118 - THE CONTEXT OF INDIGENOUS HEALTH CARE IN BRAZIL

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INTRODUCTION

Indigenous population in Brazil is estimated at approximately 460 thousand people, distributed in 225 indigenous communities, which is equivalent to 0.25% of the Brazilian population according to the National Indigenous Foundation (FUNAI), it is highlighted that this statistic includes only those living on indigenous reservations. A vast ethnic and linguistic diversity that places Brazil among the world's largest, with about 60 isolated indigenous groups of which have no information; 180 languages spoken by these groups, which make up more than 30 different linguistic (BRASIL, 2008).

According to thee National Health Foundation (FUNASA) the indigenous populations are presents in almost all Brazilian states, except in Piauí and Rio Grande do Norte, they live in 579 indigenous reserves territories that are in different situations of land regularization and occupying about 10% of the country. Another proportion lives in urban areas, usually in the suburbs (BRAZIL, 2002). Figure 1 shows that 45% of the indigenous population is concentrated in the North Country region.

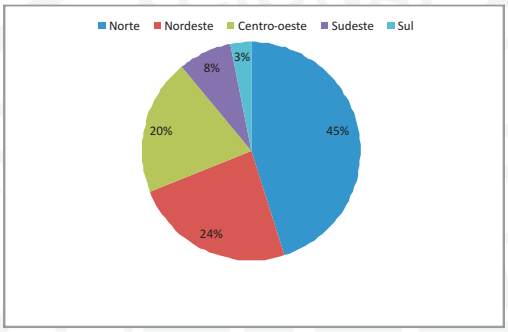

Figure 1 - Distribution of indigenous population according to Regions of Brazil, 2007.
Source: BRAZIL, SIASI/Desai – May, 2008.

These groups are different in framing and social organization aspects, politics, economic, environment interaction and land occupation. Yet, they vary in the time frame and experience in the relationship with colonization and national society expansion (BRAZIL, 2002).

To delivery an adequate health care to these population is important analyze their culture adopting unprejudiced believes, considering the preservation of millenary practice of indigenous traditional medicine as a goal to be achieved.

Respect for indigenous culture is provided by the Federal Constitution Article 231. Also as recognition in this regard, the Ministry of Health through Law 9836/99, add a device to the Law 8.080 of September 19th of 1990, establishing the Indigenous Health Care Subsystem as a component of the Unified Health System (SUS) whose base is the Indigenous Sanitary District (DSEI) designed to protect, promote and restore health, characterized as a local health system (BRASIL, 2002).

DSEIs consist of health unities within the indigenous territories, which rely on the work of the Indian Health Agents (AIS) and the Indigenous Employment Sanitation (AISAN), the primary health care unity has the multidisciplinary staff of Indigenous Health (EMSI), and the Houses Support of Indigenous (CASAI), who support the services of medium and high complexity referenced from health care system (BRAZIL, 2004). In some situations, there are health unities in villages that include permanently the EMSI.

The National Health Foundation (FUNASA) is the organization responsible for coordination, standardization and implementation of actions toward indigenous health care, States, municipalities, governmental and non-governmental organizations (NGOs) can act as a complement on implementation of actions (BRAZIL, 2004).

Concerning to social control, Langdon and Diehl (2007) report that this was an important issue coming by the new model of care was the indigenous participation, where communities had to be organized as Health Councils and hold regular meetings.

Still, according to the National Health Foundation (BRAZIL, 2002) actions and services toward the health of indigenous people must comply with the specific legislation, and must follow the principles of decentralization and regionalization hierarchy adopted by SUS, considering the local reality and cultural specificities of indigenous peoples. It suggests that the Indigenous Healthcare Subsystem has based 34 DSEIs, whose geographical boundaries should include demographic, ethnic and cultural aspects.

From the 2000 Demographic Census it was possible to known the reality of many indigenous communities. They still have low literacy rate, especially among the residents of the reserves. They had a typical situation of high birth and mortality. Poor sanitation conditions in villages. The most common types of sanitation are rudimentary fossa, ditch, river, lake or sea, which indicates a situation of absolute insecurity regarding the sewer system.

This study analyzes the health care toward indigenous people through articles published on this subject in 2008 and 2009, aiming to identify the contextual aspects of health care. It parts from reality of health care practice inside indigenous communities until the national Health Indigenous Subsystem.

METHOD

According to Beya (1988), the integrative review allows a construction of an outline about the thematic under investigation, when well conducted can demand the patterns of a primary research in regarding to clarity, accuracy and replication. It is a method of analysis that combines theoretical or empirical prior in order to promote a better understanding of a

phenomenon or a particular problem (WHITTEMORE and KNAFL, 2005).

The study followed the analytical model of Ganong (1987) who set forth a guideline to develop an integrative literature review. The process suggested by Ganong, Table 1, follow six rounds: chose a phenomenon for the review, select the studies to constitute the sample, define the primary research reviewed, analysis of findings according to inclusion criteria pre-established; interpretation, discussion and dissemination of results.

Table 1 – Guideline for conducting an integrative review set forth by Ganong.

Guideline for conducting an integrative review
• Decide on the purpose of review and formulate a question (or phenomenon); • Establish tentative inclusion criteria; • Conduct a literature search; • Develop a questionnaire or tool for the selection of studies; • Read the articles using the tool or questionnaire; • Data analysis and dissemination of results.

Source: Ganong (2007).

This study followed the rounds: identification of a phenomenon and aim of the study, defining inclusion criteria of articles, representation the characteristics of the original research, analysis of data from the articles included, interpretation of results and publication of the review. Then we analyzed the various contexts of the subject using theoretical references of Hinds, Chaves and Cypress (1992) that characterizes the context in four nested contextual layers (immediate, specific, general, and meta contexts)four-dimensional distinct from each other addressing since the particular significance to the universal.

To start, an identification of the terms with data of BIREME according to the classification of the Health Sciences Descriptors (DECS), the term was used as tool to research in the electronic databases, studies were included in accordance to some criteria: writing in Portuguese, English and Spanish, and having at least the abstracts available for the identification and full-text articles for the analysis phase in the years 2008 and 2009.

The search for studies undertaken in the electronic databases of SciELO and LILACS using the descriptor 'Indigenous health', to identify the literature on indigenous health care in Brazil, generating the study sample.

It was designed a tool based on the protocol by Polit, Beck and Hungle (2004) considering the study title, year, authors, type of analysis used in the study, key words, the place where the study was developed (in this case, Brazil), objectives of the articles, subjects, results and conclusion. This process initially selected 32 articles, at the end; only 09 met the criteria for inclusion in the review. Data analysis followed in accordance with the theoretical references already proposed.

Based on Hinds, Chaves and Cypress (1992) the immediate context focus on the present, in a happening act, these aspects can facilitate the foresee behavior patterns in one situation. Concerning the specific context, it involves immediate and past, both related to relevant aspects of the present situation. The general context constraints the life references from the individual grounded with their interpretations achieved through delayed and current situations. Finally, the meta context is a source dimension of knownledgment socially constructed, and continuous, it results in a shared social perspective.

RESULTS

The 9 articles were written in 4 different regions of Brazil (Table 2), all studies were available in full text and were classified and analyzed according to the context discussed.

Table 2 – Distribution of articles according to the regions of Brazil, 2008-2009.

Country Regions	Articles (n)
South	3
North	2
Southeast	3
Midwestern	1
Total	**9**

From the sample of 9 studies included in the review, 5 reported questions about morbidity of indigenous, showing that some diseases are not common among these groups, such as the low incidence of breast cancer among Indian women despite having little knowledge about the disease (SILVA, 2009).

Others addresses on most noticeable disease, the study of Imbiriba (2009) is an epidemiologic profile of cases of leprosy reported in Indigenous communities in three municipalities of the Amazon revealing that paucibacillary cases predominates among indigenous and non-indigenous, also the study of Kuhl (2009) outlines the nutritional factors associated with malnutrition among indigenous children of a certain reserve in Parana, showing that there is a deficit in anthropometric measurements in a considerable portion of these children.

The child health is deprived according to Pena and Heller (2008), their study shows that the poor sanitation conditions of the indigenous population in Minas Gerais lead to a high prevalence of endemic diseases such as worms, diarrhea and infectious skin diseases, directly reflecting on the health of children of these communities. In another study, in the indigenous community of Minas Gerais, Dumont et al (2008) states that a large number of people there did not need much dental treatment, but among the problems found, the dental caries was the most prevalent.

Two studies address the cultural aspects that affect directly the way of treating health and disease, for example, people from Rondônia state adopt polygamy and interethnic marriage, uses method of confinement for girls entering menarche, prohibit sex during pregnancy and up to one year after the birth of son, to have many children and produce much milk is extremely important for this group as shown Valencia (2008). And people Guarani and Kawioá from Mato Grosso do Sul attribute different causes for diarrhea in children leading to a change in the choice of treatment (ADORNO, 2008).

One study (FONSECA, 2009) reflects on indigenous collective health, adding the weaknesses of the government policies that prioritize curative action than the expense those of preventive. Finally, Puttini (2008) provides a discussion and reflection on shamanism as an object of scientific concept formed between medical practice and religious practice.

DISCUSSION

Most studies revealed concern on biological problems that affect these communities, implying that the daily practices of health in indigenous areas is still focused on the immediate and specific context, which are tied to the overall context and meta context.

The reality of communities is reported in studies as still fragile; with poor sanitation and housing, contributing to the prevalence of intestinal worms, skin diseases, diarrhea and infectious diseases like leprosy in some regions, and children with

low anthropometric measures.

On the other hand, diseases like breast cancer can be considered rare among this population, maybe because some cultural aspects acts as protective factors against the disease. The high parity and long duration of breastfeeding is considered one protective factor (SILVA, 2009).

It is perceived in the specific context that health actions should be performed in accordance to culture and legislation. That ensures the rights to respect and preservation of indigenous customs. The health practices in a multidisciplinary team should include local midwives and shamans with their practices and knowledge. These should be aggregated and be in agreement with the biomedical model.

The caregiver should understand the local system of health disease and cure. Thus, negotiation and adaptation will be possible. The study from Adorno (2000) about children of Guarani and Kawioá indigenous in Mato Grosso do Sul state, show that professionals should not consider only the biomedical perspective, but also dialogue with perception and indigenous practices. It helps to identify disease causation, in establishing the diagnosis and treatment especially the coexistence of these practices in the local context. The dialogue with the traditional practices of health is shown as a positive aspect for Public Health (PUTTINI, 2008).

Valencia (2008) studies constraint on the general context because it brings very diverse cultural indigenous aspects. These aspects can lead to conflicts when confronted to the health professional culture. The FUNASA (2004) report one of the benefits of such interaction is the different way to see the own social culture. The cultural aspects are essential to formulate the meta context. It is the health policies that valorize the indigenous people and ensure project and programs with ethnic specificity.

In a reflection on indigenous collective health, Fonseca (2009) reports that the entire existing institutional framework is well structured and there are no shortage of financial resources. Indeed, there are management problems, the lack of transverse strategy policies for raising the potential for indigenous health, drawing from his position of total dependence on government

CONCLUSION

The integrative review in this study, remarked some studies reporting that the principals of differentiated health care include the needs of these people. They were well prepared as document; however, these principles are still far from becoming reality.

The Indigenous Health is a complex theme, and sometimes controversial. Thinking about Indigenous health immediately report to traditions, languages, customs, healing rituals, shamans, legends, myths, medicinal plants, among other social elements that belong exclusively to indigenous peoples. The selected studies portray a little of this reality. It makes realize how complex is the health care to these people. Yet, how much still needs to be done to fulfill what is written.

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THE CONTEXT OF INDIGENOUS HEALTH CARE IN BRAZIL
ABSTRACT

The health care practice in indigenous health carries the health staff to a very different reality. It is unlike that reality of professional and personal education, mainly when the issues are cultural diversity, ethnicity and specific legislation. A set of law that guide the indigenous questions and need be shaped to health care delivered to these populations. This article intends identify, synthesize and analyze the contextual aspects of indigenous healthcare in Brazil in 2008 and 2009. This article is a report of an integrative review about the indigenous health in Brazil. Searches were made in electronic database of the SCIELO and LILACS using the terms 'indigenous health'. The contextual analysis divided in four nested contextual layers (immediate, specific, general, and meta contexts) was used as theoretical reference. Nine articles were included and were analyzed in accordance to the theoretical reference. Results revealed that the life conditions and health of indigenous people are still in disadvantage. It makes the health staff work in an immediate context to attend the specific needs of the population. Despite having an ideal policy and resource available, the indigenous healthcare bumps up in management problems and lack of a transversal policy.

KEY WORDS: Indigenous health; Context; Brazil; Nursing.

LE CONTEXTE DE L'ATTENTION A LA SANTE AUTOCHTONE AU BRESIL
RÉSUMÉ

L'action sur la santé des autochtones transporte l'équipe de santé à une réalité très éloignée de celle de sa formation personnelle et professionnelle, notamment en ce qui concerne les diverses cultures, les ethnies et les lois spécifiques qui régissent les questions autochtones et qui, dans une certaine mesure, modèlent la forme des soins de santé consacrés à ces populations. Cette étude propose d'identifier, synthétiser et analyser le contexte des soins de santé chez des populations autochtones au Brésil. Il s'agit d'une revue intégrative qui concerne l'attention à la santé des autochtones au Brésil à travers une recherche d'articles dans des bases de données électroniques, SCIELO et LILACS, en utilisant le descripteur « santé autochtone », ayant comme référentiel théorique l'analyse contextuelle dans quatre dimensions interactives (immédiat, précis, général et meta context). L'échantillon final fut composé de 09 articles qui furent analysés selon le contexte considéré. Les résultats montrèrent que les conditions de vie et de santé des peuples autochtones sont encore précaire, menant l'équipe à agir d'une façon immédiate pour répondre aux besoins ponctuels de la population. En dépit d'avoir une politique idéal et de disposer des ressources, l'attention aux autochtones est gênée par les problèmes de gestion et le manque d'une politique transversale.

MOTS CLÉS: Santé autochtone, contexte, le Brésil, Soins Infirmiers

EL CONTEXTO DE LA SALUD INDÍGENA EN BRASIL
RESUMEN

Las prácticas en la salud indígena llevan el equipo de salud para una realidad muy diferente de aquella de su desarrollo personal y profesional, especialmente con respecto a las diversas culturas, etnias y las leyes que rigen las cuestiones indígenas y, en cierta medida la forma de atención de la salud para estas poblaciones. Este estudio propone identificar, sintetizar y analizar el contexto de la atención de la salud indígena en Brasil en 2008 y 2009. Se trata de una revisión integradora que aborda la atención a la salud indígena en Brasil con búsqueda de artículos en bases de datos electrónicas de SciELO y LILACS mediante el descriptor 'salud indígena', con el análisis teórico del contexto interactivo en cuatro dimensiones (inmediatas, concretas, generales y metacontexto). La muestra final estuvo compuesta por 09 artículos que fueron analizados de acuerdo con el contexto discutido. Los resultados mostraron que las condiciones de vida y la salud de los pueblos indígenas siguen siendo precarias llevando al equipo a actuar en un contexto inmediato para satisfacer las necesidades específicas de la población. A pesar de un ideal político y la disponibilidad de recursos, la atención a los indígenas encuentra unos tropiezos sobre los problemas de gestión y la falta de una política transversal.

PALABRAS CLAVE: Salud Indígena; Contexto Brasil; Enfermería.

O CONTEXTO DA ATENÇÃO À SAÚDE INDÍGENA NO BRASIL
RESUMO

A atuação na saúde indígena transporta a equipe de saúde para uma realidade muito diversa daquela de sua formação pessoal e profissional, especialmente no se refere às diversas culturas, etnias e leis específicas. Legislação que rege as questões indígenas, e que de certa forma modela a atenção a saúde destinada a essas populações. Este estudo propõe identificar, sintetizar e analisar os aspectos contextuais da atenção à saúde indígena no Brasil em 2008 e 2009. Trata-se de uma revisão integrativa que versa sobre a atenção a saúde indígena no Brasil com busca de artigos nos bancos de dados eletrônicos, SCIELO e LILACS usando o descritor 'saúde indígena', tendo como referencial teórico a análise contextual em quatro dimensões interativas (imediato, específico, geral e metacontexto). A amostra final foi composta por nove artigos que foram analisados de acordo com o contexto abordado. Os resultados mostraram que as condições de vida e saúde dos povos indígenas ainda são precárias levando a equipe a agir em um contexto imediato para atender as necessidades pontuais da população. Apesar de ter uma política ideal e disponibilidade de recursos, a atenção indígena esbarra nos problemas de gestão e a falta de uma política transversal.

PALAVRAS CHAVES: Saúde indígena; Contexto; Brasil; Enfermagem.

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