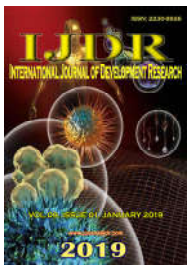
ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 09, Issue, 01, pp.25140-25144, January, 2019



ORIGINAL RESEARCH ARTICLE OPEN ACCESS

INCLUSION OF INDIGENOUS HEALTH WITH EQUITY IN CARE NETWORKS TO PARA HEALTH

[1]Rosiane Pinheiro Rodrigues, [2]Danielle Emmi Tupinambá, [3]Laura Maria Vidal Nogueira, [4]John Kennedy Ampuero de Noronha, [5,*]Milene Gouvêa Tyll, [6]Tatiana Menezes Noronha Panzetti, [7]Virginia Mercês Lara Pessoa Oliveira, [8]Marcia Andrea da Gama Araújo, [9]Simone Daria Assunção Vasconcelos Galdino, [10]Clarissa Porfirio Mendes, [11]Nathalie Porfirio Mendes, [12]Margareth Maria Braun Guimarães Imbiriba, [13]Maicon de Araujo Nogueira, [14]Hallessa de Fátima da Silva Pimentel and and [15]Regina Fátima Feio Barroso

[1]Nurse. Doctorate in Sciencesofeducationandhealth, Master in Health, EnvironmentandSocietyoftheAmazonbythe Universidade do Pará Federal University Professor oftheStateUniversityof Pará, Belém, Pará, Brazil
[2]Dr. in Dentistic. Profa. Adjunctofthe Federal Universityof Pará (Instituteof Health Sciences - ICS). Belém, Pará, Brazil
[3]Nurse. Dra. In nursingby Ana Nery School - UFRJ. Professor at the StateUniversityof Pará, Belém, Pará, Brazil
[4]Philosophy from the UFPA and Court of Justice of Pará, Belém, Pará, Brazil
[5]Nurse. Doctorate in Sciences of education and health. Master in environmental and health sciences, PUC / Goiás. Professor at the University of the Amazon. Nurse of the coronary unit at the Gaspar Vianna Clinics Hospital. Belém, Pará, Brazil. E-
. [6]Nurse. Doctorate in Sciences of education and health. MSc in Nursing from the State University of Pará. Professor at the University of Pará State University and Integrated Faculty Brazil Amazônia. Belém, Pará, Brazil
[7]Nurse. Doctorate in Educational Sciences and Health. Professor UNIFAMAZ and Cosmopolitan College. Belém, Pará, Brazil.
[8]Nurse. Doctorate in Sciences of education and health. Master in teaching health in the Amazonby UEPA. Professor of UNIFAMAZ. Belém, Pará, Brazil
[9]Nurse. Doctorate in Sciences of education and health. Master in management and planning of heal ths ervices by FSCMPA. LectureratCosmopolitanCollegeand ESAMAZ. Belém, Pará, Brazil
[10]Nurse. Master in Nursing. Nurse manager of the surgical clinic at Ophir Loyola Hospital. Belém, Pará, Brazil
[11]Nurse. Master in nursing. Professor at the University of the Amazon. Nurse atthe Hospital Pronto Socorro Mario Pinotti. Belém, Pará, Brazil
[12]Nurse. Master in nursing. Professor at the University of the Amazon. Nurse of the Secretary of State for Public Health. Belém, Pará, Brazil
[13]Nurse. Master in Teachingand Health at the Amazon by State University of Pará. Professor of Amazônia University, and State University of Pará. Belém. Pará. Brazil
[14]Nurse. Master in Collective Health - University of Pará-UFPA. Specialist in Women's and Children's Health - UEPA. Professor at the University of Amazonia(UNAMA). Belém, PA, Brazil
[15]Dra. In Social Dentistry. Full professor at the Federal University of Pará (Institute of Health Sciences - ICS). Belém, Pará, Brazil

ARTICLE INFO

Article History:
Received 22nd October, 2018
Received in revised form
19th November, 2018
Accepted 26th December, 2018
Published online 30th January, 2019

Key Words:

Public Health Policies, Health of indigenous populations.

****Corresponding author: Milene Gouvêa Tyll***

ABSTRACT

The objective of this study was to verify health actions and services directed to the Guama Tocantins Indigenous Special Health District included in the Health Care Networks (RAS-Redes de Atenção à Saúde) of the state of Para,evaluating the perception of the coordinators of the health care networks as well as of the indigenous health managers of Para, on the implementation of these actions and services in the regional plans of the four RAS (stork, urgency and emergency, psychosocial and people with disabilities) seven health regions, which encompass the Guama-Tocantins DSEI. The study was developed based on a qualitative and descriptive research using content analysis, based on semi-structured interviews with the state actors involved in the implementation and implementation of RAS and the federal managers responsible for the indigenous health policy in the Sanitary District Indigenous Special (DSEI - Distrito Sanitário Especial Indígena) Guama - Tocantins (GUATOC) of the State of Para. The obtained results express the absence of actions and services that guarantee the equity of the access to the natives in the RAS. Thus, there is an urgent need to qualify professionals for health care that respects the ethnic and cultural aspects of these peoples and especially that there is integration between the RAS managers and the DSEI managers in the planning and implementation of the actions and services, continuity of care from basic care to medium and high complexity.

Citation: ***Rosiane Pinheiro Rodrigues, Danielle Emmi Tupinambá, Laura Maria Vidal Nogueira et al.*****, 2019.** "Inclusion of indigenous health with equity in care networks to para health", *International Journal of Development Research*, 09, (01), 25140-25144.

INTRODUCTION

ndigenous Health in Brazil has a history of achievements from the 1986 health conferences and the national conference on Indian health protection, which significantly influenced the 1988 Constitution, with the legal guarantees to indigenous peoples and the construction of the System Health, which in turn would provide the basis for the creation of the indigenous health sub-system, based on the Sergio Arouca Law of 1999 (Garnelo and Pontes, 2012). From the creation of the Special Secretariat for Indigenous Health (SESAI- Secretaria Especial de SaúdeIndígena) in 2002 by the Ministry of Health (MS-Ministério da Saúde), there was a reorganization of the decentralization processes for the Indigenous Special Sanitary Districts (DSEI), in order to favor actions and services to the resolution. A major challenge for the consolidation of indigenous health policy is the social and political problems experienced by the population itself, with repercussions in the national media, with particular emphasis on the health situation (Garnelo and Pontes, 2012).

MATERIALS AND METHODS

A qualitative and descriptive study based on interviews of the actors involved in the implantation and implementation of the SAR Plans, which included eight health regions, members of the Guama - Tocantins Indigenous Special Sanitary District (GUATOC) of the State of Para, highlighting two technicians linked to the DSEI and five linked to the State Secretariat of Public Health of Para. In order to preserve the confidentiality of the interviewees, they were identified by the names of 7 (seven) ethnicities belonging to the GUATOC DSEI (Tembé, WaiWai, Xikrin, Assuriní, Zoé, Suruí and Gavião). The analysis of the data was performed using a technique by Bardin2, which proposes to make a content analysis, in a judicious way, allowing to categorize the themes of this study into four main axes, namely: the state of the art of the plans of the RAS; anthropological knowledge; implantation and implementation of RAS; integration and management. The research was carried out with the authorization of the Research Ethics Committee of the Health Sciences Institute of the Federal University of Pará, under the opinion of No. 1,906,305, obeying all ethical aspects according to resolution 466/2012.

RESULTS

Description of the four major axes categorized: the state of the art SAN plans; anthropological knowledge; implementation and implementation of SANs; integration and management.

The State of the Art of RAS Plans: The participation of the state coordinators of the health care networks and of the DSEI itself is still a great challenge in the construction of actions focused on indigenous health, because it is perceived a certain difficulty of participation of the great majority in the meetings and with this a fragility in the process of listening to the specificities of this people. It was perceived that actions aimed at indigenous health were not planned in the Ministry of Health's own guidelines, reflecting in this way the lack of attention to indigenous peoples, especially when reporting on basic issues such as lack of training and articulation of the DSEI with essential policies such as emergency and people with disabilities, but it was also evident that even in the face of this fragility in the planning of actions in the regional plans, during the implementation and qualification of the teams in the SAN, the State has been adding forces to develop skills and competences through technical cooperation of successful experiences, as observed following the lines below

> [...] I did not attend the meetings "(Hawk).
>
> […] Unfortunately I was not in the coordination "(Tembé).
>
> [...] In all these plans there is no planned activity taking into account the specificity of the indigenous population. (Xikrin).
>
> [...] The DSEI was not consulted in the preparation of the plan. (Hawk)
>
> [...] if you take the diagnostic matrix that is proposed by MS, it does not stratifies nothing "(Zoé).
>
> [...] It does not exist specifically for the indigenous population. It is as a whole for the population of the state of Pará (WaiWai).
>
> [...] The natives do not receive any specific kits that the program itself provides, nor do our teams receive any type of training. (Hawk)
>
> [...] With regard to the program of the person with disabilities we do not have any agreement, nothing is accomplished. (Xicrim).
>
> [...] We brought as an idea the process of construction that we were doing here in our workshops, which was the companion of the baby, which was an interesting work of the Dr. Zeni in Maranhão, that she shows that there was an Indian who was inside the ICU and they had the escort the way they wanted to have.
>
> [...] Alas, we brought this speech into the Holy House so that we could show them how there was respect. (Zoé)
>
> "... axis 2, it is the qualification of the professionals how to work the power of this network in the sense of the empowerment of the same knowledge, of sharing of knowledge, exchange of knowledge and etc. And within this axis, in fact we have 4 axes and from this qualification we saw the major focus for this issue of indigenous health (Assurini).
>
> [...] it was up to us to work was the question of the qualification of this professional in this reception (Assurini).

The subsystem developed for some indigenous people of other ethnicities indicates vulnerability in the planning of actions, even with the participation of the leaders of the Indigenous Health Council (CONDISI- Conselho Distrital de SaúdeIndígena), the reading of the reality of these peoples is still incipient (Oliveira *et al*., 2012). This initiative helps to strengthen the differentiated look of teams of medium and high complexity, since basic care already receives this qualification by the DSEI, as recommended in the national policy of

indigenous peoples. However, this implementation demonstrates that there is a huge gap between what is stated and formalized in the plans elaborated according to the regulations and what actually occurs in the daily services and in the flow of users (Vargas *et al*., 2010). The current model does not contemplate and does not promote the articulation between traditional systems of cures that are presented as one of the main, if not the main health care resource in indigenous communities, although there is already a policy focused on integrative practices (Oliveira *et al*., 2012). Working the qualification of professionals offering care is of extreme relevance for equitable attention, so the flexibility of the two practices is paramount for health professionals, Indians and non-Indians to elucidate the indigenous conception in the health-disease process (Oliveira *et al*., 2012). The insertion of indigenous health has been a process of conquest, since the participation of the DSEI in the construction of plans is still small. Because of this, actions and services are still fragmented, dubious and little recognized in the various plans.

Anthropological knowledge: A plurality of customs among the different ethnic groups of indigenous peoples was perceived, which promotes an important cultural shock, capable of knowledge and understanding to support and support all. Despite the responsibility of the DSEI for basic care, this does not diminish the commitment, cooperation and solidarity between the federated entities, because in a network construction, it is necessary to guarantee continuity of care in the levels of attention, as highlighted in the following statements:

> "[...] networks are generally not made for certain ethnic groups. It is the same network [...]. Because there are several questions: there is an indigenous who is in the village, and there is indigenous people in the population in general. There is no specific clipping [...]. Because, for example, for us a person who tries to kill himself, this for us is suicide and this is a symptom linked to the depressive process. The other is a spirit that has been sent by an enemy party to kill that person. It is not the person who kills himself, some ethnicities think so [...] "(Assurini).

> "... where the Indian is seen, be worked not only in the DSEI, because we know that we have the villages and that these are directly linked to the attention of the DSEI. But we have the non-villagers who enter the system as a citizen (Tembé).

> "The indigenous population we put as a whole: the person with a disability. There is no class, no race, no creed, there is a person with a disability and we trace the goals that they have the same right as any other "(Gavião).

> "In all these plans, there is no planned activity that meets the specificity of the indigenous population. This population, when it can be inserted in some of these networks, they participate as ordinary users and do not meet the specifics of this population [...] "(Xikrin).

The contradiction of medical practices and traditional beliefs of healing are paradigms that also need to be better worked and inserted in the training of health professionals so that anthropologically they know how far and can go from the knowledge of the culture of these peoples.[5] The concept of interculturality highlights the need for cultural adaptation of the health services for the understanding of a pluri-ethnic and multi-cultural Brazil (Athias, 2016). It is relevant to review concepts and legislation that support the insertion of actions according to the ethnic-cultural specificity of indigenous people, where the coordinators of the RAS review what is provided in the constitution and other indigenous policies to promote equity and in fact recognize the differentiated needs of the various ethnic groups (Athias, 2016). The recognition of the inequality between people and social groups and the recognition that many of these inequalities are unjust and must be overcome is a key factor for the notion of the equity of peoples (Teixeira, 2011).

Integration and management: It is possible to recognize the vulnerability in the integration between the coordinations of the state SANs and the DSEI, this little cooperation between the State and DSEI regarding the access of the indigenous hampers the process of standardization of actions aimed at the health care of these peoples, since some networks of attention have singular advancement as the stork network and the psychosocial, others not, as described in the reports below:

> "Because I need to know how they are conducting within the communities what is being done for the indigenous children ... here it is of the SESAI and the state does not come here" (Zoé).

> "The primary care part is not ours ... it's the federal government. So, it only comes to us when it already starts for medium and high complexity [...] "(Assurini).

> "The psychosocial network is one of the networks, taking the stork network, which has the best connection. But, we have nothing officialized within the program, too, for the specificity of the indigenous. All that we end up doing are articulations, on the basis of friendship, of convincing together with the municipal health secretaries "(Xikrin).

> [...]. Regarding the network to the emergency and emergency plan also, we do not have this resource, since no ambulance has access to our villages, because they are places of difficult access. So, when we need it, we do the DSEI transportation. Going to CASAIs and inside CASAIs is that we can do some articulation with the emergency and emergency network. (Xikrin) "[...]. The psychosocial network is one of the networks, taking the stork network, which has the best connection. (Xikrin)

> "But we participated at least in the discussions, striving for at least the indigenous population to be inserted in these other plans .... Only in relation to the stork and psychosocial network did we have an effectiveness in the elaboration of work and care processes in the health services "(Suruí).
> [...] I think that each coordination has a guideline, a directed plan (Hawk)

> [...] In the directive of ordinances is there; Reduced mobility. Older people enter as reduced mobility, regardless of whether they are indigenous or not. Now it is not specifying elderly, reduced mobility we know that are people with locomotion difficulties are inserted, the indigenous also [...] "(Hawk).

> [...] This coordination has the pretension of doing an integrated work with the other coordinations, mainly with the urgency and emergency that we know is a large number of indigenous people who even need urgency and emergency care "(Tembé).

The state affirms that in this process of the indigenous AIDIPI SESPA does not enter and also that the basic attention is of the DSEI. The latter in turn reports that the only network where there is a small initiative is with the stork and the psychosocial network, but nothing official and that depend on articulations with the municipal managers. Thus, according to MS, it is fundamental to put into practice a complementary and differentiated service organization based on the protection, promotion and recovery of health, which guarantees the Indians the exercise of their citizenship (Funasa, 2002). These networks in the indigenous lands are the points of attention of the DSEIs, who alone in the basic attention will not take care of offering actions and services according to the ethnic and cultural necessities of the natives. Needs need to be considered, because when it comes to indigenous communities, we return to the discussion about the ethical, cultural pluralization of Western sanitary practices and their linkage with indigenous health systems (Diehl and Pellegrini, 2014). The systems and programs developed to provide assistance to the indigenous need to resolve structural and financial situations, which greatly contribute to the discontinuation of health actions (Athias, 2016). The emergency and emergency network does not reach or understand the need to build strategies for such care in difficult-to-reach communities, with the DSEI (which offers basic care) responsible for the removal of this indigenous person to the nearest CASAI and thus contact the high complexity network. But, if you consider what Decree 7.508 / 2011 establishes, how will the resolution and timely access provided for in that legislation be given? It is necessary to consider what was proposed in the regional planning of SANs, to consider that management does not mean creating strategies, but recognizing their emergence and intervening at the right moment (Vargas *et al*., 2010).

Since SUS is the ratification of the State's duty to finance, organize and manage an extensive method of health care, with universal coverage to all individuals in this area 5, the deployment of the service network to indigenous groups must also be considered. This requires inter-sectoral actions aimed at the community-based elaboration of knowledge, languages and practices among the innumerable spheres involved in the elaboration, implementation and evaluation of the assistance elaborated for indigenous peoples in an attempt to produce innovative solutions (Oliveira *et al*., 2012). In relation to the stork and psychosocial network that were identified with a singular effective support, small advances are considered. However, it is still very necessary to qualify for the needs that indigenous health still faces, despite being a historical people in our society, in the current conjuncture we still see an explicit denial of Brazilian ethnic and cultural diversity (http://www .congressoanterior.redeunida.org.br). It is necessary to carry out various articulations and forms of persuasion to guarantee indigenous access to health goods and services, and it is necessary to guarantee a flow from the DSEI health post, with access through regulation and thus to have health care as any citizen of law (Molina Adnfn ?). The policy of the disabled person is based on regionalization guidelines, but does not consider the specificities that a handicapped person can have: being a quilombola, being a quilombola or even indigenous, which will be different from the approach for a non-indigenous user. I would also like to point out that SESAI also needs the other secretariats of MS to mainstream indigenous health into all policies, since there are indigenous people in all life cycles and soon they will need to be cared for in a fair, dignified and egalitarian way, considering all these aspects. Since "indigenous health policy varies from State to State, not only in the elaboration of the principles guiding the legislation, but also in the implementation of these principles by the institutions in charge of meeting the needs and demands of the Indians" (Mateus, 2017). Politics cannot be incongruent with the reality in which these people live, although their culture is differentiated from the others, they need the same equality of rights in relation to health as the others, with a closer follow-up of professionals who promote and guarantee health from primary to tertiary care, aiming not only for the curative process, but also for health promotion, as advocated by SUS in its entirety (Oliveira *et al*., 2012). It is significant that management is in fact integrated in a perspective in which the state coordination of the networks of attention can listen to the state coordination of indigenous health and thus, to have the indigenous peoples contemplated in the SAR plans, so that we can improve and modify the reality experienced by indigenous peoples of having only access to curative health, thus highlighting the attention to high complexity, leaving aside the magnitude of low complexity care that involves the promotion of health (Garnelo and Pontes, 2012).

Conclusion

It is necessary to make managers aware of the urgency in the qualification of professionals of low, medium and high complexity in relation to indigenous culture, as well as the implementation of networks in an equitable way by the state coordinations of SAN, since it is evident the development of some actions in the SAR plans, but without an effective implementation focused on what is proposed in the national indigenous health policy. The real needs of indigenous people are not taken into account and the attention provide is insufficient to guarantee the access of these peoples, since bureaucratization makes legal access difficult, thus necessitating a more organized, flexible flow chart compatible with the needs and demands of these peoples. peoples, as recommended by the SUS, in an equal way to all. Therefore, it is possible to consider that the non-integration between the spheres of government regarding the planning and implementation of the policies directed to the natives is historical. However, the Constitution of 88, the 8th National Health Conference, the National Policy of Indigenous Peoples, the SérgioArouca Law, among other legislations, are immensely based on the need for integrality, equity and universality, which must be pursued through tripartite integration and between the points of attention, foreseen in the own decree of the health care networks 4,279 / 2010 and Decree 7.508 / 11. The roles between state and DSEI can occur through dialogue through state coordination of indigenous health, which can mobilize the discussions from the needs of these peoples. It is necessary, therefore, to establish the connection between the points of attention, offered in the basic attention by the DSEI with the attention points of the medium and high complexity, of the responsibility of the municipalities and the state, through the regulation and constructed flows, that consider the distances and diversities of the villages, as well as the qualification of this professional to assist him in his

specificities. Consider this we conclude that it is of extreme relevance to consider how public policies are being elaborated nationally, since the diversity of the state is immense and for a continental state like Pará, which has 13 health regions with diverse realities, this will not be different for the indigenous population of the GUATOC DSEI. In this sense it should be noted that the plans of the attention networks do not have actions that take into account the specificities of these peoples.

REFERENCES

Athias, RM. 2016. Health services and indigenous populations. Collective [internet]. 2011 mar-abr [accesson May 26,]; (3):[close 3p.]. Availablein**:**http://www.coletiva.org/index.php/artigo/os-servicos-de-saude-e-as populacoes-indigenas/.

Bardin, L. 2011. Contentanalysis. São Paulo: Editions 70; 229 p.

Becker, SG. M. 2009. Dialogue on the health / disease process with Anthropology: interview with Esther Jean Langdon. Rev. bras. enferm. vol.62 nº.2. Brasília.

Brazil. National Health Foundation. National Policy on Health Care for Indigenous Peoples.2. ed. Brasília, DF: FUNASA; 2002. 40 p.

Confalonieri, UEC. 1989. The Unified Health System and Indigenous Populations: for a Differentiated Integration. *Cad Saúde Pública* ,5(4):441-450.

Diehl, EE. and Pellegrini, MA2, 2014. Health and indigenous peoples in Brazil: the challenge of training and permanent education of workers to work in intercultural contexts. *Cad Saúde Pública,* 30(4):867-874.

Garnelo, L. and Pontes, AL. 2012. (Org.) Indigenous Health: an introduction to the theme. Brasília: MEC-SECADI; 280 p.

Indigenous health: Interdisciplinarity, participation and the challenges of interculturality. [internet] 2017; [Access on May 31, 2017]. Available in: http://www.congressoanterior.redeunida.org.br.

Indigenous Peoples and Health: Challenges at the turn of the century. E. Jean Langdon. [internet] 2017; [Access May 31, 2017]. Availablein http://www.antropologia.com.br/tribo/nessi/textos/Margsav.htm.

Mateus AC.Os Aspectos da Interculturalidade da Saúde Indígena: Uma Questão de Participação e interdisciplinariedade. [internet] 2017; [Access on May 21, 2017]. Available in https://googleweblight.com/?lite_url=https://oprofessorweb.wordpress.com/2016/04/01/os-aspectos-da-intercultura lidade-da-saude-indigena-uma-questao-de-participacao-e-interdisciplinaridade/&ei=82 RlpYVP&lc=pt-BR&s=1&m 696&host=www.goog le.com .br&ts=1496265270&sigALNZjWnrx543EiwEsWyXGLqDR780rhifjw

Molina, ADNFN. Guide for the collective construction of the integral response to the necessities and the necessary social management. 39 p. file:///C:/Users/Rosiane/Downloads/DeNegri_Molina%20(1).pdf.

Oliveira, JWB., Aquino, JM. and Monteiro, EMLM. 2012. Promoting health in the Pankararu indigenous community. *Rev Bras Enferm,* 65(3):437-44.

Technical Note 04/2014. The integration of indigenous health in SUS: a proposal of state management. [internet] 2014; [Access May 31, 2017]. Availabe in http://www.conass.org.br/biblioteca/wp-content/uploads/2014/01/NT-04-2014.

Teixeira, C. 2011. The principles of the Unified Health System Salvador, BA; 10p. [Support text developed to support the debate at the Municipal and State Health Conferences in Salvador, Bahia.].

Vargas, KD., Misoczky, MC., Weiss, MCV. and Costa, WGA. 2010. The disarticulation between health care levels of the Bororo in the Polo-Base Rondonópolis of the Indigenous Special Health District of Cuiabá-MT. *PhysisRev. Saúde Colet*., 20(4):1399-1418.

****