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# Cultural singularities: indigenous elderly access to Public Health Service*

## Singularidades culturais: o acesso do idoso indígena aos serviços públicos de saúde

## Singularidades culturales: el acceso del anciano indígena a los servicios públicos de salud

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**ABSTRACT**

**Objective:** Describing how Kaingang seniors and their primary caregivers experience access to public health services. **Method:** A qualitative study guided by ethnography, conducted with 28 elderly and 19 caregivers. Data were collected between November 2010 and February 2013 through interviews and participative observation analyzed by ethnography. **Results:** The study revealed the benefits and difficulties of the elderly access to health services, the facility to obtain health care resources such as appointments, medications and routine procedures, and the difficulties such as special assistance service problems and delays in the dispatching process between reference services. **Conclusion:** The importance of knowing and understanding the cultural specificities of the group in order to offer greater opportunities for the elderly access to health services was reinforced.

**DESCRIPTORS**

Aged; Indigenous Population; Health Services Accessibility; Heath of Indigenous Peoples; Public Health Nursing.

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## INTRODUCTION

Population aging happens due to some changes in health indicators, especially the decline in fertility and mortality. In indigenous people, the increase of the number of elderly (even though small) in recent decades may be related to the improvement of health parameters of this population, and along with changes in health indicators are contributing to the increase in life expectancy.

This aging process implies the need for increased access to health services since the elderly are more susceptible to diseases and disabilities. Indigenous elderly share those universal aging process needs, but they differ from other population groups, especially in the cultural aspects of care. In indigenous groups, the elderly are who hold the knowledge of traditional practices of cultural care and therefore their beliefs and knowledge can influence access to health services.

The access to comprehensive health care for indigenous elderly is guaranteed by the National Health Care of Indigenous Peoples Policy (PNASPI), in accordance with the principles and guidelines of the Brazilian National Health System (SUS), considering the social, cultural, geographical, historical and political diversity and recognizing their rights to their own culture[1]. However, although guaranteed by law, the indigenous population still faces difficulties in accessing health services[2]. Even after the implementation of the Indigenous Healthcare Subsystem in Brazil and investment in establishing local health services in Indigenous Lands (TI) across the country with extensive expansion of primary care coverage, the barriers of indigenous access to SUS have not been overcome[2]. Even after all these years, the current model of indigenous health care in Brazil can still be characterized as an ongoing process[3].

The indigenous access to health departments is poorly represented in the research, with insufficient numbers of published scientific papers that analyze this topic of Brazilian indigenous groups, and these in most cases are either restricted to certain ethnic groups[3], or aren't the main focus of discussion[4-5]. Until now, studies that portray the access of indigenous elderly to health services haven't been identified in national databases. However, the issue is already being addressed in international studies[6].

Access to health services can be identified in two components: geographic and socio-organizational[7]. The first involves characteristics related to distance and means of transport to be used for the care[7]. The latter includes those features and resources that facilitate or block the efforts of people to receive the care of a health care team; for example, operating hours, the ways to make appointments, the occurrence of long waiting lines, the coverage offered after operating hours and explanation of the services to be used by the population when a health center (UBS) is not available, in addition to acceptance of cultural differences[7].

Cultural aspects should be taken into consideration when focusing on an indigenous population since their culture directly influences their thoughts, decisions and actions, especially actions regarding care[8]. Based on the above, and considering the assumptions made about the user's access to health services, this research was guided by the question: *How does the access of indigenous elderly to health services occur?* The research seeks to describe how the Kaingang seniors and their primary caregivers experience access to public health services.

## METHOD

This was a qualitative study, based on ethnographic assumptions. Ethnography is defined as the understanding of one's point of view in relation to their life and their view of the world[9], providing a detailed description of reality and the integration of information from various actors involved in the same micro-reality, a stage of interactions and conflicts[8-9].

The study was conducted in the Faxinal Indigenous Land (TIF), in the municipality of Cândido de Abreu, Parana, Brazil, where approximately 600 indigenous live, distributed in 120 families. The study subjects were 28 Kaingang elderly residents and 19 primary caregivers in the TIF. It was considered that elderly people are 60 years of age or older and the primary caregiver is the person accompanying or the primary caregiver to the elderly person, they may be a family member or not. Because it is an ethnographic study two key informants were elected to assist researchers in understanding the findings and deepen the cultural knowledge along with the worldview of those studied.

Being part of the research project "The Knowledge and Health Practices of Kaingang Elderly Families at the Faxinal Indigenous Land – PR", observations began in November 2010, totaling 11 field trips with the researchers staying for periods of seven to ten days. In the first moments in the field, it was possible for the researchers to establish a relationship with the research participants, which allowed for understanding of the world views, feelings and experiences of the elderly and health caregivers. It is noteworthy that in each visit, field researchers strengthened bonds, establishing trust.

The last moments in the field from December 2012 to February 2013 were aimed at the observation and participation of seniors and caregivers in their daily routines in order to depict indigenous elderly access to basic assistance services and SUS referral attention.

Data were collected through participant observation and ethnographic interviews aided by two instruments; a script for field observation, and another script for the interviews. Interviews were used as a way to complement and validate the insights gained by participant observation which were recorded in an MP4 player and then transcribed. The entries made in the field diary were also used as a data source.

Data were analyzed by ethnography[9], while being collected and documented. The analyzes were performed based on the records made in the field, generating new questions for observation, interviews and records in the field diary with constant feedback that provided the direction of the study.

The study met the requirements of the National Health Council Resolution 196/96, with review and approval by the National Committee of Ethics in Research (Conep), Item No. 760/2010. In order to preserve the identity of respondents, the elderly were coded with Arabic numbers preceded by the letter I and primary care providers by the

letter C, both identified by the letters F for females and M for males, followed by age. The key informants were identified with the letters IC, following the same pattern identification for the elderly and caregivers.

## RESULTS

### Getting to know the research subjects

It was found that 17 indigenous elderly were female, aged between 60 and 103 years, with an average of 72.9 years. The predominant age group was 60-69 years (n=14), followed by seniors aged 70-79 years (n=6). Seven indigenous between age 80 and over were identified, one at 103 years. Among the Kaingang elderly, 16 were married and 14 lived in extended families, consisting of up to seven people. However, there were families consisting only of elderly couples (n=4) and elderly living alone (n=3). As for education, none of the elderly were literate in the Portuguese language (n=28), showing low levels of education. Most were retired (n=26), with a minimum wage income.

Health problems mentioned were: hypertension (n=4), chronic obstructive pulmonary disease (n=1) and arthritis (n=1), and there were reports of other illnesses such as influenza (n=16), colds (n=7) and bronchitis (n=5).

Caregivers were predominantly female (n=13) between 22 and 53 years old, with an average of 32.1 years. Most were married (n=13) and lived with the elderly (n=14). It is noteworthy that only two caregivers were not related to the elderly. These had little schooling, most had four years of study (n=16). The main source of income for caregivers was crafts.

The fieldwork and the analysis of the framework of information collected allowed for the construction of two categories: "Elderly Kaingang access to health services in daily lives" and "Cultural contrasts: How the elderly Kaingang experience access to health services."

### Elderly Kaingang access to health services in their daily lives

Health care assistance services are present in the lives of the elderly and their caregivers through the work of the Multidisciplinary Team for Indigenous Health (EMSI), which offers visits to general practitioners and dentists, as well as nurse checkups and procedures such as medication administration, inhalation therapy and bandage applications, referral to specialized services and immunization campaigns.

The access of the elderly to the Basic Health Unit/Center (UBS) occurs in two ways; by free and spontaneous demand or at the request of the health team, often articulated by the nursing team. The access of the elderly to health services is characterized by the facility in getting assistance at a UBS/health center unit, either through medical, dental, or nursing consultations and/or other procedures.

It was observed that a nursing team participates effectively in the process of elderly care and is present in actions prior to doctors in providing care, and often in more serious situations prior to the doctor's shifts, referring patients to reference services. These actions allow for responsive elderly access to health services.

> *It's quick to get service at the health center. One of these days I was feeling ill, I went to the station and was seen right away. (...) The nurse saw that my blood pressure was high (...) I had the appointment and the doctor referred me to the hospital because my blood pressure did not go down* (I7;F62).

> *The nurse always finds a way to fit us in. (...) The doctor only comes in the afternoon and, if needed, they'll see you without an appointment booked* (I17;M65).

> *I went to the health center with a fever and vomiting, The nurse checked me and sent me to the hospital because the doctor would only come in the afternoon and I was very sick* (I10;F64).

On the other hand, the difficulty that some elderly have to go to the UBS was noted by the distance between their homes and the health service center. The geographical aspect makes it harder, but does not prevent access to the facility since the health care team provides transportation to meet the needs of the elderly.

> *(...) I24;M94 always goes to the health center to take inhalations (...) Today he didn't go because he was very tired. (...) He walks there with his cane, but it's far for him to go and there's a hill on the way. Because today he's feeling very tired, he stayed home (...), sometimes the car comes to pick him up, we just need to tell the nurse* (I23;F75).

Although the UBS is inserted in the TIF and acts as a facilitating factor for the elderly access to health services, their operating hours is a barrier at certain times. Outside of these hours, the transposition of indigenous to emergency services is necessary, a situation that makes the search for care tiring and stressful. This is because the economic conditions of these individuals make them dependent on public health services.

> *(...) on weekends, if you need health care service, the AIS (Indigenous Health Agent) has to call the driver to pick you up (...) we do not have another car to take, we depend on the driver to come pick us up (...)* (I15;F61).

> *Sometimes it happens that the car isn't here when someone needs it. It has happened to me. I had to go to the hospital and the car was not here (in the Indigenous Territory), it was taking another patient (...) I was waiting for the car to come back* (I28;M72).

In the SUS referral services, access to necessary care was characterized by delays, especially when there was the need for referencing the elderly to other network services.

> *Once I had to wait a long time at the hospital (...) it took so long (...) I was there for hours waiting for my aunt (I15;F61) to be referred to another hospital* (C1;F45).

> *(...) the hospital care is often time consuming, because there's a lot of people in the line. You need to wait for the doctor to see all the people who are in front of you (...) it takes too long"* (I7;F62).

Elderly and caregivers disapproval towards delays in the care system and referral process to referral network in the SUS were observed, especially considering the experience that these people had regarding primary care was different, consultations upon demand with no waiting lines. Moreover, the difficulties experienced by these indigenous people in SUS referral services show the need for restructuring the health service in providing care to indigenous elderly.

### Cultural contrasts: how the Kaingang elderly experience access to health services

In Kaingang culture, the elderly is a link between their ancestors and future generations, and is responsible for transmitting the cultural aspects of ethnicity, as well as the Kaingang cosmology, beliefs and values, teaching notions of moral conduct and learning skills. In many cases, older people act as counselors and healers, experts of remedies made with herbs. Due to the inter-ethnic contact and the changes introduced by the public health system, this reality has changed.

Since 2003, the TIF has had a UBS in its territory where held health care for the indigenous elderly takes place. On the occasion of more complex care needs, the elderly are sent to the hospitals of the closest municipalities. Thus, with the changes in the forms of care experienced by these Indians during the implementation of health services, the Kaingang elderly showed disparate perceptions of access to these services. For some seniors, the manufactured drugs arising from health services are important elements in promoting access to UBS as a result of previous experiences.

> *(...)I have this back problem, called a herniated disk (...) our medicine doesn't solve the problem, so I have treatment at the health center. (...) I did the treatment for a long time, I had to get a shot every day* (I15;F61).

It was observed that the demand for drugs is, in many situations, is the way older people seek access to health services. In these circumstances, the nurse promotes assistance to the elderly, does a nursing consultation, offers health guidance, or simply engages in dialogue in order to strengthen ties.

On the other hand, the world view; the priorities of life and the health and disease concepts of the indigenous elderly may differ significantly from that of the health professional's culture and therefore a lack of special care that meets their health needs can interfere in access to health services.

> *At the Faxinal village there's still some people resistant against medical treatment, people who only believe in the traditional indigenous medicine, especially some elderly* (C1; M53).

> (...) *The elderly lived in the woods and wouldn't accept white people's remedies. They made their remedies themselves or sought help from Kuja to cure diseases. Now the health center is here, but some elderly still prefer to have their own medicine and use ancient healing practices. Because the health service doesn't use these practices, the elderly move away from this service* (IC1;M68).

> *At the health center there's only white people's medicine. They are good to cure the pain, but not to cure diseases of the spirit* (I6;M65).

Alongside the perception of lack of consistent care, language barriers are present when older people can access health services, they feel some limitation and difficulty in understanding their needs and interpreting the health team guidelines due to the Kaingang language.

> *(...) Often they cannot understand what the doctor says. They can say that they are in pain and where it hurts. It's hard because when there's no one to help them they don't understand. When the nurse doesn't understand something, he asks for help from young Indians, who speak Portuguese.* (C19;F22).

> *(...) The Indigenous Health Agent goes with me to the hospital. She can explain what I'm feeling (...), sometimes I can't explain the sickness I have"* (I15;M61).

The nurse, on the other hand, showed greater coordination in communication with indigenous elderly, overcoming this difficulty with simple strategies such as the assistance of the Indigenous Health Agent (AIS) or young indigenous who understand both languages, Portuguese and Kaingang.

The communication gap between indigenous elders and caregivers can also interfere with the quality of care provided to this population, and even the removal of the elderly health services.

## DISCUSSION

The implementation of UBS in IT has enabled greater speed in access of indigenous health services and the use of health resources offered such as medical, nursing and dental consultations, hospitalization, tests and procedures; these are configured as the portal for indigenous elderly services in the SUS referral network.

Different from that observed in the study population, in many IT indigenous face difficulties that go beyond consultations scheduling appointments or receiving care at a UBS. This is because many in IT also do not provide primary health care services [5,10], so that the geographical access is a barrier for assistance. International studies find that living in remote areas in particular can affect the health of patients by increasing the level of risk due to isolation and lack of access to health services [11].

The geographical distance made it difficult at times for the elderly to access due to physical limitations, but it does not impede them completely. In other IT units, the geographical aspect is a major barrier for the elderly to access health services. Although arising from the inevitable aging

process, the isolation of some ethnic groups, the rejection of the urban communities, and the low availability of services in the villages are the main barriers that contribute to the limited access of indigenous health services [5-6,12].

The nursing strategy to minimize the geographical barrier between certain homes and UBS, as identified in this IT, is *the use of the vehicle provided by the Special Secretariat of Indigenous Health (SESA) for the elderly in the village displacement internal environment, for example to take it to UBS, although the function of this vehicle is for transporting indigenous patients to other SUS referral services*[13], located in the municipalities of Cândido de Abreu and Ivaiporã - Paraná.

The use of the car in transporting the elderly assists in nursing care which closely accompanies the health of the elderly Kaingang, an initiative of special attention, although this is not its main function. The SESA vehicle is understood by the point of view of the health professional as a tool that facilitates assistance to indigenous elderly[13]. The identified strategy allows for its reproduction in other IT units, in order to assist the nurses and all health care staff in caring for the indigenous elderly.

However, sometimes transport emerged as an obstacle outside of UBS operating hours. Because of the health service organization, the vehicle used for the movement of patients to emergency services is in the city of Cândido de Abreu, requiring the solicitation/use of such a service when there is a complication in the TIF.

Because of the socio-economic difficulties, the Indians depend exclusively on features offered by SUS[10]. This situation is worse in some regions of Brazil because even though the indigenous live in precarious economic conditions and there is limited transport in the villages, there is still a shortage of primary care services in IT to meet the population[5], conditions also observed in international studies[6,12]. The difficulties in shifting the community to health centers or hospitals can reduce the indigenous elderly's access to health services[6]. In order to minimize these health disparities in the United States, telemedicine technology is being evaluated as a strategy to improve access and quality of health care in remote indigenous communities[14].

Another factor that can increase the isolation of the elderly to health services is the delay in treatment in the SUS referral network services, especially as there are routing needs to specialized services. This is not a problem exclusively experienced by the indigenous, but for the entire population. The inefficiency of the health system being unable to offer these individuals easier access to primary care services overcrowds the SUS referral services.

The difficulties experienced by these seniors and caregivers in reference services demonstrate flaws in the organization of indigenous health services, requiring periodic evaluations of services and the implementation of actions to reorganize the functioning of these in order to improve access of the indigenous population to health services. This could be minimized with the implementation of UBS in IT and health promotion activities to the Indians, along with trained professionals to work in IT[15]. In international study, beyond the qualification of professionals to attend to the indigenous, strategies to improve health outcomes should be supported by a strong and visible labor force between professionals and users, based on the recognition of the family and the individual in planning care[16]. Strategies that can help reduce referrals to services of greater complexity of care, minimizing their overcrowding.

The current indigenous health policy is determined with respect to traditional healing practices and is not a replacement for biomedical services, but little is done to implement focused care policies to focus on the problem of interculturalism, and therefore measures need to be established that enhance the articulation of traditional healing practices with biomedicine[3]. The lack of access to culturally appropriate health services (meaning culturally congruent), may have negative influences on professional care[16], since culture can mitigate or exacerbate the challenges of indigenous access to health services [11].

The change in care mode, modified on the basis of interethnic contact and the changes introduced by the public health system, have led the elderly to experience access in several ways. Some elderly, due to positive experiences from health services such as the efficiency of health care, have given preference to professional assistance and therefore have greater access to these services. This reveals that the Kaingang culture is in permanent transformation and redefinition, which allows for some care practices such as the use of manufactured drugs, and their validation between different generations, even among the elderly. This is only possible because the culture is not static, meaning that it is accompanying the changes in society and changes according to social interactions[9].

Already incorporated into Kaingang culture, manufactured drugs are in great demand by the elderly. In addition to symbolizing a matter of power between indigenous groups, they are seen as an indispensable resource for the assistance of EMSI in the villages, and a lack of drugs is seen as disrespectful to health, since it is essential in the treatment of diseases[15], and bring comfort as much as other therapeutic practices.

The search for drugs in many situations has promoted the access of some indigenous elderly to health service. Despite the nurses' working over hours and other factors that interfere with the care of the elderly as previously identified[13], on the occasions when the elderly demand health service, it should be valued and interpreted as an opportunity to promote health and strengthen the connection to the indigenous community. The nurse can work in partnership with the AIS by way of regular monitoring of the elderly through home visits and an active search for those missing who are undergoing treatment. Thus, the nurse will provide information that will facilitate the construction of strategies to meet the indigenous elderly.

As to PNASPI, access of indigenous health services should be effected in accordance with the cultural idiosyncracies of each group[1]. However, there is a lack of congruent cultural care in assisting the indigenous elderly away from these health services. This is because the assistance to indigenous health is still guided by biomedical concepts

without emphasis on cultural aspects. There are few studies that describe the practice of special attention in the villages[5].

The special attention include notions about the concepts, values and practices in health of all people and of coordination between the indigenous and biomedical knowledge mediated by AIS, as well as between the community and team members[1]. However, the success in offering services that respect and are linked to traditional practices largely depends on the commitment and efforts to empower all members of EMSI, including AIS, for special attention[17].

Although health professionals recognize the importance of a comprehensive and differentiated assistance to the Kaingang elderly, mishaps in the service organization limit individualized and curative care[13]. Often, health professionals don't have information to understand how culture influences the perception of the indigenous in seeking professional assistance[6], even though respecting the cultural aspects of indigenous peoples is provided in PNASPI[1]. This leads to disappointing the elderly with the provision of care and in some cases leads to these Indians being reluctant to use the health service[6]. Therefore, health professionals and especially nursing must be prepared to promote and provide culturally congruent care.

The lack of culturally congruent care along with the inability of health professionals to talk in the native language creates a difficult situation for the Kaingang elderly who use the professional health system, as well as many indigenous[6,18].

For the indigenous elderly of the TIF, Portuguese is their second language in terms of fluency and comprehension, as speaking the native language is a way to preserve cultural traditions and the Kaingang identity[19]. The difficulties of understanding diseases/illnesses and the treatments required may result in significant gaps in communication, affecting the elderly's access to the health services and the quality of their experiences with these services[13,18].

Some initiatives have helped to lower the barriers created by these cultural differences, such as the inclusion of AIS to EMSI[1]. Among health professionals, nurses have shown greater coordination in communicating with indigenous elders, using simple strategies such as the help of AIS and/or young indigenous to minimize the difficulties imposed by the language barrier.

Where possible, the Kaingang elderly are accompanied by an AIS for care in the SUS referral network services in order to facilitate communication and therefore provide the elderly quality of access in health care[1]. In Australia, some hospital services started using knowledgeable interpreters of indigenous languages as a way to support the cultural needs of indigenous patients during their contact with the hospital system for a better understanding of the sickness and treatment[18].

## CONCLUSION

This study has allowed us to describe how the access of indigenous elderly to public health services is. They found it easy to make appointments and access/receive health resources such as appointments/consultations, medications and procedures performed by nursing staff. On the other hand, the distance of some residences to UBS and the hours of operation represented a barrier to access. Access to the SUS services referral network was marked by delays in care and referral to other specialist services.

The analysis showed the existence of failures in health services for special service, such as the lack of consistent care for the cultural needs of the indigenous elderly and the difficulty of communication between professional/patient due to the Kaingang language. These findings reinforce the importance of knowing and understanding the cultural specificities of the group in order to offer greater opportunities for the elderly to access health services, as well as comprehensive and effective care that respects cultural differences.

Access is a challenge in the construction of comprehensive health care for the Kaingang elderly and an important element in the management and evaluation of indigenous health services. Thus, the nurse has a responsibility to promote the user's access to health services, and is of paramount importance in establishing strategies for providing indigenous elderly increased access to health services.

Among the limitations of this study was the fact that it was a single Kaingang IT, therefore it is suggested to carry out similar studies with other ethnic groups so that new strategies for the access of the indigenous elderly to health services may be brought to attention.


### RESUMO

**Objetivo:** Descrever como idosos Kaingang e seus cuidadores principais experienciam o acesso aos serviços públicos de saúde. **Método:** Estudo qualitativo, norteado pela etnografia, realizado com 28 idosos e 19 cuidadores. Os dados foram coletados entre novembro de 2010 e fevereiro de 2013 por intermédio de entrevistas e observação participante, analisados por meio da etnografia. **Resultados:** Revelaram as facilidades e as dificuldades no acesso do idoso aos serviços de saúde. Facilidade para obter recursos de saúde como consultas, medicamentos e procedimentos rotineiros. Dificuldades como falhas nos serviços para a assistência diferenciada e lentidão no processo de encaminhamento entre os serviços de referência. **Conclusão:** Reforça-se a importância de conhecer e compreender as especificidades culturais do grupo, a fim de oferecer maiores oportunidades de acesso do idoso ao serviço de saúde.



### DESCRITORES

Idoso; População Indígena; Acesso aos Serviços de Saúde; Saúde de Populações Indígenas; Enfermagem em Saúde Pública.



### RESUMEN

**Objetivo:** Describir cómo prueban los ancianos Kaingang y sus cuidadores principales el acceso a los servicios públicos de salud. **Método:** Estudio cualitativo, orientado por la etnografía, realizado con 28 ancianos y 19 cuidadores. Los datos fueron recogidos entre

noviembre de 2010 y febrero de 2013 por medio de entrevistas y observación participante, analizados mediante etnografía. **Resultados:** Revelaron las facilidades y las dificultades en el acceso del añoso a los servicios de salud. Facilidad para lograr recursos de salud como consultas, fármacos y procedimientos rutineros. Dificultades como fallos en los servicios de asistencia distintiva y lentitud en el proceso de tramitación entre los servicios de referencia. **Conclusión:** Se refuerza la importancia de conocer y comprender las especificidades culturales del grupo, a fin de brindar más oportunidades de acceso del anciano al servicio de salud.

**DESCRIPTORES**
Anciano; Población Indígena; Accesibilidad a los Servicios de Salud; Salud de Poblaciones Indígenas; Enfermería en Salud Pública.

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