CARE FOR THE HEALTH OF HALITI-PARESÍ INDIGENOUS WOMEN
O CUIDAR DA SAÚDE PARA A MULHER INDÍGENA HALITI-PARESÍ
CUIDAR DE LA SALUD PARA LA MUJER INDÍGENA HALITI-PARESÍ

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ABSTRACT

Objective: to verify how indigenous women define and promote health. **Method:** qualitative, descriptive-exploratory study with 12 Haliti-Paresí indigenous women. Data were produced through semi-structured interviews. The thematic Content Analysis technique was used to analyze the data, based on the Theory of Diversity and Universality of Cultural Care. **Results:** it was found that the natives define health as something primordial that gives meaning to life and goes beyond the biological dimension. In addition, there is a link between popular and biomedical knowledge, with a preference for indigenous knowledge applied within the community. They recognize that unhealthy habits are present in their daily life and show concern and seek ways to promote family health. **Conclusion:** cultural values need to be integrated into the assistance to improve indigenous health, from the perspective of building a new paradigm to approach the health-disease process. **Descriptors:** Women's Health; Health of Indigenous Populations; Health-Disease Process; Cross-Cultural Nursing.

RESUMO

Objetivo: verificar como as mulheres indígenas definem e promovem saúde. **Método:** estudo qualitativo, descritivo-exploratório, com 12 mulheres indígenas Haliti-Paresí. Os dados foram produzidos a partir de entrevistas semiestruturadas. Para análise dos dados, utilizou-se a técnica de Análise de Conteúdo na modalidade Análise Temática, fundamentada na Teoria da Diversidade e Universalidade do Cuidado Cultural. **Resultados:** identificou-se que as indígenas definem saúde como algo primordial que dá sentido ao viver e que vai além da dimensão biológica. Além disso, há uma articulação entre os saberes populares e biomédicos, com preferência aos saberes indígenas aplicados no interior da comunidade. Elas reconhecem que hábitos não saudáveis estão presentes no cotidiano indígena e demonstram preocupação buscando meios para promover a saúde da família. **Conclusão:** os valores culturais necessitam ser integrados à assistência para melhoria da saúde indígena, em uma perspectiva de construção de um novo paradigma para abordagem do processo saúde-doença. **Descritores:** Saúde da Mulher; Saúde de Populações Indígenas; Processo Saúde-Doença; Enfermagem Transcultural.

RESUMEN

Objetivo: verificar como las mujeres indígenas definen y promueven la salud. **Método:** estudio cualitativo, descriptivo-exploratorio, con 12 mujeres indígenas Haliti-Paresí. Los datos fueron producidos a partir de entrevistas semi-estructuradas. Para análisis de los datos, se utilizó la técnica de Análisis de Contenido en la modalidad Análisis Temático, fundamentada en la Teoría de la Diversidad y Universalidad del Cuidado Cultural. **Resultados:** se identificó que las indígenas definen la salud como algo primordial que da sentido al vivir y que va más allá de la dimensión biológica. Además, hay una articulación entre los saberes populares y biomédicos, con preferencia a los saberes indígenas aplicados en el interior de la comunidad. Ellas reconocen que hábitos no saludables están presentes en el cotidiano indígena y demuestran preocupación buscando medios para promover la salud de la familia. **Conclusión:** los valores culturales necesitan ser integrados a la asistencia para mejorar la salud indígena, en una perspectiva de construcción de un nuevo paradigma para enfoque del proceso salud-enfermedad. **Descriptores:** Salud de la Mujer; Salud de las Poblaciones Indígenas; Proceso Salud-Enfermedad; Enfermería Transcultural.

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INTRODUCTION

Brazil is considered a country with a wide cultural diversity that currently faces very challenging intercultural issues, especially concerning the health of indigenous peoples. According to the Brazilian Institute of Geography and Statistics (IBGE), 896,917 thousand people declared or considered themselves indigenous, 572,083 thousand were living in rural areas and 324,834 thousand were living in cities. Based on these results, there has been a significant demographic growth that deserves attention from the administrative and management bodies that care for this Brazilian population segment.¹

A historical retrospective of indigenous health shows that only in the 1990s this became the responsibility of the Ministry of Health (MOH). Through the National Health Foundation (Funasa), the MOH created the Special Indigenous Sanitary Districts (SISDs) to improve health care, assuring them a holistic attention with respect to their ethnic and cultural differences, with actions necessarily integrated into the Unified Health System (SUS).²

In 2010, through the Special Secretariat of Indigenous Health (SESAI), the MOH assumed the execution and coordination of the Subsystem of Indigenous Health Care throughout the national territory, with the responsibility of developing and prioritizing actions for health promotion and prevention and recovery of diseases, in line with public policies and programs established by the SUS. As a result, specific policies were created, such as the 2002 National Indigenous Peoples Health Care Policy (PNASPI), which came to ensure a better quality of care provided, and to ensure the integrity and equity of health services, especially the articulation of native therapeutic practices and Western medicine that have repercussions on a new model of health care.^{2,3}

However, in the practice, the proposed health model has several administrative and assistance failures, raising a concern for the health of indigenous women.^{3,4} The transformations of the female figure in contemporary society, the recognition and conquest of their spaces have strengthened some characteristics that may make them more vulnerable, with consequent abandonment and/or loss of cultural identity with the need also for a confrontation in the management of a new social profile. This situation affects the health and quality of life of different social groups, especially

indigenous women, who represent a segment of the population that has had a notable growth.

The World Health Organization (WHO) defines health as complete physical, mental and social well-being and not merely as the absence of diseases, and also established that health should be a right guaranteed by the State. However, the behaviors of a population in face of their health problems, including the use of therapeutic resources, are built in the intimacy of their daily life, as result of the contact with their people, rising from their socio-cultural context.⁵

Several scholars, such as Leininger,⁶ have highlighted and emphasized the importance of associating cultural anthropology with the health area, because they consider this link to be fundamental to the understanding of the health-disease process. For example, indigenous peoples have their own concepts and perceptions of health and illness.

Therefore, prior knowledge of the signification of health in this community that determines the thinking and attitudes of the population towards the health-disease process is fundamental for the efficiency and quality of the health care actions of health professionals that assist these people.

OBJECTIVE

- To verify how indigenous women define and promote health.

METHOD

Qualitative, descriptive and exploratory study,⁷ held in the Wazare indigenous village, located in the so-called Chapadão do Parecis, in the municipality of Campo Novo do Parecis/MT, Brazil. The choice of the place was based on its geographical location in the indigenous land of Utiariti, a large indigenous settlement in Mato Grosso. The subjects of the research were 12 women who met the inclusion and exclusion criteria. The inclusion criteria were: being over 18 years of age, belonging to the Haliti-Paresí ethnic group, and understanding and speaking Portuguese (Brazil). The exclusion criteria were: women who were not present at the first moment of data collection. The determination of the sample size was based on the data saturation method.

Data collection took place in December 2015, in two moments conveniently established by the researcher herself. The first moment was intended for the presentation of the research to the women of the village and the second, for the realization

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of the semi-structured interviews guided by a script prepared by the researcher including closed questions (sociodemographic aspects) and open questions (perception about health, health promotion and disease prevention and therapeutic practices used to restore health). The interviews were recorded with aid of a digital device only after authorization of the indigenous participant during the average period of 35 minutes. The questionnaire was applied individually in a reserved environment chosen by the participants.

The technique of content analysis in the Thematic modality was used to analyze the data,⁷ based on the Theory of Diversity and Universality of Cultural Care (TDUCC) by Madeleine Leininger (1925-2012). This theory recognizes that cultural factors influence the health-disease process and, as a tool, it makes professional knowledge and practice to become culturally grounded, conceptualized, planned and operationalized in the complex context of indigenous and non-indigenous peoples. For this, this theory uses an interrelated set of nursing concepts and hypotheses based on individual and social needs, including manifestations of behaviors related to care, beliefs and values, with the purpose of performing effective and satisfactory care.

Thus, upon completion of social interactions, the empirical material was read and transcribed verbatim. An alphanumeric coding was used for organizing the results and preserving the anonymity of participants. The letter W indicates woman and the numerical element only indicates the order of the discourse in the development of the analysis. Three categories stemmed from this analysis: 1) Perception of health of indigenous women; 2) Self-care to promote health and prevent diseases; and 3) Behavior adopted before health problems.

This study is part of a matrix study entitled "Health Situation of the Paresí" which is approved by the National Ethics Research Council (CONEP) under n° 819.939/2014 and Presentation Certificate for Ethical Assessment (CAAE): 04647412.0.1001.5541. All those involved agreed to voluntarily participate in the research and read and signed Informed Consent Terms (ICT).

RESULTS AND DISCUSSION

Twelve indigenous women aged between 20 and 59 years, with 2 to 7 children, participated in the study. Most of them had complete elementary school, were common-law married, and lived in a traditional Indian home. Most interviewees spent their time

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caring for their families, their children and household chores, as well as handicrafts.

♦ Perception of health of indigenous women

The perceptions about the health-disease process of indigenous women deserve special attention because of the transformation in the roles assumed by women in society, which has a consequent reflection especially in their internal environment, with their people.⁸

In the study, the mention that health gives meaning to life reveals that they understand health as a social issue that goes beyond the biological dimension. Health is intrinsically related to personal and family well-being, and reported as a primordial thing that gives meaning to life.

Having the energy to do the tasks, to do everything. It is to live well (W1).

Health is to feel good, lighter, happier (W4).

[...] It is to be happy with life, to be good with myself (W7).

As the discourses show, the women attribute to the term health meanings that are associated with a set of health promotion actions of psychological and social dimensions. Thus, these expressions constitute a form of social representation of the way of understanding the health-disease process.

The representations of health and disease are not only cultural practices that allow the creation of knowledge, but also the interpretation of the society that produces them. Therefore, knowing the thoughts of an ethnic group make it possible to explain their attitudes, as well as raise possibilities to rethink more effective and strategic health actions, which are often different from those offered by health professionals in the indigenous context.⁹

In this perception, it is clear that the understanding of health is permeated by concepts legitimized and disseminated by science, as well as those legitimized by the tradition of the people.

In this way, each culturally established person or social group can not only know and define the ways in which they experience and perceive their world, but also relate those experiences and perceptions to their beliefs and health practices, which can consequently strengthen the prediction and planning of nursing care.⁵

In this study, although health perception was predominantly seen as essential to living well, some discourses supported the limited concept of health.

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Health is to be without headache, pain in the body, without muscular pain (W3).

To have health is not to get sick (W9).

Health means the person to be healthy (W10).

This thought of health as an absence of disease, widely disseminated among the Western culture, can be observed in other ethnic groups, especially those located near urban areas. These ideas can continue to be fed in an indigenous community that is assisted by professionals with few technical skills and limited perspectives of social anthropology and health. Thus, in a scenario in which the professionals do not have the competence to deal with the vulnerabilities of this group, the consequences can be disastrous, and may influence the emergence or even the lack of perception of new problems.⁴

One of the main obstacles faced in the health care for this population is the non-indigenous assistive culture reproduced by many professionals and managers,⁴ who do not recognize the integrality of the indigenous people within their territory of values, remaining unrelated or in conflict with this plurality. For Cardoso,³ the problems of indigenous health are related to the low resolution of health actions in the local districts, high turnover of professionals, lack of infrastructure, resources and equipment for certain procedures and actions offered by SISDs, as well as the relative lack of integration and of an effective communication system with the other SUS care networks.

Although not enough to prevent recurrence of the various problems faced by the indigenous population in Brazil, the restructuring of indigenous health policies over the last 20 years and the consequent creation of SISDs since 1999 have not only brought the proposal of differentiated attention as one of the basic pillars in the formulation of health care models for indigenous peoples, but also the establishment of how services should be organized in order to ensure such differentiation.²

In the Funasa documents, especially in PNASPI (2002), differentiated attention is defined based on the cultural, epidemiological and operational specificities of this population, considering both traditional therapeutic practices and their articulation with the western biomedical practice.¹⁰

As a way of strengthening cultural aspects, this policy has as one of its guidelines the preparation of human resources to act in the intercultural context, with a special emphasis

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on the training of Indigenous Health Agents (IHAs) as a strategy to improve the health care for this population. The purpose would not be to replace indigenous practices by Westerners, but to increase the indigenous collection of therapies and health care with articulation between different sets of knowledge and aiming, therefore, to improve the quality of life.^{4,10}

However, an evaluative report published on the health policy for indigenous populations in Brazil also indicates that despite the process of districting resulting from the creation of SISDs, the care model implemented in the districts follows the logic of service production. The topographic-bureaucratic concept of health districts as geographic, populational and administrative spaces where the units and services are coordinated still prevails to the detriment of the logic of health demands and problems and the need to reorganize work practices and processes. That is, the model is conceived more as an organizational model than as a care model.^{3,11}

In some speeches, also became apparent health binding care with hygiene, children, food and home.

[...] Having hygiene in the house, especially when it comes to eating. Mainly in the case of people who live in the village, taking care of the garbage around the house, in the village courtyard, taking care especially with the garbage inside the house. Then when my house is clean, I have the house clean, the canister clean (W3).

[Health] is to have a healthy diet, then personal hygiene, of the environment where one lives, is prevention (W5).

Taking good care of the house, of the children, having a good diet (W8).

The concern with basic sanitation, throughout history, has almost always been related to the transmission of diseases, justifying the discourses that emphasized sanitation to obtain health.³ The importance of basic sanitation services in disease prevention is undeniable, especially considering the current scenario marked by serious disparities between indigenous children and other Brazilian children, with a high mortality rate among the first linked to a high prevalence of infectious diseases, nutritional deficits, and poor access to health care services.¹²

However, although sanitation services are fundamental, this is not the only factor to improve the living conditions of the population. Sanitation should be incorporated into a development model that also addresses social issues. The way of living and interacting in this population contributes to the change of

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this scenario, but attitudes such as the incentive to exclusive and prolonged breastfeeding, besides the consumption of indigenous traditional foods and preservation of the environment are often ignored in health care.¹³

Therefore, in the care for this population, the providers should be caution about the frequent actions rooted in the western culture and avoid to exclude the ways in which these subjects care and preserve their health within the community and that are determinant for their health-disease process. Thus, a nursing care aligned with the indigenous culture minimizes violence and violations against the inheritance and patrimony of these peoples.⁹

Therefore, a cross-cultural approach requires mutual learning in which all learn, transform and renew themselves in respect for each other and in the appreciation of human beings in their peculiarities. For this, it is essential the training and improvement of health professionals aiming at actions that articulate the open and participative dialogue focused on the care of the community into the managerial and assistance actions.^{4,14}

♦ Self-care to promote health and prevent diseases

The self-care developed by indigenous populations can be understood through social representations that, in the view of Durkheim,¹⁵ reflect how the group itself thinks about its relations with the objects that affect them.

In this study, although these representations demonstrated care in diverse extensions, their meanings presented some similarity and got closer when they put in evidence the health of the children.

I take care of the children really [...] I avoid that he [son] stays in the river for too long time or that he gets a cold, take the necessary precautions even, so they do not get sick (W1).

[...] I keep the house clean, I make food, I want them [children] to be well fed, so they do not get sick, well, healthier (W9).

Concern about caring for children may be related to maternal sensitivity and protection, as observed in some indigenous peoples who believe that parents are responsible for the disease process of their children, and that illness is a form of punishment in the face of possible failings of the parents.¹⁶

It was also observed that hygiene and cleanliness were mentioned as measures to promote health and prevent disease. Thus, these findings, coupled with the fact that most of the study participants are mothers who dedicate their time to caring for the

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family and the house, refer to the traditional family model in which the woman has clearly defined roles. They, therefore, take on the role of good mothers, always willing, dedicated and responsible for the family space.⁴

Furthermore, the participants recognized that non-indigenous living habits are present in the daily lives of the community, and many of these contribute negatively to the health of their people.

For my daughter I always say, you have to eat little, because it is good for health, although everything that is bad we like, just like she likes a lot of soda. [...] I avoid too much soda for the kids, for my daughter, and that's no use, she likes skinny, but I try to control it, even for us, there at home (W4).

What is the main thing here is soda, right? that's what I said, let's drink it only on weekends (W11).

In some studies it is possible to notice that the westernization of the indigenous culture has caused great impact on the profile of these peoples and has contributed to the epidemic picture of obesity, anemia and hypovitaminoses.^{17,18} Nevertheless, in this study it was possible to verify that the indigenous people are aware and recognize these transformations as a problem and show concern for the search of means to promote health in their families.

Baggio et al.¹⁶ found in their research indicatives of nutritional deficiencies among Brazilian indigenous children in the last years, especially as a result of the incorporation of inappropriate life habits. These findings were confirmed in the present study. Women considered feeding as a fundamental care for health maintenance, and admitted the incorporation of low-nutrient foods and concern with their consumption. It is worth emphasizing that eating habits are learned early in life and that the type of food consumed is strongly influenced by cultural variables.

The change in food consumption among indigenous people towards a sugar-rich and salty diet can be explained, for the most part, by the proximity of the communities to the urban area. This aspect facilitates the access to industrialized products as well as the territorial restriction of these peoples. All these factors have contributed to the substitution of their way of subsistence that included hunting, planting and fishing, as pointed out by the I National Survey of Health and Nutrition of Indigenous Peoples conducted in 2008/2009.¹⁹ It is also possible to see that this new way of life in some ethnicities bring

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risks to future generations, such as dissolution or abandonment of cultural aspects that maintains the roots and balance with nature.^{17,18}

Therefore, nursing professionals play a fundamental role, since they are more present and closer to these territories and have innumerable potentialities for the operationalization of care. In this sense, studies by the American nurse and anthropologist Madeleine Leininger are of paramount importance for the strengthening of nursing, as science and art, appreciating the beliefs, values and practices of the most diverse social groups during their professional assistance, insofar as it offers respectful and meaningful care to individuals within their diversity.²⁰

Transcultural Nursing provides a holistic and comprehensive framework for the coherent care of diverse cultures. A social group is believed to be able to guide the professionals to provide the type of care that they want and need, a fact that requires, therefore, knowledge of the cultural background, besides sufficient training for its effective application.^{21,9}

Thus, it is possible to promote health by adopting practices that are consistent with the beliefs and behaviors of the indigenous community, aiming at a therapeutic care based on the harmony of the popular and the technical-scientific spheres, thus forming a transcultural care.²⁰

♦ Behavior adopted before health problems

Indigenous peoples have peculiar perceptions about health, illness and treatment that are intrinsic to their culture. Their health problems are routinely treated with experienced people from their own community who hold knowledge of the history of the group and have the ability to deal with supernatural forces, the power of healing and prevention, called by many Indians as Shaman or Pajé.¹⁰ Thus, often their ills are taken to the care of this social representative.

The shaman always has their medicines, the pray, they pray at night, there is a leaf that they pass, it indicates the herbs that are right for people [...] (W9).

[...] When we need we give medicine, otherwise we will always treat it with medicine from here. Tea, we bathe with some grasses of the bush that the pajé tells us (W11).

As noted in the speeches, these women continue to use traditional practices, many of which are handed down from generation to generation. They are recognized by the

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community as having the power to restore physical and spiritual health through the use of herbal teas and prayers.

They often choose to be treated first within the community and if the problem is not solved they seek a representative from the group to go the referral health service to receive care from doctors and/or nurses.

Oh, a lot of times, before going to the doctor, we try to give a natural remedy, that we do ourselves, and then if that doesn't solve the problem, we have to take him to the doctor (W5).

Look, here we use some traditional medicines that we, the mother of the people or even we know, and when we need it, we call health professionals, the health base (W3).

[...] We try to solve here in the village; if we can not cure the person, we communicate the pole and then go to town (W8).

These discourses reveal the distinct model of organization and assistance of the indigenous services proposed by the PNASPI that strengthens the ethnic-cultural preservation of this population. This new care model, which can be called "differentiated attention", takes into account cultural, epidemiological and daily specificities, with respect to the system of social representations, values and practices related to becoming ill.³

In this sense, the concept of inter-medicalization was observed. This is considered fundamental for the consolidation of the principles that govern the creation of the sub-system of attention to indigenous health: the recognition of indigenous therapeutic practices, including promoting the articulation of these practices with those of Western medicine.

[...] Here in the village is more the flu, right? Because of this drought, then we have homemade tea, along with the medicine, paracetamol, these basic things (M4).

Oh, a lot of times, before going to the doctor, we try to give a natural remedy, that we do ourselves, and then if that doesn't solve the problem, we have to take him to the doctor (W5).

When there is a need, we give medicine from the city, when that is not needed, we always get medicine from here, tea, we bathe with some weed (W7).

Although the interaction and use of both traditional indigenous medicine and western biomedical knowledge is common, there is still a lack of appreciation of indigenous traditional knowledge in the practices. An example of this is the study by Rissardo et al.²³ in which the practices of care for

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newborns, from the point of view of Kaingang indigenous women, were analyzed and the author was able to conclusively demonstrate a devaluation of native cultural practices, even though the medical knowledge did not replace traditional indigenous care.

Lima et al.²⁴ also found a similar result when analyzing the performance of Family Health Strategy (FHS) nurses in the northeast of Paraíba regarding self-care practices of indigenous origin. According to this author, nurses were unaware of the historical and traditional context of the ethnic groups they assisted and underestimated their practices, vertically dictating other health behaviors from the non-indigenous culture.

Although the evolution of science and its importance in human development can not be denied, one can not fail to see that this is not the only truth to guide human life in society which, before the process of disease, is often mistakenly based in the exclusive strategy of therapeutic processes. Thus, it is necessary to consider that health is not reduced to the field of scientific medical knowledge and that its prospection must take into account the human being in all its historical and cultural context.^{20, 25}

CONCLUSION

This study allowed us to know the perceptions of Haliti-Paresí women on health, evidenced by the adoption of traditional indigenous and biomedical knowledge in the everyday life, which commonly occurs together with a greater appreciation of the popular knowledge applied within the community itself.

The cross-cultural approach of professionals with this population allows preserving indigenous traditions without ignoring scientific advances to improve the health condition, valuing the diversity of beliefs and cultures in the care process. Thus, professionals of different services must be prepared to assist this population that is vulnerable to contact with non-Indian ways and experiences.

Thus, preserving and respecting the traditional practices of these peoples is still a challenge for the health system and entities, which requires further discussion. Therefore, it is essential to know the cultural and social context and the real daily life of indigenous people and their families from the perspective of building a new paradigm to approach the health-disease process. It should be emphasized that training health professionals in higher education institutions regarding anthropological, philosophical and social

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disciplines is still done in a timid manner, and not as something very important. In turn, in the practice, this brings as a result the desensitization and restricted view of a merely biomedical assistance.

Finally, some limitations were observed in this study, among them the sample size and the discussion of a single ethnicity. The authors highlight the need for further investigations on the theme to identify the similarities and differences on the care and relative behaviors to provide new information to guide health managers and practitioners in the planning of actions directed at indigenous people.

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