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PROFILE OF NURSES WHO WORK IN INDIGENOUS AND NON-INDIGENOUS HEALTH CARE

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ABSTRACT

Objective: The study aims to characterize the profile of nurses who work with the indigenous and non-indigenous population of Alto Rio Negro, Amazonas. Method: quantitative study was carried out, with data collected through a questionnaire applied to 84 nurses, most of them are female, brown, married, and whose statistical analysis of association have compared the professionals according to the form of contract. Results: It was observed that the main differences between the groups were age (P = 0.043), hiring by Non-Governmental Organization, temporary contract for services and permanent education (P = 0.003). The permanent education has a high frequency of offer to professionals (80.9%). It is worth mentioning the variety of complementary training to the detriment of the field of family health and indigenous health (8.5% and 5.9%, respectively). Conclusion: The results indicate the need for reorientation regarding the training and performance of professionals, as well as the direction of actions that consider the epidemiological, operational and cultural specificities of the population in the region.

Keywords: Family health care. Indigenous population health care. Public Health Nursing.

INTRODUCTION

In the current context of the Brazilian health system, the Family Health Strategy (FHS) has the main methodology of implementation and organization of Primary Health Care (PHC). The FHS has the role of reorienting the Brazilian health care model based on primary care, guided by the principles of the Unified Health System (UHS), establishing responsibility between health services and the population. It should prioritize actions for the promotion, protection and recovery of the health of individuals and families in an integral and continuous way[1].

The FHS staff should be composed of a nurse, a general practitioner, a nursing technician and community health agents. This team is responsible for continuous care of people who live in the area of coverage, which should also be integrated into a network of services of various levels of complexity, within the context of health care networks, guaranteeing resolution and integrality, monitoring of the users of its territory[1].

In the context of indigenous health, the health care subsystem, regulated by Law No. 9,836/99, was implemented, aiming to implement and to manage differentiated health actions directed to indigenous peoples, considering their cultural specificities. The management of this subsystem is the responsibility of the Special Secretariat of Indigenous Health (SSIH) and the Ministry of Health, responsible for 34 Special Indigenous Sanitary Districts (SISD) that have been implemented in order to operationalize the adequate health care to indigenous people. SISDs are composed of a network of hierarchical services, with increasing complexity and articulated with other levels of UHS care. As in the FHS, the indigenous health actions are developed by a multidisciplinary team, composed of doctors, nurses, nursing technician and community health agent[2].

The SISDs health care model is characterized as proposed by the FHS, as described in the National Primary Care Policy (NPCP)[1]. Thus, SISDs should ensure health promotion activities and uninterrupted provision of primary health care services in indigenous villages, adopting programmed demand and national program strategies for disease prevention and control[2]. For this, professionals should be able to plan, to organize, to develop and to evaluate actions that respond to the needs of the community, in articulation with UHS.

The nursing area has contributed to the implementation of social and public policies, aimed at strengthening UHS, through the FHS and the

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subsystem of indigenous health care, developing practices in care, management of health services and education, in public and private institutions[2,4].

In the State of Amazonas, seven SISDs were implemented, which have, in proportional terms, the largest indigenous population in the country, with 183,514 thousand self-declared indigenous people. In the Alto Rio Negro region, the municipalities of São Gabriel da Cachoeira and Santa Isabel do Rio Negro are among the five municipalities of the country with the highest proportion of indigenous population in their territory. Around 75% of the inhabitants of the rural area of these municipalities have declared themselves as indigenous[2,5].

Similar to the primary care teams in the FHS, in which nurses are responsible for the organization and work process[6] in the indigenous area, nurses have assumed a central role in the teams, given that they stay longer in an area if it is compared to doctors as well as the requirements inherent in their activities[2]. This role demands more creativity and autonomy in the development of their competences and, on the other hand, increases the level of their responsibility, often leading to an overload of work[2,3]. Work in indigenous health care, as well as in other levels of health care, requires the articulation of actions to promote health. Considering that there should be integration of the multi-professional team and knowledge of other public services, adding technical and popular knowledge, as well as mobilization of institutional and community resources, public and private ones to face and to solve health problems[4]. This also needs to be aligned with the specific needs of the indigenous population, especially when thinking about the cultural issues involved[2].

In addition to cultural specificities, nursing practices among indigenous peoples cannot be decontextualized from the need to transform a reality marked by intense inequalities, aggravated by environmental, economic, social and political crises that influence the conditions of life and health. These factors influence care and require work from professional training[7,8].

In view of the challenges presented, inherent in the demand for work in indigenous health care, the knowledge of the nursing professional profile proposed here, although dealing with local realities, has the potential to contribute to the improvement of the performance conditions of its role as a nurse, as well as the need for care that emanated from the implementation of a subsystem for the health of indigenous peoples in Brazil. It is important to highlight the relevance of the proposed clause, given the recognition of indigenous health as a specialty of nursing by the Federal Nursing Council (FNC), through resolution 581/2018[9], and the scarcity, in our country, of research that addresses the profile of nursing professionals who work in the indigenous health subsystem and in municipal health services that face similar conditions of care for their residents, whether they are indigenous or not.

The importance of this study is also evident, since the foundations of the National Policy on Health Care of Indigenous Peoples (NPHCIP)[2] have a conceptual alignment very articulated with the NPCP and, consequently, with the FHS. Therefore, this profile can respond to the demands of primary care in other health territories.

Thus, the present study aims to identify the profile of the nurses who work with indigenous and non-indigenous populations in Alto Rio Negro region of the State of Amazonas, observing differences by place of employment, if it is the Health District Special Indigenous or Municipal Health Secretariats. It is intended to recognize specific characteristics among the profiles of these professionals that influence their performance, as well as the results can provide information that favors to understand and to qualify the organization of the services and offers of health care in function of the needs of the indigenous and non-indigenous population.

METHOD

This is a transversal, exploratory, quantitative study carried out in the Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD) and in the Primary Health Care (PHC) services of the municipalities of São Gabriel da Cachoeira (SGC), Santa Isabel of Rio Negro (SIRN) and Barcelos, in Amazon.

The three municipalities, where the indigenous lands studied are also based, form an extensive region (295,917.10 km2) known as Alto/Médio Rio Negro, which represents 35% of the total area of the state of Amazonas[5]. The population is approximately 96,616, with 75% of the population living in rural areas. It is indigenous, belonging to 23 (twenty of three) ethnic groups in four linguistic trunks (Eastern Tukano, Aruak, Maku and Yanomami). The social indexes of the region are well below the national mean, with the IDHM (Municipal Human

Development Index) varying from 0.47 in Santa Isabel do Rio Negro, 0.62 in São Gabriel da Cachoeira and 0.50 in Barcelos[5].

The population of the study was the universe of 91 nurses working in the PHC of the Municipal Health Secretariats (MHS) of the aforementioned municipalities and the Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD). From these, 84 professionals that work to indigenous people participated in the study (accounting for 92.3% of the total), from them 67 (79.8%) nurses attending the indigenous population living in the village in the ARN-ISSD and 17 (20.2%) FHS nurses of the urban area of the municipalities, managed by the municipal health secretariats (MHS), which serve the population, regardless of whether or not people recognize themselves as indigenous. At the time of application of the research, 02 (two) professionals were away for health treatment and 5 (five) in vacation, excluded from the data collection.

The data collection was performed from June to August 2015, through the application of a questionnaire by a single researcher, containing demographic variables, professional training, permanent education and questions that approached the work with ARN-ISSD and MHS. For professionals who work in the indigenous area, the data were collected at the municipal headquarters, and there was no need for researchers to access the indigenous area.

All professionals were invited to participate by means of a cover letter delivered at the institutions and thereafter maintained previous contact to schedule the beginning of data collection.

The database was formulated in the Program SPSS® version 21, with double typing. For the statistical analysis, we used percentage frequency and central tendency measures, such as mean and median. The association between the proportions of the categorical variables was tested using Fisher's exact chi-squared statistic. The Wilcoxon test was used to compare the continuous variables, because the non-normality of the data using the Shapiro Wilk test, which led to the presentation of the medians after data analysis. Throughout the statistical analysis, we considered the level of significance $P < 0.05$.

This study was approved by the Ethics Committee of the Nursing School of the University of São Paulo, under the protocol 1,084,040/2015 and followed the ethical principles of resolution 466/2012.

RESULTS

Table 1 shows the sociodemographic characteristics of the professionals, according to the place of work, ARN-ISSD or MHS, with a higher frequency of professionals in the first one. The predominance of females does not differ with respect to the workplace, whether it is ARN-ISSD or MHS. With the exception of one professional of MHS and one from the ARN-ISSD, they are Brazilian. Regarding skin color, there is no statistical difference between the groups, and almost 50% of professionals of the brown color are observed. Marital status also shows no difference between workplaces, with 46.4% married and 47.6% singles. The median age of the group was 35 years-old, with a statistically significant difference ($P = 0.043$), between ARN-ISSD (32 years-old) and MHS (37 years-old).

From the characteristics presented in Table 2, considering the hiring/bonding of the Nurses who work at ARN-ISSD and MHS in the Alto Rio Negro Region, in relation to the hiring agent, for 100% of the nurses from ARN-ISSD, this occurred by Non-governmental organizations (NGOs) under the CLT regime. At MHS, the admission happened through direct administration, by temporary contract of services, and only 1.2% of professionals entered through public selection; the majority (98.8%) stated that the hiring occurred in another way (friends and relatives, interview, curriculum selection).

Table 3 refers to the professional training and qualification of nurses, with almost half of the professionals saying that they did not have complementary training (46.4%), 43.3% in ARN-ISSD and 58.8% in MHS. Among those who have some type of complementary training, there was quite a variety of specialties. The most frequent area was specialization in Urgency/Emergency (15.5%), similar in both groups. Only professionals of ARN-ISSD affirmed specialization in indigenous health, work nursing, family health and intensive care. Even so, in very low frequencies, with 10.4%, 9.0%, 7.5% and 5.9%, respectively. Most of the professionals confirmed the existence of permanent education (80.9%) at their workplace, however, with a significant difference between groups, being higher for professionals of ARN-ISSD ($P = 0.003$).

Table 1. Socio-demographic characteristics of the nurses who work in Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD) and Municipal Health Secretariats (MHS), Alto Rio Negro Region, 2016.

Variables	INSTITUTION						X^2
	ARN-ISSD n= 67		MHS n = 17		TOTAL n = 84		
	n	%	n	%	n	%	P*
Gender							
Female	46	68.6	14	82.3	60	71.4	0.372
Male	21	31.4	3	17.7	24	28.6	
Nacionality							
Brazilian	66	98.5	16	94. 1	82	97.6	0.366
Peruvian	1	1.5	1	5.9	2	2.4	
Skin color							
Yellow	1	1.5	1	5.9	2	2.3	0.348
White	14	20.8	6	35.3	20	23.9	
Indigenous	18	26.9	5	29.4	23	27.4	
Black	4	6.0	0	0	4	4.7	
Brown	30	44.8	5	29.4	35	41.7	
Marital status							
Married/ Stable union	32	47.8	7	41.2	39	46.4	0.907
Divorced/ Separated	4	6.0	1	5.9	4	5.9	
Single	31	46.2	9	52.9	40	47.6	

* Fisher's exact test

Table 2. Hiring/bonding characteristics of nurse who work at Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD) and at Municipal Health Secretariats (MHS), Alto Rio Negro Region, 2016

Variables	INSTITUTION					
	ARN-ISSD n = 67		MHS n =17		TOTAL n = 84	
	n	%	n	%	n	%
Hiring agent						
Direct Administration	0	0	17	100	17	20.2
Non-governmental Organization (NGO)	67	100	0	0	67	79.8
Employment Contract						
Temporary service contract	0	0	17	100	17	20.2
NGO/CLT	67	100	0	0	67	79.8
Forms of admission						
Others	66	98.5	17	100	83	98.8
Public selection	1	1.5	0	0	1	1.2

Note: Data that are not suitable for statistical test and calculation of P-value.
CLT= Consolidation of Labor Laws (Consolidação das Leis Trabalhistas)

Table 3. Professional Training and qualification of nurses who are inserted in the Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD) and in Municipal Health Secretariats (MHS), Alto Rio Negro Region, 2016.

Variables	INSTITUTION						X^2
	ARN-ISSD n = 67		MHS n =17		TOTAL n = 84		
	n	%	n	%	n	%	P*
Additional Training							
Yes	38	56.7	7	41.1	45	53.6	0.286
No	29	43.3	10	58.9	39	46.4	
Permanent Education							
Yes	59	88.0	9	52.9	68	80.9	**0.003**
No	8	12.0	8	47.1	16	19.1	
Lato sensu specialization area**							
Urgency/Emergency	11	16.4	2	11.7	13	15.5	**
Indigenous health care	7	10.4	0	0	7	8.5	
Work Nursing	6	9.0	0	0	6	7.2	
Family Health	5	7.5	0	0	5	5.9	
Intensive Therapy	4	5.9	0	0	4	4.7	
Obstetrics	3	4.6	2	11.7	5	5.9	
Others	2	2.9	3	17.8	5	5.9	
Do not have post-graduation degree	29	43.3	10	58.8	39	46.4	

Note:** The statistical test was not applied. More than one specialization could be informed.
* Fisher's exact test

As for the formation time (Table 4), the mean was 7.3 years, with no difference between ARN-ISSD and MHS. The time of work in primary care in the MHS is higher, when it is compared to the indigenous health in the ARN-ISSD. The length time of work in Alto Rio Negro region is higher in the ARN-ISSD. The weekly workload in the ARN-ISSD is slightly higher (44 hours) than in the MHS (40 hours). Such differences should be understood in their raw values, as it was not possible to test statistically due to the low frequency for the diversity of responses.

Table 4. Median and mean values of training and work time of nurses in Alto Rio Negro Indigenous Special Sanitary District (ARN-ISSD) and in Municipal Health Secretariats (MHS), Alto Rio Negro Region, 2016.

Variables**	INSTITUTION						
	ARN-ISSD		MHS		TOTAL		Wilcoxon
	n = 67		n = 17		n = 84		
	Med*	Mean	Med*	Mean	Med*	Mean	P
Time after graduation	5.0	6.6	6.0	9.2	5.1	7.3	0.158
Time of work in the primary care	1.5	2.6	3.0	6.5	3.0	6.0	
Time of work in Alto Rio Negro Region	1.4	2.4	1.2	2.1	1.3	2.0	-
Weekly working hours in the MHS,S**	44	44	40	40	40	40	-

*Median
** The variables referring to the "Time" use the unit of measure in "years" and the variables referring to the work hours, use the unit of measurement "hours".

DISCUSSION

The predominance of women in the study participants was observed. The feminization found among nursing professionals reaffirms the "tradition and culture of this category, which has always contributed to the feminization" also in the area of health. This profile is in line with the study of the nursing profile in Brazil that analyzes the geopolitical characteristics of the nursing professional[10,11]. However, the study reveals the growing presence of men, evidencing the emergence of a new trend, the masculinization of the category. For the authors, this "trend is recent, and dates from the beginning of the 1990s and it has been firmly established"[10,11].

The median age of 35 years-old is a non-young mean among professionals from both institutions. This result is similar to that found in a study carried out in the Northeast region, which obtained a high concentration of nurses working in the FHS with an age group above 30 years-old[8]. However, the results contradict the findings of the research on the Nursing Profile in Brazil, which reveals nursing as a profession in rejuvenating, having more than 61.7% of the total representatives up to 40 years-old, "which means that the nursing team is predominantly young"[10]. Regarding race, it is important to note the existence of indigenous nurses, a situation that is not common in other regions of professional nursing practice.

The fact that approximately half of the professionals refer to complementary training denotes the general tendency to seek improvement in professional qualification[8]. It is possible to observe, however, that professionals entered to primary care area without specific training, considering the low frequency of this qualification, especially family health (10.4%) and indigenous health (7.5%). The lack of specific training to work in indigenous health care leads health professionals to contradictions between the desire to respect the practices of indigenous peoples and the anxiety in resolving health needs, thus favoring the imposition of professional care[12].

This situation leads to the reflection on possible difficulties encountered in the field of work by these professionals and the preparation for action, especially in indigenous PHC, which may lead to conflictive relations and friction between professionals and users, resulting in a not very effective health care. The experience in the field of indigenous health, by the authors, allows us to observe that the practices of the professionals who work in the indigenous health suffer from the confrontation of different worldviews between professionals and indigenous people, and may have negative repercussions on the quality of health care of indigenous people and, consequently, compromising the quality of the delivered care.

On the other hand, diversified specializations, focused on hospital aspects, may reflect the opportunities for more frequent offers, to the detriment of those more specifically concerned with PHC or indigenous health[8].

The high frequency of continuing education declared by professionals is an indicator that the contracting institutions prepare their professionals. However, one cannot say about the specificities of this education and how much it meets the needs, since it was not the target of this research. However, it

is known that more knowledgeable professionals provide more qualified health care[9]. The qualification of the health professional is certainly one of the paths and, not least, one of the challenges to be faced in order to achieve a higher quality of health care services. However, other measures, such as wage increases, new forms of employment contracts that guarantee stability and strengthen the employment relationship are fundamental[13].

Differences in recruitment between ARN-ISSD and MHS professionals may also reflect differences in professional development. It was observed that the majority of ARN-ISSD professionals have a labor relationship with NGOs, under the legal regime established in the CLT (Consolidation of Labor Laws), undergoing a load of 44 hours per week. In MHS, the temporary contract for services rendered predominates, by the direct administration of the municipality, with a 40-hour weekly load. These are types of contract that, because they do not offer stability, make it difficult for the professional to link with the service and with the served population, an indissociable characteristic of the work, whether in Indigenous Health or PHC in the municipality. It should be noted that there are insufficient data to refer to precarious links, but there are studies that point out how precariousness is detrimental to the service[13].

In addition, since the implementation of the indigenous health subsystem in 1999, human resources have been recognized as essential elements for the implementation of this subsystem [2]. The hiring through NGOs has placed workers in a situation of precariousness and devaluation of professional work, motivating labor actions, insecurity and turnover of health teams, making it difficult to structure services and to implement the health care model for this population[14].

The type of temporary contracting for service provision, used in the MHS of the municipalities under study, is a reality found by other authors who investigated the contracting ways[15,16]. Temporary hiring[16] is one of the factors that reinforce the precariousness of the work of the FHS teams, being responsible for the high turnover, which interferes both in the qualification of the professionals and in the performance of the actions of the Program[16]. Therefore, the situations of human resources management in the municipal districts of Alto Rio Negro, without formal employment ties, are not capable of ensuring the long-awaited overcoming of the high turnover of these professionals, as other studies have indicated[15,16].

Regarding the professionals' entry into the ARN-ISSD and the MHS, the majority in both institutions stated that it was an indication of friends and family, invitations, interview, selection of curricula or simply occupation of available vacancies. When health professionals are hired for a specific period of time, without a selective process, guided by other means, such as an appointment, invitation or simple occupation of a vacancy, the manager will not accept that other interested parties with the same requisites vacancy[16]. Therefore, the working class is at the mercy of municipal managers and in a vulnerable condition, which can lead to a series of abuses, repercussions on intimidation of professionals and the reduction of their political space and bargaining power, violating basic rights.

Several factors tend to influence that the length of stay of many professionals in the work with the indigenous population is not long, which is a negative factor, since the turnover of professionals compromises the professional-patient bond and, consequently, damages to the longitudinality of the care. The high turnover in multidisciplinary indigenous health teams is a feature both among non-indigenous professionals and among indigenous health workers, and has been a problem since the implementation of ISSDs, resulting in interruptions in care, even in relatively accessible regions[17,18].

The profile presented here highlights the need for a look aimed at professionals who work in the indigenous area. Looking at the specificity of primary care and the peculiarities of the indigenous population, it is considered that even with the limitations of this study, a problem arises that can compromise care. From the limitations, it is worth noting that this study aimed to look at the profile of these professionals, it was not possible to advance in the causes or the knowledge of the work process; another factor is that the professionals' answers were used, whose trustworthiness may be permeated by the fear of job loss, due to the way of hiring. However, it is considered that even with these possibilities, the situation presented here approximates reality and serves as a reflection on professionals who work in indigenous health.

CONCLUSION

The profile of the professional who works with the indigenous population of the Alto Rio Negro region indicates that the demographic and social aspects do not differ between MHS and ARN-ISSD, but the operational aspects of hiring and supporting professional performance, such as education, seem to be more favorable to those hired by the ARN-ISSD. These characteristics may have repercussions on the professional-patient bond, both employment and service bond, when talking about the relationship with patients. Therefore, being aware of these aspects is essential in the quality of nursing care in primary care for indigenous and non-indigenous populations who live in a particular health area.

PERFIL DE ENFERMEIROS (AS) QUE ATUAM NA SAÚDE INDÍGENA E NÃO INDÍGENA

RESUMO

Objetivo: O objetivo do estudo foi caracterizar o perfil dos enfermeiros que atuam junto às populações indígena e não indígena do Alto Rio Negro, Estado do Amazonas. Método: Estudo de caráter quantitativo, com coleta de dados por meio de questionário aplicado a 84 enfermeiros, em sua maioria do sexo feminino, pardos, casados, cujas análises estatísticas de associação comparam os profissionais conforme forma de contrato. Resultados: Constatou-se que as principais diferenças entre os grupos referem-se à idade (P=0,043), contratação por Organização Não Governamental, contrato temporário para prestação de serviços e educação permanente (P=0,003). Esta última tem elevada frequência de oferta aos profissionais (80,9%). Destaca-se a variedade de formação complementar, em detrimento do campo da saúde da família e da saúde indígena (8,5% e 5,9%, respectivamente). Resultados: Indicam necessidade de reorientação quanto à formação e atuação dos profissionais, assim como o direcionamento de ações que considerem especificidades epidemiológicas, operacionais e culturais da população na região.

Palavras-chave: Saúde da família. Saúde de populações indígenas. Enfermagem em saúde pública.

PERFIL DE ENFERMEROS(AS) QUE ACTÚAN EN LA SALUD INDÍGENA Y NO INDÍGENA

RESUMEN

Objetivo: El objetivo del estudio fue caracterizar el perfil de los enfermeros que actúan junto a los pueblos indígena y no indígena del Alto Rio Negro, Estado de Amazonas-Brasil. Método: Estudio de carácter cuantitativo, con recolección de datos por medio de cuestionario aplicado a 84 enfermeros, en su mayoría del sexo femenino, pardos, casados, cuyos análisis estadísticos de asociación comparan a los profesionales según la forma de contrato. Resultados: Se constató que las principales diferencias entre los grupos se refieren a la edad (P=0,043), contratación por Organización no gubernamental, contrato temporario para prestación de servicios y educación permanente (P=0,003). Esta última tiene elevada frecuencia de oferta a los profesionales (80,9%). Se destaca la variedad de formación complementaria, en detrimento del campo de la salud de la familia y de la salud indígena (8,5% y 5,9%, respectivamente). Conclusíón: Resultados indican la necesidad de reorientación en cuanto a la formación y actuación de los profesionales, así como la orientación de acciones que consideren especificidades epidemiológicas, operacionales y culturales de la población en la región.

Palabras clave: Salud de la familia. Salud de pueblos indígenas. Enfermería en salud pública.

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