

Perceptions and actions of the multi-professional health team on traditional indigenous medicine

Percepções e ações da equipe multiprofissional em saúde sobre a medicina tradicional indígena

Percepciones y acciones del equipo multidisciplinario de salud sobre la medicina tradicional indígena

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ABSTRACT

Objective: understanding the perceptions and actions of a multi-professional health team regarding the practice of traditional indigenous medicine in an Indigenous Health Care Center. **Method:** this is a descriptive qualitative study carried out in an Indigenous Health Support Center in a municipality in the state of Pará, which included eight professionals from a multi-professional team. Data was collected in 2018 and examined using the content analysis method. **Results:** insertion and practice of Christianity; shamanic rites and leadership; and the attitude of the multidisciplinary team were the categories listed, which point to the understandings and actions of the multi-professional team and the spatial organization of the Health Center in the municipality. **Final considerations:** there are new customs and values among ethnic groups, due to the approach of religious groups, whose actions were recorded and apprehended by the team of health workers.

Descriptors: Delivery of Health Care; Health Services; Indigenous Peoples; Health of Indigenous Peoples; Traditional Indigenous Medicine of the Americas.

RESUMO

Objetivo: compreender as percepções e as ações de uma equipe multiprofissional em saúde quanto à prática da medicina tradicional indígena em uma Casa de Atenção à Saúde Indígena. **Método:** estudo qualitativo descritivo, realizado em uma de Casa de Apoio à Saúde Indígena em um município do Pará, que incluiu oito profissionais de uma equipe multiprofissional. A coleta de dados foi realizada no ano de 2018 e estes foram examinados pelo método da análise de conteúdo. **Resultados:** inserção e prática do cristianismo; ritos e lideranças xamânicas; e postura da equipe de multidisciplinar foram as categorias elencadas, que apontam os entendimentos e atuações da equipe multiprofissional e da organização espacial da Casa de Saúde do município. **Considerações finais:** há novos costumes e valores entre as etnias, em virtude da aproximação de grupos religiosos, cujas ações foram registradas e apreendidas pela equipe de trabalhadores em saúde.

Descritores: Atenção à Saúde; Serviços de Saúde; Povos Indígenas; Saúde das Populações Indígenas; Medicina Tradicional Indígena das Américas.

RESUMEN

Objetivo: comprender las percepciones y acciones de un equipo multidisciplinario de salud sobre la práctica de la medicina tradicional indígena en una Casa de Atención para la Salud Indígena. **Método:** estudio descriptivo cualitativo, realizado en una Casa de Apoyo a la Salud Indígena de un municipio de Pará, que incluyó ocho profesionales de un equipo multidisciplinario. La recolección de datos se realizó en 2018 y los datos fueron sometidos al método de análisis de contenido. **Resultados:** inserción y práctica del cristianismo; ritos y líderes chamánicos; y actitud del equipo multidisciplinario fueron las categorías enumeradas, que indican la percepción y las acciones del equipo multidisciplinario y la organización espacial de la Casa de Salud del municipio. **Consideraciones finales:** existen nuevas costumbres y valores entre las etnias, debido a la presencia de grupos religiosos, el equipo de los trabajadores de la salud registró y aprendió las acciones de los indígenas.

Descriptor: Atención a la Salud; Servicios de Salud; Pueblos Indígenas; Salud de Poblaciones Indígenas; Medicina Tradicional Indígena de las Américas.

INTRODUCTION

Traditional medicine has gained prominence in public health debates. This is precisely because it represents a popular practice that is widely disseminated and easily accessible to local populations^{1,2}. The Brazilian Amazon has records of indigenous ancestral medicinal knowledge and the use of medicinal plants, which point to their medicinal potential for various purposes, which remain among the generations of indigenous peoples^{3,4}.

Therefore, there is a diversity of elements to be discussed, considering ancestral practices and health policies, which meet the praxis of intercultural contexts, in view of differentiated care and social participation and control⁶⁻⁸. Therefore, the actions and behaviors of these peoples in the face of health and disease processes must be identified and perceived as a multiple system, since they are mediated by the institutions that surround them and by concomitant interactions^{4,5}. These records corroborate the issue of actions, based on intercultural scenarios^{5,6}.

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In this sense, the inclusion of socio-diversity represents an important challenge for health professionals. This was the reason why the Special Secretariat for Indigenous Health (*Secretaria Especial de Saúde Indígena*, SESAI) was created, to articulate and incorporate the cultural diversity of indigenous peoples into conventional health techniques. However, the assistance mechanisms of public health care policies remain centered on biomedical methods, which limits initiatives to include ancestral practices in health services, following the hegemonic perspective of traditional knowledge and nullifying indigenous cosmology, and the behaviors and variations of elements that support indigenous health care^{5,6}.

Given this panorama and the demands of the World Health Organization (WHO), the National Health Conferences (*Conferências Nacionais de Saúde*, CNS) and the National Conferences on Indigenous Health (*Conferências Nacionais de Saúde Indígena*, CNSI), the incorporation of policies was approved; notably, those involving cultural heritage, autonomy, and acceptability⁸. These demands aim to subsidize actions based on various exercises, linked to natural mechanisms for disease prevention and health promotion and recovery, such as the National Policy for Integrative and Complementary Practices (*Política Nacional de Práticas Integrativas e Complementares*, PNPIC)⁷, do SUS.

On this path, the Indigenous Health Center (*Casa de Saúde Indígena*, CASAI) in the municipality of Oriximiná (PA), which belongs to the Guamá-Tocantins Indigenous Health District (*Distrito Sanitário Indígena Guamá-Tocantins*, DSEI-GUATOC), stands out. Its multi-professional health team serves a very ethnically diverse population in the lower Amazon region of Pará, that needs to travel from the villages to urban centers to undergo procedures at other levels of SUS complexity. The reason for this is that the strategies of the National Policy for Comprehensive Health Care for Indigenous Peoples (*Política Nacional de Atenção Integral a Saúde dos Povos Indígenas*, PNASPI), created in 2002, are aimed especially at primary care.

It should be noted that the ethnic groups historically served by CASAI in Oriximiná show evident changes in the manifestations of healing rites. These are the result of years of work by missionary organizations⁹. This is an issue that must be understood in the work of the health team, considering differentiated care, due to local cultural specificities⁷.

Bearing in mind some aspects, such as the population of approximately 900,000 indigenous people in Brazil, divided into 305 ethnic groups¹⁰ and the gap in scientific production on the subject, and to meet the observation priorities of the National Agenda of Health Research Priorities, the following question arose: how do health professionals at a CASAI perceive and act towards traditional indigenous medicine? Also, how do they implement the practices of this knowledge in conventional health care services, considering the public policies in this area?

Therefore, this study aimed to understand the perceptions and actions of a multi-professional health team regarding traditional indigenous medicine in a CASAI.

METHOD

This is a qualitative and descriptive study, as it considered the use of interpretative/theoretical frameworks, making relations with human groups and their social dynamics¹¹. Eight professionals working in the service in question took part in the study, including nurses, nursing technicians, managers, a social worker, and a nutritionist. The study's methodological procedures followed the principles of developing qualitative research (COREQ).

The research was carried out at CASAI in the municipality of Oriximiná, located in the state of Pará, in the Brazilian Amazon. The CASAI of the Oriximiná Indigenous Center, which serves approximately 2,400 indigenous people, works with a multi-professional team. In turn, it is managed by a nurse and has the direct assistance of a multi-professional team. This team provides services to indigenous people from 13 ethnic groups (Wai Vai, Tiriýó, Katxuyana, Tunayana, Kahyana, Katuena, Mawayana, Tikiyana, Xereu, Hixkaryana, Katuena, Aparai and Wayana), spread over 21 villages in the geographical territory of Oriximiná.

This CASAI was chosen because it is located in an area covered by a bauxite mining company. It was also chosen because its actions are likely to have implications for the health of local inhabitants, because it has a diverse team of professionals, and because of its proximity to the researcher. A prior contact was made, following a technical visit to the site, when the aim of the study and the procedures for carrying it out were explained, by means of a direct invitation to the locals along the way of the visit.

The inclusion criteria were: being a health professional or manager of the CASAI in question and being over 18 years old. Participants who were unable to speak Portuguese, who had cognitive difficulties, and who had no formal ties with any of the parties were excluded from the study.

The information was collected between September and October 2018 and was carried out by a nurse researcher, at the time a PhD student in Socio-Environmental Sciences, with experience in field research. As for the interviews, they were carried out through prior personal contact with managers to describe the research and with participants chosen for convenience through a technical visit to CASAI. Those involved already knew the researcher from a previous visit to the site in 2016, so there were no refusals from the participants identified.

The data was collected through semi-structured interviews with the researcher and interviewees. These interviews were recorded on audio tapes, lasting an average of 30 minutes, in a restricted room at CASAI. They were carried out by prior appointment, during the interviewees' working hours, without the participation of third parties.

These interviews used the following guiding questions: has there been any training for the health service in caring for traditional populations practicing indigenous medicine? Is traditional indigenous medicine used in your protocols? Do you carry out activities that encourage the use of medicinal herbs? Have you identified service users who are faith healers and/or similar? Have you identified indigenous medicine users among your patients? Do you know of any health policies that encourage traditional indigenous medicine? The transcripts of the interviews were not given to the participants, but *feedback* on the study took place after the formal presentation of the research at the research center.

In the data examination phase, Bardin's¹², technique of content analysis and organization by categories was used, highlighting phrases and fragments. From this process, three main themes emerged: new religious practices; shamanic rites and leadership; and the attitude of the multidisciplinary team, which were interpreted and evaluated, based on the objective of the study and considering the practices perceived, the rites signaled by the indigenous people and the attitude of the CASAI professionals.

The research in question was approved by the Human Research Ethics Committee. The appropriate consent form was also used. Participants were coded by the letter "E" followed by a decimal number.

RESULTS

Eight workers took part in the study, including managers, nurses, a social worker, a nutritionist, a nursing technician and an interpreter. Of these, seven were female and one male. With regard to the length of time they had worked in the indigenous healthcare network, one worker had been employed for more than ten years; five, between four and nine years; and three, three years or less. The categories resulting from the analysis are presented below.

New religious practices

This category was formulated based on the knowledge and experiences of health professionals in the context of CASAI employees entering the villages for strategic health actions. According to the team, the arrival of religious groups in indigenous spaces has changed the rites, cures, and practices of ancestral medicine in the territories where the team works:

Today almost all of those who live in the Wai Wai village are evangelicals [...] Those from Mapuera are almost all evangelicals. There was a missionary who wiped out the Wai Wai people's medicinal plant culture. (E1)

The church is very influential towards them because they say it's mysticism, witchcraft, so they lose out. (E3)

The church tried to make them all shamans, healers, and faith healers, the church took all this leadership and began to indoctrinate them, and then turn them into pastors, and by being pastors they lost the other side. (E8)

Shamanic rites and leadership

According to the need to recognize the dynamics of each village, the health team reports situations encountered and challenges in extracting information:

There aren't any more. If there is, it's very hidden, there may well be, but they don't show themselves. (E3)

I go to Mapuera a lot, because it's our biggest village, there are some, but it's very hidden, I think they're afraid of society. There was a case recently where an indigenous person died and they said: ah, it was the shaman and so and so who did this to him, so today they're very wary, they don't mention the healer, the shaman. The only one we see free is the midwife. (E7)

There are also dichotomous situations in the territory, which indicate paradigms in the acceptance or not of indigenous people, in relation to the maintenance of traditional health practices:

We've already discovered that they do it hidden. We'll ask the question, we'll ask them what it's like, but no, they won't tell us because they can't, because they say God will punish them, even because of their religion [...] we can't get it. We ask AIS, who lives in the old Mapuera Village: Do you have that plant for stomach aches and headaches: she says: I do, but I don't know where it is, I don't know where it is anymore [...] we even have a form that was first to ask the users questions [...], but we couldn't because when we went to the villages with this list of questions he said...it was an old shaman, an old man...that we shouldn't talk, we can't talk, because God punishes, He is listening, we can't do it. (E2)

Some use "Oburtiri", the "Caxiri" which was a traditional drink of theirs, and it's a hallucinogen, so they don't use it on this river anymore. If you go to another river, the Trombetas River, they are very strong in the use of "caxiri". But they don't talk about it outside the village, they say no, they don't use it. So they end up following certain Oguns, but they don't open up." (E3)

Where there are remnants of this traditional medicine, of these cures, of the healer, of the shaman, is in the Cachorro River of the Carrianas, in the Trombetas of the Kaxyuaná, Thyhyanas. They still have shamans, they still use them. (E4)

Multi-professional team attitude

This includes initiatives to revive the use of medicinal plants through partnerships with educational institutions:

The pharmacists went to Belém and another state. They worked on this rescue, they did the planting part and the practices, so they were qualified. The social worker also spoke about it [...], to try to rescue it, but they didn't succeed. (E1)

There's a project to plant some herbs inside CASAI so that they can be used in addition to the medicines. (E4)

We already entered the village [...] and we made the vegetable garden, and we were going to leave a space for the medicinal garden. When we entered the village, we weren't going to take the plants from here, we wanted to collect them from there, and we wanted to know what they had inside the village. We went to the indigenous villages of the Cachorro River: Santidade and Chapéu. In these two villages we were going to combine the two gardens, the medicinal and the organic, but we didn't manage to do it. (E2)

In the same direction, the CASAI team searched for memories of traditional indigenous medicine:

Some academics of indigenous teachers are talking about the use of plants, recognizing which plants they are. I believe that we can do this by working like ants, not imposing, but showing them, cultivating with them, getting them to come closer. Not in all the villages, but I believe that in some they will accept it. (E3)

In the conversations we had with them, we tried to ask: when you have a certain pathology, what do you use? (E4)

And there are records of professionals' attitudes towards traditional indigenous medicine practices:

We have from GUATOC a project of traditional plants to encourage use, so as not to do the medicinal part, to have this rescue. But when we get to the village, they don't accept it [...] there's a movement to rescue it, but it's a conflict, and there ends up being a conflict within the community, because some say it's witchcraft, even because the shaman has been lost, the healer has been lost, even the traditional midwife, they've been lost within the community, because the church is very strong. (E3)

DISCUSSION

CASAI in Oriximiná is a territory with a diversity of symbolic elements. These, in turn, are connected to the technical work of the multi-professional team. This is due to both the environment and the relations with indigenous leaders who are present, showing the systematic network involved between service, health, and culture^{5,6}.

It should be reiterated that the interviewees are close to the representatives of the Wai Wai ethnic group, above all because of the constant presence of their members at CASAI. On the other hand, it was noted that the process of evangelization of the indigenous peoples of Oriximiná took place mainly through evangelical missions, in which the ethnic group that suffered the greatest intervention from religious groups was the Wai Wai, especially the group based in Mapuera village. It is known that missionary movements have been registered in the villages and among the indigenous ethnic groups of Oriximiná since the middle of the 20th century⁹, so new dynamics are the fruit of ruptures, observed in evangelical missions to indigenous peoples, directing them towards Christianity¹³.

It is necessary to understand these phenomena as part of an integrated system that involves behaviors and values, and historical processes that produce new behaviors, which should be given due attention by the SUS. This is because they point the way to decision-making by health professionals^{5,6}. On the other hand, geographical singularities, such as those of the region under study, can also create confrontations with external influences, fact identified by professionals, showing their own understanding of the local reality^{5,13}.

Restricted geographical access to some villages has meant that external actions, such as those of the missionaries in question, have not been carried out. But it is in these places that health professionals are able to identify common rites among indigenous peoples, such as the use of traditional alcoholic beverages¹⁴. These exercises reveal the resistance of small indigenous groups, aimed at maintaining their ancestral medicine practices, illustrating particular ways of caring for the peoples of the region¹⁵, an aspect that should be considered in the operationalization of health control⁶.

It should be noted that the indigenous people have no interest in exhibiting their cultural manifestations in environments outside their villages, so as not to provoke retaliation from religious leaders. In this way, despite the confirmation of the use of traditional indigenous medicine, it can be seen that a postural code has been established among health professionals, which is in line with the social rules of good conduct in relations with indigenous people. There are also different organizational systems for maintaining health among the ethnic groups served^{5,6}.

It should be noted that indigenous social control plays an important role in this process, since it has the mission of ensuring the specific needs of intercultural care^{6,16}. This is throughout SESAI's care network while ensuring that the dynamic nature of culture, perceived interactions, and different behaviors are visualized, discussed, and implemented. These activities are the responsibility of the multi-professional team, from the perspective of different types of knowledge and actions^{5,16}.

The behaviors learned by the multi-professional team indicate a continuous process of mutual influence with the indigenous peoples⁹. This may occur under the guidance of a leader, usually a shaman or chief — or an indigenous evangelical pastor¹⁷ —, due to their religious affiliations. There are different patterns signaled by workers, evangelical groups, or indigenous cosmologies, such as in the case of the Wai Wai^{5,9}.

Naturally, the multi-professional team has organized itself for these purposes, both empirically and through research processes that bring together indigenous people and academic partnerships, which are fundamental in looking at permanent health training^{5,18}. The planning and development of activities with the participation of third parties allows for the establishment of reflections on the service and the work of the team, fostering discussions on health needs and care, which favors the implementation of public policies^{5,6,19}. Furthermore, teaching-service integration has been observed in health courses and shows positive results, despite some difficulties, such as those present in the management of these policies²⁰.

In the case of Oriximiná, the initiative included setting up community gardens in the villages, with the aim of encouraging the consumption of natural products^(21,22). It was a social inclusion and health promotion project²³, representing an important step towards the recovery of ancestral practices and the implementation of the PNPIC. This project was built in partnership with a higher education institution.

In relation to the perception of conflicts, which are related to the beliefs and medicinal references absorbed by the indigenous people and carried out by SESAI, it was noted that the therapeutic itinerary of the indigenous people has changed. This is due both to its evangelization processes^{10,18} and to the insertion of the conventional medical model, which altered the way health was carried out during the process of creating SESAI, a pertinent reflection of the actions directed by biomedical reasoning²⁴. In fact, this new path meets health equity, showing how networks of systems and entities influence health care, a discussion that crosses the work of professionals in the area in question^{5,25}.

Historically, it is known that the implementation of public policies has presented controversies, regarding concepts, the inclusion of insights, knowledge and practices, and indigenous¹⁶ demands, regarding the rights of these peoples⁴, leading to conflicts. Furthermore, there are difficulties in contextualizing these actions on an intercultural level from the perspective of indigenous¹⁶ peoples, as a result of the implementation of behaviors. Mainly, when these are linked to national and international references, not specific to the needs of the ethnicities served at CASAI, moving away from equality and the right to maintain their cultures^{4,25}.

Therefore, it is important that the planning of health actions for indigenous peoples identifies and considers the historical processes of these groups, in addition to addressing the inclusion of the cultural systems and subsystems involved in them^{5,26}. Continuing education, for example, favors vertical implementation, which incorporates all these codes, ranging from territorial management to direct social assistance and reflecting on the results and operational

models of the SUS. In addition to integrating actions, permanent education in indigenous health needs to be guided by a participatory perspective²⁷ and by ethnic and cultural aspects^{6,16}, such as expanding the conception of health, incorporating the diversities and pluralities of each indigenous group into care in health^{4,6}, based on their knowledge, producing integrative and complementary practices²⁷ in the field of health.

Therefore, the eventual recovery of rites from traditional indigenous medicine and the record of different dynamics must be revealed, in order to inform about potential blockages established by religious leaders, due to the practice of Christianity^{15,16}. Furthermore, the assimilation of experiences, and the skills of these achievements, is an activity that requires a correct understanding of the cultural systematics⁽⁵⁾. And this is to understand defensive postures on the part of some of the leadership of the new religious organization.

FINAL CONSIDERATIONS

In this study, it was observed that the multidisciplinary team perceives different behaviors between ethnicities, regarding the practice of their traditional medicine. This is because local health professionals consider the importance of this medicine and seek to revive it. And they do so through the implementation of academic partnerships, ongoing education and sensitive listening to the beliefs and values of traditional cultural codes.

To this end, it is necessary for the health professional to rescue such behaviors, through public policies. In this way, it helps the Support Centers to integrate them into care networks, implementing successful village experiences in these spaces. It is understood that the insertion of these operations must be approached, based on a dialogue between indigenous leaders and health professionals, including to encompass the notes of the National Policy for Comprehensive Health Care for Indigenous Peoples.

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