Cogitare Enfermagem

ORIGINAL ARTICLE

CONSTITUENT ELEMENTS OF CARE: (DIS)CONNECTIONS THAT CHALLENGE THE INTEGRALITY IN HEALTH FOR INDIGENOUS PEOPLE WITH TUBERCULOSIS*

HIGHLIGHTS

1. Indian Protection Service implements indigenous health experiences.
2. Comprehensive assistance made with the intersection of knowledge.
3. Reception, bond, resolvability, and accountability as constituent elements of care.

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ABSTRACT

Objective: To analyze the production of care, regarding reception, bonding, resolvability, and accountability, for indigenous people with tuberculosis. **Method**: Qualitative study, with systematic observation, document analysis, and semi-structured interviews with health workers and indigenous health management and the municipal health department of Banzaê/Bahia - Brazil. Data triangulation was carried out from interviews, documentary records, and field observation. **Results**: The reception is given when the need for understanding and respect for cultural specificities is recognized, the bond is related to the health worker's culture, the resolvability is hindered due to municipal management, and there are divergences among those responsible for indigenous health in taking responsibility for care. **Conclusion**: Collective actions are necessary between the municipal, state instances and the Special Indigenous Sanitary Districts, regarding the path of the health services network.

KEYWORDS: Preventive Care; Indigenous Health; Tuberculosis; Integrality in Health.

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INTRODUCTION

In Brazil, according to the demographic census of the Brazilian Institute of Geography and Statistics (IBGE)[1], the indigenous population corresponds to 1,693,535 people, which represents 0.83% of the country's total inhabitants. In 2010, the IBGE counted 896,917 indigenous people, representing 0.47% of the country's total residents, which demonstrates the increase in the indigenous population and, consequently, the improvement in search and registration methods for this population with the use of new data collection technologies in the 2022 census.

Brazilian Indians live in 579 Indigenous Lands (IL), distributed in all states, except Piauí and Rio Grande do Norte. Its population is made up of 305 ethnic groups, speakers of 274 languages, having different political, social, and economic ways of understanding, living together, and organizing themselves in the world[2-3].

According to the National Policy for Indigenous Peoples' Health Care (PNASPI), the required differentiated care is presented with the proposal of articulating the health care model, officially instituted with various indigenous traditional practices, in the appreciation and inclusion of this knowledge in the routines of health teams[2].

Despite the advances achieved with PNASPI, it is essential to continue solidifying an inclusive care model that takes into account respect for indigenous people regarding their cultural, historical, and habitual practices, and that promotes the improvement of quality of life[4].

Health care is interpreted as a way of providing health based on more relational productive forms between Health Workers (HW) and users, unique to each territory, built from humanizing actions of the subjects involved in this process, with the aim of building a comprehensive and responsible care model for people's lives[5]. It is defined that the professional dimension of care is guided by elements that, according to their use, confer the ability to produce health care, such as: technical competence of each specific knowledge core; ethical posture of health professionals in seeking to adequately respond to the health needs of users, through the mobilization and rearrangement of care practices in their real working conditions and the ability to create bonds with people who need their care[6].

In this sense[4], "care is the natural ethics of health operators", therefore, it expresses the dedication of the health professionals towards the service users through a set of actions that refer to solidarity, which involves bonds of affection and respect for others, in order to promote quality of life. Producing care lies in the creative capacity to establish new and unique arrangements in health care[7-8] and, in the context of indigenous health, in line with their sociocultural peculiarities. Thus, we understand that the production of care is aligned with the principles of integrality of the Unified Health System (SUS) in which the health system must be organized in a way that ensures everyone has access to services, assuming health as a fundamental right and a responsibility of the State. Furthermore, it requires that the actions of the health system be equitable, aimed at reducing social and economic inequalities[9].

The integrality in health is characterized as one of the guiding principles of PHC and constitutes an important tool for adjusting to the health needs of the population, considering aspects of the health situation diagnosis and the capacity of care units and the organization of the Health Care Network (HCN)[10]. However, the concept of integrality in health care for

indigenous peoples is to ensure access through the ethical call for health practices and the organization of the SUS[11].

However, in this work, we adopt the concept of health care through the notion of integrality in health, using the principles of reception, bonding, resolvability, and accountability as defining arguments, as we understand that it encompasses aspects of user self-care and the organizational and professional dimension in health care[12].

In this direction, we adopt the reception of the indigenous user with TB, focusing on the sociocultural aspect of the health-disease-care process, which considers the subject in their uniqueness and insertion in a society whose phenomena related to cultural and social aspects are inherent to each ethnicity[13].

The analytical determination of bonding, as understood in this work, is characterized by the shift from the territorial constraint of the health team to the link with indigenous users. This approach allows both the relationship of affective interaction and of a moral nature. The affective bond stably and durably connects TS and users by incorporating internal spaces that are occupied by affectively significant people. On the other hand, the moral bond, in which the connection of the HW to the SUS user depends on the professional's awareness as responsible for the user, family, and community, based on the adoption of ethical and moral principles inherent to their professional practice and as a human being[4,6].

Another central aspect that must be guaranteed, being a principle of Primary Health Care (PHC), is resolvability, which represents the ability of the health service, according to its level of competence, to respond positively to the individual and/or collective demands of SUS users, whether at the first contact, or at other levels of the HCN[7,14].

The accountability for health care, by both the team and the management, safeguards the possibility of not rejecting the indigenous user in the SUS and providing a positive response capable of solving their health problems. The combination of caregiving acts with the result of healing, promotion, and health protection is a critical knot that needs to be worked on between managers and HW[8]. Thus, making decisions on aspects related to indigenous health with TB is to give visibility to a serious Public Health problem such as TB, while at the same time revealing the complex scenario of inequality between indigenous and non-indigenous people.

The objective of this study is to analyze the production of care, regarding reception, bonding, resolvability, and accountability, for indigenous people with tuberculosis in the indigenous land of a municipality in Bahia, with a view to contributing to caregiving practices in a comprehensive and integrated manner between health care and management workers.

METHOD

This is a qualitative approach study, therefore it is the method that allows the social to be subject to investigation through the study of its meanings and the understanding of people's actions as social subjects, affirming itself in the field of symbolism and subjectivity[15].

The study was conducted at the Ribeira do Pombal Base Hub, located in the same city and belonging to the 9th Special Indigenous Sanitary District, and in the municipality of Banzaê/BA, where 95% of the Kiriri Indigenous Land is located, consisting of 10 villages. According to the 2022 IBGE census, 2,539 indigenous people from the Kiriri ethnic groups

and a family from the Tuxá ethnic group reside in these villages, corresponding to 21.2% of the municipality's population.

Data collection was carried out between the months of June and August 2018. The research participants were the managers of the municipal health department where the indigenous land is located, managers of the Indigenous Base-Pole, and health workers of the Multidisciplinary Indigenous Health Teams (EMSI). The research participants were intentionally chosen based on their practical experiences in assisting, managing, and coordinating TB control actions. In total, there were nine participants, four of higher education level and five of secondary education level. As an inclusion criterion, we determined that EMSI health workers and managers should work in the TB control service, having at least one year of practical experience. Due to the qualitative nature of the research and the characteristics of the object of investigation, we used semi-structured interviews, systematic observation, and document analysis as data collection techniques.

A semi-structured interview was conducted with an interview script organized based on a guiding question and the four dimensions of the development of health care practice, such as: reception, bonding, resolvability, and accountability. In the systematization of the analysis of the interviews, we followed from categorization, coding, categorization, and analysis and interpretation[16].

In the first phase, we carried out the sorting of the material from the semi-structured interviews to choose the documents to be analyzed. Next, we performed the coding, with the decomposition of the text into units of meaning. In the categorization, the core meanings or recording units were identified, manifested in the study results, in order to give meaning to the analytical dimensions proposed by the study.

Finally, we performed the analysis and interpretation of the data through the treatment of the obtained results and interpretation. At this stage, it is necessary to find concepts that encompass components with shared characteristics and that relate to each other[16].

In systematic observation, we examine the flow of assistance, the programmatic actions of the teams for treatment adherence, the instruments used, and the agents involved in the care process for the indigenous person with TB and their interrelation with the dimensions of care used as a reference for this study.

The data collected during the observation were inserted into the text in conjunction with the other empirical data and theory, without the need for individualized identification. The documentary analysis was carried out by the thorough reading of the Multi-Year Plan, Management Report, Integrated Agreed Programming Report, National Register of Health Establishments, and National Health Fund.

As a method of analysis, we used data triangulation, based on the content analysis of the interviews and the monitoring of the research participants in their daily work during five days of data collection, through the field diary, where we recorded the participants' habits and attitudes. These observations were used to corroborate the information collected in the interviews and documentary records.

The research was approved by the Human Research Ethics Committee of the Universidade Estadual de Feira de Santana under protocol No. 2,524,301 and by the National Research Ethics Commission under No. 2,691,442. All interviewees spoke Portuguese and were able to understand and sign the Informed Consent Form. The researcher's entry into the field was carried out through personal communication about the project's approval by the

Research Ethics Committee (with the delivery of a copy of the opinion), and, consequently, permission to start data collection.

RESULTS

Among the study participants, reception is given from the moment the need for understanding and respect for cultural specificities is recognized, as evidenced in the following converging statements.

[...] indigenous health we know is a differentiated health. So, we professionals who work there, we also have to have a differentiated care. The care, let's say, of a non-indigenous population is one way, the care of indigenous health is another [...]. It's completely different [...]. (E8)

It's very easy for us to say I'm working with an indigenous person, but it's not easy to understand what they are culturally. One must understand each person's individuality in order to provide the necessary care. The care is differentiated. (E3)

On the other hand, we identified divergent discourses. The understandings apprehended about interethnic contact and its determinations in the reception of indigenous people with TB demonstrate that living with non-indigenous people was beneficial, as the indigenous people acquiesced to the importance of polychemotherapy in the treatment of TB.

He who has already adhered to the issue of non-indigenous culture can understand better [...] and he who is more isolated is already more difficult, we have to work with him in other ways. (E8)

[...] that indigenous person who is not part of the coexistence [with non-indigenous people]*, they have resistance, they do not adhere to the treatment.* (E9)

Furthermore, the investigation made it possible to apprehend the existence of superficiality in relationships and the deficiency in the commitment of health workers. We identified that the bond is related to the health worker's culture, as evidenced in the following statements.

When you go every day, he likes it when you care about him, that is the bond you establish between the team and the family [...]. (E3)

[...] we end up creating a very strong bond with them, so they trust us, in what we say. (E8)

The bond is only harmed when it comes to medical professionals and nurses, who generally always change, in this case. (E5)

Considering the line of reflection of the participants, we understand that the strengthening of bonds lies in the fact that the health worker takes ownership of the health problems of the indigenous person, but mainly in the construction of solid relationships and cultural engagement with this community.

Regarding the organization of the service to respond positively to the needs of users in the care network, such as technical and management co-responsibility of the services,

the participants' speeches reveal that the resolvability is compromised by the subtracted capacity to respond to the user.

[...] the secretary sometimes cannot forward, then we have an institutional supporter who is the wife of the Finance Secretary, we manage or do it privately. (E2)

I think the exams should be faster within a month the bacilloscopy [...] to know if that patient will start treatment or not. (E3)

The exams are difficult. Here they are by quotas, so we have few spots for the indigenous area. There are many patients who pay for private consultations while waiting, but those who cannot afford it do not pay. Who determines these quotas is the municipality itself. (E4)

The speeches complement each other by arguing that the resolvability of care is hindered due to municipal management. Likewise, the participants consider that the maintenance of the TB transmission chain is due to the lack of resolvability at the municipal level and the care network and fragility in guaranteeing TB diagnostic support tests in order to provide resolutive care to the user.

As for accountability, making health care happen through the management of health services is a reality to be achieved to ensure integrality in health for indigenous people with TB, as evidenced in the statements:

[...] earlier this year I contacted all the agencies, whether municipal, state, and federal, and we make a plan. This planning is forwarded and you don't get any feedback. [...] It only depends on people committing, being more responsible to give some feedback to this patient because he needs it [...]. (E3)

There is no accountability on the part of the municipality, because we start from the following point: the indigenous area is seen by the municipality with different eyes, the indigenous population is not seen as a citizen, it is seen as an indigenous people who stole the territory of Banzaê. (E8)

According to the speeches, the lack of unity among the managing bodies responsible for providing care contributes to the inefficiency of the health service directed at the indigenous population with TB.

DISCUSSION

As for the reception, the research participants recognize the need for understanding and respecting cultural specificities as a way to welcome the indigenous person and their complaint. However, they consider that interethnic contact favors the HWs with regard to the user acquiescing to the PHC and, consequently, the treatment of TB, as there is no cultural estrangement between HWs and users.

For some authors[13] a more sensitive and dialogical intercultural communication in indigenous contexts is necessary. They consider it a great challenge to provide health care in spaces where customs and worldviews differ from their academic training, in which the values and knowledge based on the references of the Biomedical Cultural System (BCS) conflict with the cultural system of indigenous communities. Similarly, the testimonies corroborate with other studies[17], by stating that the indigenous opinion on the health-disease process

is different among indigenous people with different contacts with non-indigenous people and their cultures. In this way, the closer the approach to non-indigenous culture, the better the understanding of the SCB or the easier it is for non-indigenous knowledge to prevail. Given the above, with regard to TB, interethnic contact is a facilitator for acceptance and not abandoning treatment through polychemotherapy.

Regarding the bond, we identified the culture and/or understanding of the indigenous culture of HW as a positive factor and the precariousness of the service of medical professionals and nurses as a negative factor. In the understanding of the interviewees, similar to that of some authors[14], users aim for health care centered on them. Thus, they seek distant and trustworthy relationships with the healthcare worker to ensure that their problem will be understood and that everything within reach will be offered to protect and improve their life.

The resolvability within the HCN revealed insecurity in accessing the demands of indigenous people with TB. The care network is not organized, both at the municipal level and in the state's Health Region. The research participants pointed out that because the indigenous people live in a demarcated area, reconquered through a struggle process, they are not considered as citizens of the municipality, but they appear to be unaware of the flows established within the HCN. Thus, it is perceived that there is no resolvability, based on the uncoordinated way in which the elements of the health system solve the problems of indigenous people with TB[12].

Regarding accountability as a dimension of care production, we identified disagreements among the participants. Furthermore, contesting the condition of the user of rights and access translates, through exclusion, the situation of social vulnerability in which the indigenous person is inserted and, consequently, the vulnerability to illness from tuberculosis.

In this regard, it is well known that the Special Indigenous Sanitary Districts still owe an effective organizational model for the following reasons: conflicts and disintegration among institutional instances for their broad instrumentalization, low coverage in Indigenous Territories, lack of infrastructure and human resources for the formation of local management and multiprofessional teams, and others[18]. In the same way, it does not reach the logic of health needs and problems and the need to reorganize practices and work processes, so that they are inserted into a social process for improving the health conditions of indigenous people.

FINAL CONSIDERATIONS

This study focused on the provision of care to indigenous people of the Kiriri ethnicity with tuberculosis, addressing the dimensions of reception, bonding, resolvability, and accountability. In the presented context, we highlight the need for prior training of health workers to work in culturally diverse environments. This is due to the fact that HW, during their training process, tend to reproduce a fragmented view of care and, consequently, of the ethnic diversities of indigenous people in Brazil. Furthermore, the study revealed that the organizational structure of the care network in the empirical field does not allow for an effective operationalization to ensure the comprehensiveness in health care.

Given the impressions brought, we understand that the production of care for indigenous people with tuberculosis needs to be discussed to modify collective conduct

between the municipal, state, and Special Indigenous Sanitary Districts. The objective is to reconstruct the practices of health workers and the organization of the HCN that directly impact the integrality in health and allow safety in access to health services.

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Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work - **Jesus SS de, Freitas MYGS, Servo MLS, Santana N, Rodrigues IS, Santos G de B, Silva SS**. Drafting the work or revising it critically for important intellectual content - **Jesus SS de, Freitas MYGS, Servo MLS, Rodrigues IS, Santos G de B, Silva SS.** Agreement to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved - **Jesus SS de.** All authors approved the final version of the text.

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