PERCEPTIONS OF FAMILY HEALTH TEAMS ON PROFESSIONAL CARE FOR INDIGENOUS CHILDREN[1]

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ABSTRACT
This qualitative study aimed to identify the professionals' perceptions of family health teams on the care provided for indigenous children. Depth interviews have been conducted with nine professionals who work in the health teams in two Indigenous Settlements of Santa Catarina, Brazil. Data content analysis has been discussed in the light of Madeleine Leininger's Theory. Young adults have characterized the interviewees´ profile, lack of specific training to work with indigenous health care and job turnover. Two categories have come up: ways to develop care and relationship between the team leaders and indigenous community. Contradictions between the desire to respect indigenous costumes and the anxiety to solve their health needs have favored the necessary behavior on professional care. Communication obstacles are among the difficulties encountered by the team. Childcare has followed a collective model on that population, in which indigenous leaders evaluate the professionals work.

Keywords: Indigenous Population. Child. Family Health. Community Health Nursing.

INTRODUCTION

The child health care is a priority in Brazilian politics of primary care with the specific focus of the actions, looks for change of child health indicators in Brazil from the multidisciplinary work of the teams of the family health Strategy (FHS). The integral attention to health of children is addressed in assistance to families for health promotion, prevention of diseases, and the healing and rehabilitation actions [(1).]

Since 1999, the Ministry of health, through the National Health Foundation (FUNASA), responsible for the integral attention to health of the indigenous peoples of Brazil, structuring and operationalizing the Indigenous health care subsystem. This is organized in Special Indigenous Sanitary Districts (DSEI), which articulate the unified health system (SUS) [(2)].

Additionally, there were changes in the Indian health system with the creation of the order of the MS No. 2,656, October 17, 2007, which defines the composition of the multidisciplinary teams of basic attention to indigenous health (EMSI), from two cores: I) Basic Core attention to indigenous health, responsible for the implementation of basic actions of attention to this population and composed of health professionals; II) core Indigenous health care district, responsible for the implementation of the activities of integral attention to health of the indigenous population. The municipalities was set in conjunction with Funasa, the profile of professionals to the EMSI [(3)]. The professionals who integrate the EMSI and serving the population of certain Indian lands are also linked to the ESF of the respective municipalities, having received the introductory training for this job.

An important aspect to consider is that the teams when they work within the indigenous areas, leaving the work space of our society to integrate in the space of these populations. In this sense, the professionals of the teams need to know the rules of coexistence in this different pre-existing workspace and create new rules of coexistence of the team[(4).]

However, the professionals who are part of the family health team in indigenous territories, as well as the nurse who in their assistance assignments and auxiliary and technical leadership in nursing, and community health

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agents, are more easily with opportunities for childcare and family in ethnic diversity. However, despite the research already undertaken[5-10], whose theme is focused on disease and health culture there is still a gap about these ESF professionals who work in indigenous lands (TIs) face and perceive their work.

The objective of this research is to know the perceptions of professionals in family health teams about the care that they provide indigenous children.

The theoretical framework was based on the concepts of the theory of Cultural care diversity and Universality of the nurse and anthropologist Madeleine Leininger, complemented by other authors..

METHODOLOGY

This is a descriptive study of qualitative nature, developed with two teams of ESF working in indigenous lands (TI) from Guarani, Kaingang people and ethnic groups in the South of Brazil.

Such TIs have general characteristics similar; both are located in rural areas of two cities, being divided by ethnicity and Guarani Kaingang people. The indigenous population in Santa Catarina is 16,041 people, being resident in an urban area and 7,680 8,361 in rural area, according to preliminary results of the Census Population Universe of 2010[11].

The health units have different physical structures, which vary on the type of seat, which range from makeshift rooms (in the Community Hall in schools) provided by the community, the appropriate buildings and who have all the material structure necessary for the action of the ESF teams (medical and dental offices, waiting room, living room and bathroom procedures).

Data collection took place in the period June to December 2009, through personal interviews in depth, in the places and at the times chosen by informants. Informants who have consented to participate in the study were nine health professionals. The interviews took approximately an hour and a half and were recorded under authorization of the participants. The form-guide of the interview had a part intended for identification of interviewees, and another with an initial question, trigger of testimonials. The remaining questions were focused on the deepening of research-related data.

Data analysis occurred concurrently to the collection and followed the proposal of Leininger [12.13] in the first two phases: description, organization of raw data and identification of categories and subcategories.

The project was approved by the Committee of ethics in research with [the] n 041/09. To ensure the anonymity of informants were used just abbreviations of each profession, followed by the number corresponding to the order of informants interviewed.

RESULTS AND DISCUSSION

Profile of health professionals

Among the nine professionals from two teams of ESF, participated: a doctor, a dentist, two nurses and five nursing technicians (three of them of Indian origin). As for the genus, informants were eight women and a man. These are young professionals, ages 20 to 49 years. The three nurses of Indian origin had older than 33 years. The average time of activity in the field of health between the respondents was eight years, and assistance to the indigenous population was two years and six months.

With respect to training professionals received for working with the indigenous population, it was found that only three nurses had specific training, that is, the nursing technical course for indigenous peoples. As for other professionals nurses, doctor and dentist, reported that only received short courses promoted by FUNASA. According to key informants, these trainings were addressed general themes related to the development of health programs as: vaccination, children's health, women's health for the population in general, without addressing specifically the approach the indigenous population.

The objective of the ESF full assistance family and the community, you need a strong bond between the professionals and the population assisted. Notes on the data that the average time of professionals in TIS is two and a half years, showing that there is a rotation of these professionals, as it is presented in the

literature with regard to ESF, which is high, especially among doctors. In relation to this turnover nurses also occurs, but is less. As for the reasons for turnover, include the precarious link in the recruitment of professionals, political problems among professionals and managers, as well as the lack of job satisfaction in activities developed within the framework of that policy [14].

It is said that the training of professionals, made only with General ESF courses without addressing content focused on cultural diversity, contributes to the cultural imposition. About the lack of training of professionals working with the indigenous population, other studies [15] also obtained this result, saying that the lack of adequate training, be it on an ongoing basis, as recommended by National health care Policy for indigenous peoples-PNASPI, or of specific courses, results in lack of preparation on the part of the professionals for work in specific ethnic contexts.

Analyzing the data on the turnover of professionals and anthropological cluelessness to assist this population, infers that there is difficulty in the application of three modes of actions and decisions in the care proposed by the theory of Leininger, namely: preservation/ maintenance, accommodation/negotiation, standardization/restructuring of care, which is fundamental to avoid ethnocentrism and provide culturally congruent care[16].

As regards the perception of the professionals about their work, emerged two categories: ways to make care and the team's relationship with the leaders and indigenous community.

Ways of carrying out professional care

Are described two subcategories that represent the findings of this category: the attitude of professionals against the popular indigenous people care and communication.

As regards the attitude of professionals in relation to direct care and health education, the results show that this is not fixed or rigid and differs among the pros. That seek to respect the culture of the population, but are faced with professional duty, which requires different postures in your actions. The key informants reported that it is necessary to know and respect the care carried out by indigenous population:

> Us {Team} gives guidance {professionally}, how I know, but not interrupt what the mother is doing (3).

Although they have mentioned respect for indigenous care, seek to oversee the treatment prescribed and curb what the professionals consider harmful, through home visits.

> I have been collecting medicines, House by House. Went there on the shelf and looked: ah! This here you picked up that day, so that you will no longer use (2).

In the actions of care carried out by professionals in the childcare there is difficulty in finding a balance between the duties of their professional culture and respect for the culture of the people who provide the care. When the informants describe the caution, imply the power of professional duty, and consequently the imposition of professional care. The care happens when health professionals put their values, their beliefs and practices, about other cultures, believing that their ideas are the most appropriate or true and, thus, higher than those of another group, this posture, based on one dominant cultural orientation. In this way, it is clear the scientific explanatory model, professional health system on the popular system of care, with which the population is more used [16-17].

Another fact that deserves mention is that the territorial proximity of health teams with the home and favored by the ESF policy have free passage in the households, allowing them to exercise direct supervision, as mentioned above.

Also in the health education of the indigenous population, the informants report that relevant knowledge is considered popular, and seek not to impose its concepts. Report also that persistence is required to teach the care.

> Sometimes, you have to understand the form of them, and you cannot go far beyond what you can do [...]. I got there and I was getting to know them slowly, the family, the way they [...] I did not get imposing (1).

On the other hand, in the testimony of informants, that there is concordance with knowledge and popular practice, since this is in accordance with professional knowledge.

> The doctor does not prohibit the culture [...] she respects, since it has the care that must be (5).

Show that it is necessary to explain several times the care to be held, need to insist and repeat the very same information:

> [...] of vagarious, we was talking, kind of matching them, giving example [...]. Us repeats and repeats and when we note that the resistance is greater, we still repeating (ENF 1).

An issue to consider in cultural imposition is the existence of a cultural bias also called ethnocentrism, i.e. the position convinced that their own values and practices are superior to those of the other, which can lead to a lack of cooperation, cohesion, or effective assistance [17]. It is worth mentioning that this imposition of professional care can still generate difficulties in communication with the population, and may interfere significantly in assistance provided. That stance comes against the position of Leininger [14] that emphasizes the need to understand and appreciate the culture of the other, so that the care provided is congruent.

Health professionals to recognize the different systems of care and health practices that exist between cultures can minimize cultural conflicts. However, not to impose a health care system in a dominant relationship with another culture requires that meet the health system, in this way, prevent unwanted changes to the culture of care on the other. Moreover, much can be learned from the different healthcare systems, and learn new ways of care [16].

Yet on the professional attitude in health education, the informants also report that the team should follow the indigenous professional guidelines, whenever possible to demonstrate care practices, and after this, observe the families run-in.

> Examines the child: If you are overweight, or if you are starting to get at nutritional risk, we already speaks for them {parents} and shows the card, shows the blip in the curve of weight (ENF 2).

The informants who already have more experience consider that the practice of health education has a positive impact on the child's life because realize that there is changes in habits and behaviors of families as well as the acquisition of new skills for the prevention of diseases and child care.

> Had many children with low birth weight, so we was directing that the child have to offer what she should eat, pick up on your lap. With this {guidelines} the child was gaining more weight and the mother was developing this want to care for the child until later (ENF 1).

It observed that the indigenous knowledge is dynamic, creative and subject to influences, making constants negotiations and renegotiations between different forms of medical knowledge [18].

Despite the positive results mention find it difficult to develop such a practice, because of the weakness in communication with their mothers, by the negative influence of the generational beliefs, the appreciation of medicalization, precarious housing conditions very different and other reasons.

Regarding the subcategory communication with the indigenous population, the informants reveal that experience situations of difficult communication on the actions of care, especially by the difference of the language. Given this, teams seek the support of community members who speak Portuguese to assist them, translating the team talk with the population assisted.

> The lectures there in kindergarten, the teacher has to be translating {children}. Children talk to each of them, but you don't know what they are talking about (Another 1 Professional).

Another difficulty encountered in communication, according to the informants, is the fact that many indigenous people talk with the health team.

> Sometimes we note that they {native} do not want to talk [...]. Has happened several times, I meet a person and she did not speak a Word, just answered with the head, yes and no "(Another 1 Professional).

In relation to communication, are striking the difficulties encountered by health professionals, either by the language, but also in the absence of dialogue and interaction of professionals and of the indigenous population. It is assumed that

this fragility in the dialogue possibly is related to the fact that some professionals have been recently working in indigenous lands and, consequently, not understand the linguistic and cultural expressions of this population, or because they do not understand that the time to express themselves and gain confidence in the team can be different between cultures. It is also considered that the power pervades the posture and the ducts of the health professional exercising great influence on the population and on the reception of the same [19.20].

Given this, it should be noted that the communication also depends on the understanding of the health care team about the worldview, the beliefs, the values and customs of the population that is under their care. However, there is a need for professionals to acquire a better understanding of the concept of culture, considering the cultural dynamics and the use of a guiding theory for the extent of the congruence of the care. The theory of diversity and Universality of Madeleine Leininger's Cultural Care provides a sufficiently clear conceptual framework for nursing practice, enabling the desired approach between the different cultural systems of health care, and an important guide for nurses and team leaders in indigenous lands.

The team's relationship with indigenous community leaders

In this category, shows that the health teams have the support of the indigenous community in child care, and the care is in not only the form of individual and family, but also a collective task. Among the participants of the child protection network, as well as health professionals were the leaders, teachers and volunteer Pastoral da Criança.

The leaders, who are the chiefs of the indigenous communities, oversee the work of the health team, delivering judgment on the activities:

> If I do the evaluation of a child [...] have to give a good guideline, justify, because otherwise the leadership comes to charge (ENF 1).

Still, the informants reveal that the leaders and the community also oversee and enforce changes of health professionals in the teams, when they don't feel satisfied.

> If they {indigenous community} do not like my work, the community asks me to take leadership {team}. (Another Professional).

In addition to the role of controller of health teams, leaders have an important role to support and help to the professionals when needed:

> When a child always comes back low weight, we take the lead [...]. So we note that the leadership has a domain on top of them [...] (ENF 1).

Schoolteachers have a key role in support of the health care team to indigenous children. Teachers identify children in need of assistance and the lead or the route to health unit.

> At school, the teachers are very friendly. Children get sick they bring up at (3).

According to the informants, the school is provided by the care the children team, by means of participation in health promotion actions that are developed:

> We do this awareness in school to promote the growth and development of the child. [...]At school, we have the PSE, which is the school health programme, which works with teachers, developing the health of students (ENF 2).

Also the women's voluntary support of Pastoral da Criança, which are natives and residents of the communities, to accompany the child development/growth and promote prevention of diseases.

> The pastoral da criança do snack {on the day of weigh}.Cake with nutrients, juice, milk, wafer [...] and help in the guidelines and in weighing (5).

The perception of the professionals, the presence, the intermediations and the support of indigenous leaders and other servants of the community, help to legitimize the actions and official health care, interfering somehow in the culture, when you try to synchronize the popular with the professional.

Thus, the role of the agent in the family health team is essential, because it belongs

to that community; know the potential and health needs and culture of the population and the challenges to face them [21].

It should be remembered that the ESF has in its principles of action, integration and the link with the community, the humanization of care, the completeness, as well as the development of intersectoral actions. According to the Ministry of health, the professionals of the ESF teams must plan, organize, develop and evaluate actions that respond to the real needs of the community, articulating the various sectors, establishing a permanent interaction with the community in order to mobilize it, stimulate their participation and wrap it in health promotion activities, so that the actions to be more resolute[20.21].

Through the analysis of the results of this research, it is possible to say how challenging it is for the professional system to recognize and act on ethnic differences, since it turns out that they have had no education or training regarding the cultural care practice. In this perspective, the differences in values, beliefs and cultural habits must be recognized and respected, without impositions of the values on the part of health professionals, but management and skills to deal with such differences in the provision of care.

FINAL CONSIDERATIONS

Returning to the aim of this study, we emphasize that the pros are obstacles in communication, by the difficulty to understand the language, by the silence and little interaction of indigenous families. Future surveys will deepen knowledge about the real difficulties in this intercultural meeting, seeking technologies for effective dialogue.

As for the attitude in the development of their actions, there is willingness to abide by the professional care performed by families and the indigenous community, however, there is difficulty in performing an attentive listening and stripped of their personal and professional culture, which may be leading to inhibition and mothers of children into silence when they are in the environment health unit. The turnover of the professionals and the lack of a more solid basis training in anthropology culturally congruent care difficult. In this way, there is a need for further research, including, learn more about the differences in the relationship of the indigenous population with the pros.

For nursing is required knowledge of how middle-level professionals from indigenous people perform their care and how to face the differences between the professional knowledge and practice. Cultural conflicts existing in professional practice without indigenous descent are present in this study, but little is known about the ways in which they express the cultural conflicts in indigenous professionals. Also if should seek more data on the ratio of nurses to the health residents and members of these peoples. The control of indigenous leaders about health professionals, reported still in its infancy in this research data is also worth deepening.

With respect to assistance itself, the data show that there is a tendency of professionals to impose their beliefs, practices and values about another culture, by the academic training where is inculcated the hegemony in their health care professional. In this way, initiatives and projects of municipal managers must include permanent professional education in indigenous lands, to work with a concept of culture that help them to reflect on their actions and recognize its dominant cultural values and ethnocentric tendencies

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ABSTRACT

This qualitative study aimed to identify the professionals' perceptions of family health teams on the care provided for indigenous children. Depth interviews have been conducted with nine professionals who work in the health teams in two Indigenous Settlements of Santa Catarina, Brazil. Data content analysis has been discussed in the light of Madeleine Leininger's Theory. Young adults have characterized the interviewees´ profile, lack of specific training to work with indigenous health care and job turnover. Two categories have come up: ways to develop care and relationship between the team leaders and indigenous community. Contradictions between the desire to respect indigenous costumes and the anxiety to solve their health needs have favored the necessary behavior on

professional care. Communication obstacles are among the difficulties encountered by the team. Childcare has followed a collective model on that population, in which indigenous leaders evaluate the professionals work.

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PERCEPCIONES DE LOS EQUIPOS DE SALUD DE LA FAMILIA SOBRE EL CUIDADO PROFESIONAL DE LOS NIÑOS INDÍGENAS

RESUMEN

Estudio cualitativo que tuvo por objeto conocer las percepciones de los profesionales de los equipos de salud para la familia, sobre el cuidado que los mismos ofrecen a los niños indígenas. Fueron realizadas entrevistas completas con nueve profesionales que actúan en los equipos de salud, en dos Poblaciones Indígenas de Santa Catarina, Brasil. El análisis de los datos fue discutido con base a la Teoría de Madeleine Leininger. El perfil de los entrevistados se caracterizaba por la edad joven y por la falta de capacitación específica para trabajar atendiendo a la salud indígena y la rotación en el empleo. Así, aparecieron dos categorías: la manera de realizar el cuidado y la relación del equipo con los líderes y la comunidad indígena. Las contradicciones entre el deseo de respetar las prácticas de los pueblos indígenas y la ansiedad por resolver las necesidades de la salud favorecen las conductas impositivas sobre el cuidado profesional. Los obstáculos en la comunicación aparecen entre las dificultades encontradas por el equipo. El cuidado de los niños sigue un modelo colectivo en esa población y los líderes indígenas evalúan el trabajo de los profesionales.

Palabras clave: Población Indígena. Niño. Salud de la Familia. Enfermería en la Salud Comunitaria.

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