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NURSES AND HEALTHCARE FOR THE ELDERLY INDIGENOUS PEOPLE: THE GERONTOLOGICAL PERSPECTIVE[1]

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ABSTRACT

The objective of this study is to characterize the healthcare practices of nurses for elderly indigenous people in native lands in Espírito Santo. This is a descriptive research with a qualitative approach carried out in from November to December 2015 with nurses that work in Indigenous Basic Healthcare Units. Thematic content analysis was used to treat the data and resulted in the following categories: Administrative activities focused on care; Assistance activities focused on care; and Educational activities focused on care. The implementation of the current indigenous health care model, started 19 years ago, can still be characterized as an ongoing process. It can be said that public policies have advanced, but there is much to be done for their establishment and for the delivery of quality services. It is crucial that nurses understand the reality of the lands where they act, and reflect on their practice, taking theoretical references of transcultural nursing to assist natives in a comprehensive manner, planning actions to address the aging process, starting with the knowledge of their lifestyle and cultural habits, and ethical and religious values.

Keywords: Nursing. Primary Health Care. Transcultural Nursing. Elderly. Native elderly.

INTRODUCTION

The indigenous population in Brazil has a great ethnic diversity distributed in three hundred and five ethnic groups dispersed throughout a huge territorial extension, creating challenging intercultural issues. They have a constitutionally guaranteed right to be recognized for their differences that are manifested in their cultures, languages, ways of relating with the environment, spirituality, education, health practices, and forms of social and political organization.

According to the guidelines of the National Policy on Health Care for Indigenous Peoples (NPHCIP), basic health care actions are guided by the District Plan for Indigenous Health (DPIH) in its 34 decentralized Management Units, located in territorial spaces, called Special Sanitary Indigenous Districts (SSID), operationalized with the support of multidisciplinary teams of Indigenous Health (MTIH)[(1)].

To this end, strategies and programs must adapt to the local needs and specific possibilities of each region, taking into account the social, political, cultural, geographical and historical particularities of the peoples, guaranteeing all rights of citizenship, defense of their dignity, well-being and the right to life. It is fundamental that professionals working with indigenous health develop cultural skills to minimize conflicts that arise when dealing with differences, with a view to promoting health and preventing diseases to contribute to improving the living conditions of this population[(2)].

Few studies have addressed the health conditions of indigenous peoples, especially elderly indigenous people, access to health services and the form of assistance provided taking into account the socio-cultural diversity. It is estimated that among the total number of indigenous people in the country, 8% are 60 years old or older, with a predominance of women[(3)].

The scenario of old age that is outlined requires that care practices for the elderly be better qualified and more resilient, because, regardless of skin color, race and ethnicity, aging causes physiological

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limitations, functional disability, and greater vulnerability to chronic diseases[4,5], placing people in a frame of late and polarized epidemiological transition.

The aging process implies the need to expand the access to health services because the elderly are more susceptible to diseases and disabilities. Indigenous elderly people share the universal needs of the aging process, with differences coming from the specific cultural aspects of each ethnic group[6].

In order to provide care taking into consideration the culture of the clients, it is necessary to preserve their beliefs and values, resorting to negotiation and dialogue between the professional health system and the traditional indigenous system to produce a beneficial or satisfactory health, trying to combine the two types of care, i.e. the biomedical and the traditional medicine.

It is important to emphasize that, in many cases, the elderly act as counselors and healers and have traditional knowledge of indigenous health, based on a holistic approach whose principle is the harmony of the individual with the surrounding universe, leading them to believe that their beliefs and knowledge can influence the access to health services[6].

It is believed that, because nurses are caregivers of people in the various stages of the life cycle, they can provide assistance to the elderly in different situations including activities in the Indigenous Basic Healthcare Unit (IBHU) and in places and situations in the village such as home visits, voluntary work and educational actions, making it possible to assimilate the practices of traditional care in their professional life.

Thus, the objective of this study was to characterize the health care practices carried out by nurses for the indigenous elderly people in the indigenous lands in Espírito Santo.

METHODOLOGY

This article is the part of the master thesis titled "Nursing and health care practices of elderly indigenous people", linked to the Professional Master course in Nursing of the Federal University of Espírito Santo (UFES).

This is a descriptive, qualitative study. Five nurses working in five Indigenous Basic Healthcare Units (IBHUs) participated in the study. These IBHUs are located in Indigenous Lands (IL) of the municipality of Aracruz, Espírito Santo, where 3654 individuals are distributed in two ethnic groups: Guarani Mbyá, with 248 individuals, and Tupiniquins, with approximately 3406 individuals. In this population there are approximately 178 people aged 60 years or more, corresponding to 5% of the indigenous population in the two ethnic groups[7].

Data were collected through individual interviews conducted with semi-structured scripts that had the following guiding questions: What does it mean for you to be a nurse who provides care for indigenous health?; Talk about your daily work as a nurse of indigenous health. The interviews were previously scheduled with the nurses through a telephone contact, and conducted at the Healthcare Unit, in a private place, at the date and time chosen by the individuals. The interviews were recorded and later transcribed and typed in a Word document for Windows version 2008. Data were collected from November to December 2015.

Data were submitted to thematic content analysis[8] and resulted in the following categories: Administrative activities focused on care; Assistance activities focused on care; and Educational activities focused on care.

The professionals participating in this study expressed their agreement by signing the Informed Consent Term. To preserve anonymity, they are identified with the letters "N" (Nurse), followed by an identification number (N1 to N5). The survey was approved through Opinion nº 1. 125,768/2015 of the Research Ethics Committee of the Health Sciences Center/UFES and the Indigenous Special Sanitary District of Minas Gerais/Espírito Santo (DSEI MG/ES).

RESULTS AND DISCUSSION

Among the various health fields, the Family Health Strategy (FHS) provides a privileged space for the differentiated application of care practices, promoting a closer contact with the context of the population and its main demands and also favoring the development of care practices that may include administrative, welfare and educational activities[9].

Because this is an indigenous population, cultural aspects must also be taken into account, since culture directly influences thoughts, decisions and actions, especially when it comes to care[10].

The care provided by these professionals to the elderly indigenous people allowed the construction of three thematic categories: Administrative activities focused on care; Assistance activities focused on

care; and Educational activities focused on care, as presented below.

Administrative activities focused on care

The presence of nurses in primary care favors identifying factors that can cause damage to the elderly's health, using interactive and proactive, individual and collective actions that promote healthy living and active aging. It also represents a propitious scenario for geronto-geriatric nursing develop as an emerging specialty, collectively building and consolidating its actions with elderly users and their families[11]. In the attention to Indigenous Health, nurses have been fundamental for expansion and consolidation of the reorganization of the healthcare model.

The nurses' daily routine is permeated by conflicts in their professional practice and the expectations they project in their performance. These conflicts arise from the permanent struggle for production of new ways of providing healthcare in a context in which management strategies and ideological aspects predominate[12].

> In indigenous health I have a more administrative role, as if I were an administrative nurse, even though I know that I also need to be involved with care [...], I don't know if it's because I come from an area that was totally centered in care that when I got here I found myself a little lost, because here I see myself behind the table for too much time [...] This is terrible for me. (N1)

Moreover, the loads imposed on nurses are not proportional to the conditions they are given to respond with quality to the prerogatives of indigenous health and to meet the spontaneous demand. Thus, experiences of conflicting situations in decision-making are commonplace, and activities will be neglected in order to complete others.

Thus, it is rare for nurses to leave the health unit to intervene directly in the community, to know the territory where the processes of being healthy and suffering of the individuals, their affections, their senses of life, their relationships, their culture and their ways of living life.

As responsible for managing the unit, nurses need to establish strategies to guarantee the quality and continuity of care[12]. In this perspective, nursing care should be culturally competent, appropriate and sensitive to cultural specificities.

Assistance activities focused on care

The Tupiniquins and Guarani peoples have long experienced high disease rates, clearly reflecting the precocity of food and behavioral changes that are increasingly rooted in the lifestyle of these peoples in the region and that constitute an epidemiological and nutritional transition[13].

A study carried out with the Guarani Mbyá people, in Espírito Santo, showed that they differentiate the diseases of cultural origin from those resulting from the secular contact with the non-indigenous populations. The people further emphasized that diseases of cultural origin are mainly due to the malevolence of spiritual forces which affect the soul and often the body of the individual or even the community. Such malevolent agents may be supernatural beings inhabiting places forbidden to man, such as stones, rivers, forests, or, they may originate from the transgression of moral norms, social norms, from evil-doing of others, or from witchcraft practices[13].

The choice of food should also be carefully observed by those who seek to live in accordance with the Mbyá precepts. Although medicinal plants occupy a prominent place in the Mbyá medicine, there are other substances also used in preventive and curative practices such as animal oils, fats and honey of certain bees that also have a unique importance in autochthonous medicine.

It is also worth emphasizing the Guarani way of being, which involves the organic interaction with nature that is between the maintenance of the traditional system directed by the leaderships, elderly and women, and the changes introduced in the way of life of the people through inter-ethnic contact brought from outside[14].

> The hyperdia is a huge bottleneck, we have many difficulties, adherence, our bottleneck is the use of medication, a complicating factor, patients who present much resistance, they say they take the natural remedy, but suddenly the blood pressure rises [...] "They {the elderly} do not like to leave the village [...] Among the Guarani people, there are 9 elderly [...]. None is bedridden. I believe they have quality of life. They are Indians (N3).

The emergence of chronic noncommunicable diseases such as diabetes mellitus, arterial hypertension, and heart diseases appear as a real thermometer of the social, economic, ecological and cultural transformations of indigenous peoples.

Older people are the main users of the various

levels of care, mainly due to more complex clinical situations (polypathology) and need for more care (associated with greater functional dependence). Understanding the indigenous health as part of the vast field of population health is therefore important.

It is also important to note that due to the increase of the population's life expectancy, the epidemiological profile among the elderly, extended to the indigenous elderly, it is fundamental to evaluate the functional limitations in the practice of health services, because disability causes costs for the community in general, including increased demand for health services, reduced quality of life, increased costs of care, and increased morbidity and mortality.

It is worth emphasizing that in the health area, transculturality can be observed in two ways. On the one hand is the health care provided by professionals with scientific background that diagnose and provide care for the disease with the goal to maintain individual and collective well-being, and on the other hand, the medicine of the shamans and their knowledge and practices of spiritual healing that transcend biomedical care, in the relationship of men with nature and spirituality[13].

Therefore, the recognition and appreciation of the knowledge of village leaders is essential for dialogue and subsequent articulation between indigenous knowledge and scientific knowledge, with health promotion, adherence and care actions.

> As a nurse in the indigenous field, everything we do has to go through village leaders, some things. We follow this rule of the community, but we do not leave our role as nurses. We cannot ignore the leaders, because otherwise we will be charged. The tribal chief (cacique) is always present when there is any problem or decision to be made. The relationship between nurses and the tribal chief is a partnership that helps, and we do not feel alone to make decisions (N5).

The health professional has on one side his commitment to offer health care and on the other side the indigenous people seeking various answers to what is going on. At that moment, different worldviews meet and confront each other in an attempt to decode the meanings of what each one understands about the health/disease process and the different therapeutic measures[15]. This plurality constitutes a great challenge for health professionals who are at the limit of understanding what is natural or what is a cultural behavior of the people with whom they are interacting.

> Cultural issues interfere more with the Guarani people. They are more entrenched, more closed [...] in the Guarani people there is enormous resistance to take medication, the team has a lot of difficulty, but it is their culture and they end up developing diabetes, for example. The cultural issue makes them very dependent on the multidisciplinary team. (N4)

> Only a few elderly people, the ones with very advanced age, sometimes prefer to take tea, a bath herb, as a treatment; the grandchildren already prefer to use the medication of the healthcare unit. (N1)

Thus, it is quite common to observe that elderly people retain or even use health care practices learned earlier in their life with their ethnic group. Therefore, it is of utmost importance that these cultural practices are not only respected and maintained, but also rescued to permeate healthcare.

Care will be culturally beneficial or congruent when health professionals know the client's culture and ways of caring for them, and direct their professional practice to patterns, lifestyles, beliefs and cultural values, taking into consideration the individuals as participants in the planning and actions for their own care[16].

Nurses develop care activities at the IBHU that include vaccination, dressings, verification of vital signs, newborn screening test, and care for women's health and child health. The elderly are included in this context.

The actions of primary health care professionals still have imprecise knowledge of the needs of the indigenous elderly people; they are rather restricted to activities foreseen in programs of the Ministry of Health (MOH), such as hypertensive and diabetic groups, among others.

Such programs do not respond to the complexity of the determinants of the health-disease process of the indigenous elderly because they are still carried out in a standardized, vertical and prescriptive way, modulated by biological and political factors without, however, attending to aspects of the indigenous culture.

There is also the challenge health professionals face to provide assistance to indigenous peoples, especially the elderly, in a space of cultural diversity expressed through languages, colors and customs that make up the cultures in which the actors live daily, together with the challenge of intercultural communication, history, and worldview among other factors[15].

This plurality represents a great challenge for health professionals who are at the threshold of

understanding what is natural and what is a cultural behavior of the people with whom they are interacting.

In this sense, the nurses' place within the health team has been built historically through actions that have undergone changes over the years, resulting from the needs that emerge from society.

Care will be culturally beneficial or congruent when the health professionals know the culture of the clients and their ways of caring, and direct their practice to the standards, lifestyles, beliefs and cultural values of the clients, considering the individuals as participants of the planning and actions of their own care[16].

Gerontological nursing care requires skills and knowledge, a dialectic relationship between professionals and the elderly associated to a posture of permanent reflection and effective investment on the part of the professionals. By doing so, it will be possible that the assistance concretely meets the needs and potentialities of elderly people and their families. It is important to stress that planned care strategies must be open to the creativity, intuition and imagination that integrate the true sense of caring based on the different realities encompassed in the meaning of the aging process[17].

Educational activities focused on care

There is still an invisibility of elderly people because of the lack of knowledge of policies, such as the aging process. The elderly indigenous people end up inserted in programs/projects developed according to the proposals of the Ministry of Health, as evidenced below:

> When we invite people to the hiperdia group, I think 90% are elderly people, sometimes they just come for a prescription and for medical consultation I try to explain to them the care, the medication, so that they can understand. We do a talk round, and guide them about hypertension, diabetes, body care, in a simple language. (N2)

> The hiperdia we do in the unit in the day to day (consultations), the lectures we do in the lodge. Generally, the elderly are in the hiperdia group. Most of them have hypertension or diabetes... we give the vaccines for the elderly and everyone has the vaccination card, but the elderly notebooks are missing. (N5)

Health care must overcome technical limitations, because several factors can determine aging, such as biological, socioeconomic, environmental and cultural factors. Such evidence demonstrates the need for permanent exchange of knowledge between the health team and the elderly indigenous community, respecting their life experiences.

Considering that care for the elderly is multidimensional and influenced by several and distinct phenomena in the actions of caring and assuming that in the villages they present a demand for care, for both the independent and the totally dependent elderly, basic care needs to be organized with teams with a view to improving the care provided to the elderly.

In order for nursing care to achieve the desired efficiency, promoting a form of care that values the diversity of the world's races, it is necessary that knowledge and skills through cross-cultural care be the basis of the actions.

Regarding the use of cross-cultural nursing in gerontological care in the development of studies using the Leininger Theory, it is suggested that nursing takes life history into consideration, adapting to culturally congruent care practices and associating health education in specific care models for this population[18].

It is worth emphasizing that gerontology is multidisciplinary because it reunites theoretical concepts from different areas around its object of study, and is still interdisciplinary in view of the complexity of the phenomenon of aging that requires not only the union of existing knowledge in several areas, but also the construction of a new body of scientific knowledge to guide the practice.

To facilitate the access of the population to educational groups, some teams organized these activities within the community, in places provided by the residents, associations, the Local Health Council, within the village:

> We really like to do groups there in the field. We call the people, everyone around the place where we are, there we talk, explain and see their needs. (N5)

Furthermore, these activities help in the care process, as they reveal components of the territory that are significant for the health of the population, such as housing, basic sanitation, social interaction and safety.

Among the educational activities focused on care, the study also revealed that nurses develop health promotion and disease prevention actions. It was observed that these activities are frequently present in the home visits.

The spiritual and/or health leaderships in an indigenous community are extremely strong characters and opinion makers among their people, because they are used in emergency situations, with or without the presence of MTHI in the territory. These authorities should be highlighted and respected by health professionals in order to create positive links with the community and avoid conflicts arising from divergent views in the processes of illness and cure[19]. In this way, the recognition and appreciation of the knowledge of village leaders is essential for an articulation between popular and scientific knowledge with health promotion, adherence and care actions.

> As a nurse in the indigenous field, everything we do has to go through village leaders, some things. We follow this rule of the community, but we do not leave our role as nurses. We cannot ignore the leaders, because otherwise we will be charged. The tribal chief is always present when there is any problem or decision to be made. The relationship between nurses and the tribal chief is a partnership that helps, and we do not feel alone to make decisions (N5).

The tribal chief is one of the most important members of the village, responsible for the harmony of the community, and usually supported by a council of elders. The spiritual leaders exert influence within the community as responsible for health in the villages. They are the link between the indigenous and non-indigenous people with respect to tolerance, respect for indigenous medicine, avoiding prejudice or imposition in the exercise of activities, recognizing the cultural specificity of the group, for the success of health care.

In the speech of one of the interviewees it was made clear that:

> Policies speak of empowerment, interculturality, and it is very complicated ... one has to know to understand culture because it creates a lot of conflict... working with indigenous health is challenging... (N2)

Therefore, each measure to be taken must result from a wide discussion with the communities and from the development of appropriate technologies to the reality of the territory and the indigenous way of life, in order to produce lasting results that can bring about a new look and new knowledge and forms of acting, producing intersectoral and intercultural dialogue between peoples with profound historical, political and socio-cultural differences. This is a relevant and necessary practice for life in contemporary society. The measures must also result in the development of clinical, epidemiological and anthropological studies that contemplate the need of each indigenous people[20].

FINAL CONSIDERATIONS

The cultural diversity of indigenous peoples in Brazil is projected in the challenges for implementation of public policies. Even after almost two decades, the current model of indigenous health care in Brazil is still characterized as an ongoing process under construction. It can be said that public policies have advanced as a discourse of the State, in the recognition of rights to access goods and services, but not in the practice; there is still much to be done for effective allocation of quality services.

Nurses working in the basic care of indigenous health, in Indigenous Basic Healthcare Units (IBHUs) still have imprecise knowledge about the need of the elderly indigenous, because the actions are restricted to activities foreseen in the programs of the Ministry of Health (MOH), such as hypertensive and diabetic groups, among others. It is necessary to bring nurses closer to the reality where they act and to allow a reflection on their practice, in order to fully assist the elderly indigenous people. In addition, they should base their actions on a theoretical framework for their professional practice, grounded on theories of so-called cultural or transcultural nursing, which in Brazil can be called intercultural.

In the context of the issue of elderly indigenous people, one of the challenges is to carry out studies and research aimed at evaluating health services, taking into account the point of view of knowledge of the specificities of ethnic groups, and also considering the mapping of the demands of these people in their representations of the health-disease process.

O ENFERMEIRO E O CUIDADO AO INDÍGENA IDOSO: O OLHAR GERONTOLÓGICO

RESUMO

O objetivo deste estudo foi caracterizar as práticas de cuidado à saúde realizadas pelos enfermeiros aos indígenas idosos nas terras indígenas localizadas no Espírito Santo. Trata-se de uma pesquisa descritiva com abordagem qualitativa, realizada no período de novembro a dezembro de 2015, com enfermeiros que trabalham nas Unidades Básicas de Saúde Indígena. Os dados foram submetidos à análise de conteúdo temática, a qual derivou nas seguintes categorias: As atividades

administrativas voltadas para o cuidado; As atividades assistenciais voltadas para o cuidado; e As atividades educativas voltadas para o cuidado. O modelo atual de atenção à saúde indígena, implantado há 19 anos, ainda pode ser caracterizado como um processo em construção. Pode-se dizer que as políticas públicas avançaram, mas há muito a ser feito para sua efetivação e destinação de serviços de qualidade. É essencial que o enfermeiro compreenda a realidade onde atua e reflita sobre sua prática, busque referenciais teóricos na enfermagem transcultural, para que possa atender de forma integral o indígena, planejando as ações para lidar com o seu processo de envelhecimento, a partir do conhecimento dos hábitos de vida, valores culturais, éticos e religiosos.

Palavras-chave: Enfermagem. Atenção Primária à Saúde. Enfermagem Transcultural. Indígena idoso.

ENFERMERO Y EL CUIDADO AL INDÍGENA ANCIANO: UNA VISIÓN GERONTOLÓGICA

RESUMEN

El objetivo de este estudio fue caracterizar las prácticas de cuidado a la salud realizadas por los enfermeros a los indígenas ancianos en las tierras indígenas ubicadas en Espírito Santo-Brasil. Se trata de una investigación descriptiva con abordaje cualitativo, realizada en el período de noviembre a diciembre de 2015, con enfermeros que trabajan en las Unidades Básicas de Salud Indígena. Los datos fueron sometidos al análisis de contenido temático, que derivó en las siguientes categorías: las actividades administrativas dirigidas para el cuidado, las actividades asistenciales dirigidas para el cuidado y las actividades educativas dirigidas para el cuidado. El modelo actual de atención a la salud indígena, implantado hace 19 años, aún puede ser caracterizado como un proceso en construcción. Se puede decir que las políticas públicas avanzaron, pero hay mucho que hacer para ponerlo en marcha y destinar servicios de calidad. Es esencial que el enfermero comprenda la realidad donde actúa y reflexione sobre su práctica, busque referenciales teóricos en la enfermería transcultural, para que pueda atender de forma integral al indígena, planificando las acciones para lidiar con su proceso de envejecimiento, a partir del conocimiento de los hábitos de vida, valores culturales, éticos y religiosos.

Palabras clave: Enfermería. Atención Primaria a la Salud. Enfermería Transcultural. Indígena anciano.

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