, as well as verifying that it is necessary to improve the physical structure for better accommodating these users.

Category 2 – The feeling about leaving the indigenous land

Os sentimentos mais relatados foram: preocupação com familiares, tristeza pelo distanciamento da aldeia e a saudade do convívio familiar, como se observa nos seguintes relatos:

[...] *because of that I left my village, I left my family, I want to go back as soon as possible, because I have been here for too long* (Tucunaré).

[...] *sometimes we have a son studying, we cannot leave him alone, it is very difficult for me to leave the village* (Matrichã).

[...] *I did not want to come here because I have family, daughter, son, I have a house there, here I did not like being in the city, but I have to stay here because I am going to undergo treatment* (Mapará).

The feeling is because I am so far from my village, sometime I get sad, there in the village I am going to get happy, isn't it? Because in my village I am this way, here in the city now I am sad because I am away from my village (Pirapitinga).

How it can be noticed, the family has fundamental role in the recovering and maintenance of health, as the affective bonds, according to Borges and Franco (2012), promote better results in the individual recovering.

According Becker et al. (2009), the processes of health and illness have to be examined within their historic, social and cultural contexts. Even with the medicine advances, one cannot interfere with the ethnic and cultural aspects, devaluing the local wisdom and practices.

The places outside the village should be readjusted with characteristics that are not so away from the local customs. This way, the occidental and the indigenous medicine should be articulated so that the objectives are reached with safety and well-being for both the patient and the family during the treatment phase (Lorenzo, 2011).

Category 3 – Perspectives regarding the improvements in the period of stay in the Casai/Santarém

The Casai would be bigger, to receive more people, so that we would be more distant from each other, more space, because it is not possible to sleep because it is very hot, [...] then, when we have to go to the bathroom, we also wait for the other, then sometimes the water ends, not in my village, when I am there I am ok. It is river there, here there is no wind, it is very hot, the Casai has to improve (Pescada).

The Casai would be good big like this. It is very small, it is not good. As I underwent surgery, it is very hot here, we do not sleep well at night, the bathrooms are bad (Filhote).

For the Casai to improve, it has to be bigger, because when we are here, we are not relatives, we are from different ethnic groups, others are katwenos, waianos. We talk to each other, we live well together, close, but we do not like it because in our house it is different, because the others live in another village, we live in another village, the Casai would be better to have the room for each one. (Pirarucu).

It is evident the intercultural conflict, once this process of changes interferes, significantly, with the health-illness process, making them more vulnerable to health deterioration. Therefore, Nascimento

et al. (2011) highlight the need to understand the context in which this user is inserted, valorizing his/her culture and belief, so that the health care is established in full.

Pontes, Garnelo e Rego (2014) emphasize that the incomprehension of these cultural differences, by health professionals and managers, can be expressed, for instance, in the cultural inadequacy when organizing services offered in the Casai, such as: the mix of people from different ethnic groups, seen as a situation of risk to health, as well as the disregard of the traditional diets and food restrictions of the sick families.

Aspects related to the infrastructure and ambience are also mentioned:

[...] here it is different to take a bath, there is different water, there in my village there is only river, we always take a bath. Here there is not, it is really different, if the water ends, we cannot take a bath. Here the food is also different, it is only in the stipulated time, in the morning to have breakfast, at noon lunch. There in the village we always have food, here it is different from my village (Pirapitinga).

[...] we are suffering here, there's no tap water, the bathroom does not work well, the Casai has to improve a lot (Curimatã).

The Casai has to be well adjusted because when I got sick, I stayed lying down on the hammock, everybody together, there's a lot of noise as well, the children, the indigenous people cannot bear it, the Casai has to improve [...] who is priority has to stay alone in the room (Caratinga).

Other perspectives of improvement are related to booking appointments, examinations and to the acquisition of medicines necessary to the treatment:

It is difficult to book appointment [...] sometimes we ourselves have to pay for it. The Casai does not pay, see? It is, it has to improve, the Casai has to support us to make these things, examinations, whatever (Pirarucu).

[...] the Casai has to buy medicine for us [...] we have the right, we do not have money to buy medicine either. The Casai has to improve, the health center has to improve as well, we stay all together and the bathrooms do not work well. It is only one big room, it is very hot too. (Acarí).

In these speeches we can notice the indigenous people's dissatisfaction regarding the Casai's physical conditions to provide accommodations for them and their companions, and one understands that the ambience represents a fundamental role in the therapeutic inclusion of this population. Fact also observed in the study performed by Pontes, Garnelo and Rego (2014), in which the Casai's conditions were inappropriate for accommodation of patients and family members, what represents not to be a reality exclusive of the Casai/Santarém, but also of other Casais in Brazil, there being, thus, need of a different sight to this theme.

Final Remarks

This study made possible the identification of the difficulties faced by the indigenous people during the stay in the Casai and provided discussions with the local coordination, being the results were presented at a meeting, aiming at readjustment in some points mentioned by the indigenous people, according to the reality of each ethnic group. These findings shall promote, maybe in the medium and long term, discussions regarding the indigenous health policy in several levels, as well as new approaches to improve the service for these customers during their stay outside the villages.

The main difficulties mentioned at Casai/Santarém were: appointments booking, long wait for hospital procedures (appointments, examinations and surgeries); financial difficulty to buy medicine or book particular appointments and examinations; different food in relation to the traditional one; language and cultural barrier; difficulty of adaptation regarding the Casai's physical structure and the coexistence with different ethnic groups; environment change impact on the routine.

These difficulties were not compared among the ethnic groups, as one noticed that such difficulties were faced by all groups that participated in the research, as well as due to the disproportion of the number of participants of each ethnic group, and it could not be extended to other ethnic groups that did not participated in it. Thus, we suggest the performance of other studies with the same focus in order to amplify and promote discussions on this theme.

On the improvement perspectives, they suggested what could be improved at Casai: the physical structure, to preserve the privacy of each ethnic group through separated rooms; financial support to buy medicine; agility to book appointments; referral to the references; and nourishment according to the indigenous eating habits.

However, despite the increasing changes and advances in indigenous health in Brazil, improvements that can truly meet the health peculiarities of the ethnic groups are necessary. Other factor to be considered is the physical structure of the Casai/Santarém, which differs from what was set forth by the National Policy of Health Care to the Indigenous Peoples.

We highlight the importance of sharing the decision-making with the indigenous people, mainly on these services budgetary and management dispositions, to improve the assistance and the prevention of health deterioration.

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Authors' contribution

Souza was the advisor responsible for the research, participating in all phases; Silva and Nascimento participated in the data collection and analysis and in the wording of this article; Nascimento participated in the organization of the project for submission to CEP and Conep; Figueira carried out the data analysis, wrote the article and did the critical review.

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