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INDIGENOUS NURSES: PARTICIPATION OF NURSING TECHNICIANS AND AUXILIARY IN INDIGENOUS HEALTH CARE SERVICES[1]

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ABSTRACT: The aim of this study was to analyze the participation of Indigenous nursing technicians and aides in Indigenous health care services offered in the Xapecó Reserve, Santa Catarina, Brazil, focusing on the training and activities executed. Data collection (participant observation and interviews) and analysis were based on the ethnographic method. Sixteen key informants were interviewed, including nursing technicians and aides, training instructors, staff nurses and health service users. The training courses contained little or no emphasis on local knowledge and health practices. Other than the role of facilitator and mediator between the health team and community, the activities performed by the Indigenous nursing technicians and aides differed little from those of non-Indigenous people in the same categories. In this context, both the training of these workers and the activities executed by them reinforce the clinical curative model, which hinders articulation with local knowledge and Indigenous health practices, a principle of the National Policy of Health Care for Indigenous People.

KEYWORDS: Nurses' aides. Health services, indigenous. Indians, South American.

INDÍGENAS COMO TRABALHADORES DE ENFERMAGEM: A PARTICIPAÇÃO DE TÉCNICOS E AUXILIARES NOS SERVIÇOS DE ATENÇÃO À SAÚDE INDÍGENA

RESUMO: O estudo objetivou analisar a participação do técnico e auxiliar indígena de enfermagem nos serviços de saúde da Terra Indígena Xapecó, Santa Catarina, Brasil, focando formação e atividades executadas. A coleta dos dados (observação participante e entrevistas) e a análise seguiram o método etnográfico. Foram entrevistados 16 informantes-chave, dentre auxiliares e técnicos, docentes dos cursos de formação, enfermeiros e usuários do serviço. Os cursos de formação tinham pouca ou nenhuma ênfase nos conhecimentos e práticas locais de saúde. Os indígenas formados em enfermagem, nível médio, executavam atividades análogas àquelas exercidas pelo profissional não-indígena da mesma categoria. Atuavam, ainda, como facilitadores e interlocutores entre a equipe de saúde e a comunidade. No contexto estudado, a formação desses trabalhadores e as atividades executadas reforçam o modelo clínico curativista, que dificulta a articulação com os saberes e práticas locais indígenas de saúde, base da Política Nacional de Atenção à Saúde dos Povos Indígenas.

PALAVRAS CHAVE: Auxiliares de enfermagem. Serviços de saúde do indígena. Índios sul-americanos.

INDÍGENAS COMO PROFESIONALES DE ENFERMERÍA: LA PARTICIPACIÓN DE TÉCNICOS Y AUXILIARES EN LOS SERVICIOS DE ATENCIÓN A LA SALUD INDÍGENA

RESUMEN: El estudio analizó la participación del técnico y auxiliar indígena de enfermería en los servicios de salud de la Tierra Indígena Xapecó, Santa Catarina, Brasil, con énfasis en la formación y actividades realizadas. La recolección de datos (por observación participante y entrevistas) y análisis siguió el método etnográfico. Participaron en las entrevistas 16 informantes clave, entre los auxiliares y técnicos, profesores en los cursos de formación, enfermeros del equipo y los usuarios del servicio. Los cursos de formación tuvieron poco o ningún énfasis en el conocimiento y en las prácticas locales de salud. Los indígenas con formación de auxiliar o técnicos en enfermería realizaban actividades similares a las realizadas por profesionales no indígenas en la misma categoría. Sin embargo, los indígenas asumían la función de facilitadores e interlocutores entre el equipo y la comunidad. En este contexto, la formación de estos trabajadores y las actividades realizadas refuerzan el modelo clínico curativo, lo que dificulta la articulación con el conocimiento local y las prácticas de salud indígena, base de la Política Nacional de Atención de Salud a los Pueblos Indígenas.

PALABRAS CLAVE: Auxiliares de enfermería. Servicios de salud del indígena. Indios sudamericanos.

INTRODUCTION

The provision of health actions and services to Indigenous people in Brazil has changed a lot since the establishment of the Indigenous Health Care Subsystem (SASI), in 1999, under the responsibility of the National Health Foundation (FUNASA) until 2011, based on the National Policy of Health Care for Indigenous People (PNASPI).[1] SASI integrates the Unified Health System (SUS) and is geared towards providing differentiated attention to Indigenous people, being run through the Special Indigenous Health Districts (DSEIs). The 34 DSEIs in the country shelter different ethnic group, in territories with village populations, and include health centers in the villages, Base-Units and Indian Health Support Houses, as well as Primary Care Multidisciplinary Teams for Indigenous Health (EMSI).[2] The services of medium and high complexity are referenced in the SUS network.

SASI and PNASPI represent advances in the health care of Brazilian indigenous people, marked by a history of social, economic and health inequalities when compared to Brazilian society in general. The changes brought about by the model are reflected in a larger participation[3] of indigenous peoples in the formulation, implementation and evaluation of health actions and services, as well as increasing the number of professionals in the EMSIs.[4] In this sense, nursing plays on a key role in inter-ethnic contexts as a producer of health care sensitive to the social, cultural, political and economic dimensions of each ethnic group, by linking the knowledge and practices of Indigenous health care and the biomedical model, basis of the principle of differentiated attention proposed by PNASPI.[1] Nevertheless, some authors[3,5-7] indicate that one of the main difficulties with differentiated attention is the lack of education and training of health professionals to act in specific inter-ethnic contexts.

SASI and PNASPI emphasize the role of Indigenous health agents (IHAs), exercising the link between the community and the staff, and between Indigenous knowledge and biomedicine. Studies[3-7] report the insecurity of IHAs and many of them see the need to study more, with training as nursing technicians or aides[4,6] being one of the strategies used.

At EMSI, nursing technicians and aides, after IHAs, are the closest professionals to the population. Authors emphasize that the care model carried out by mid-level nursing professionals is technical and an uncritical reproduction of the existing practices,[8] and the activities based on production procedures that reinforce a curative and immediate model.[9] Accordingly, it is relevant to investigate the training of Indigenous people as nursing technicians and/or aides, and the activities developed, seeking to understand their participation in the Indigenous health care model. Moreover, the theme involving nursing and Indigenous health has not been published in journals in the field or in other publications. Therefore, the study contributes to promote an unexplored aspect about workers of the SUS, presenting relevance for public policies, as it may provide subsidies to implement differentiated attention to Indigenous peoples.

It is understood that the training process and the activities developed in everyday professional practice in the community are important elements to contextualize the participation of these workers in the Indigenous health care model. Thus, the objective of this study was to analyze the participation of Indigenous workers with training as nursing technicians or aides, identifying the courses taken and the activities developed in the Xapecó Indigenous Reserve (IR), Santa Catarina.

POPULATION AND METHOD

The Kaingáng, the study site and multidisciplinary Indigenous primary health care teams

The Kaingáng, from the Jê linguistic family, is one of the five largest ethnic groups in Brazil,[10] living in São Paulo, Paraná, Santa Catarina and Rio Grande do Sul. The Xapecó IR has 11 villages and is located at Ipuaçu and Entre Rios, west region of Santa Catarina, inhabited (with approximately 4,823 individuals)[10] mainly by the Kaingáng, but also by Guarani Indians. During the period of this research, it counted on an infrastructure of education (four schools, one of them offering elementary and high-school education, located in the main village) and health (five health centers). Sanitation was poor and there was no garbage collection. The Kaingáng had several sources of income, such as employment outside the IR or in schools and health centers in the villages, government pensions and programs (e.g., Bolsa Família, a government funding program). This IR belongs to the Base-Unit of Chapecó, part of the DSEI Southern Interior, with regional coordination in Florianópolis.

Access to primary health care was given in the five health centers in the IR (three located in the territory of Ipuaçu, served by an EMSI, and two in Entre Rios, under the responsibility of another EMSI). Medium and high complexity care were referenced in the SUS network services of counties neighboring the IR, or more distant counties, depending on the case.

In the Xapecó IR, between December 2010 and February 2011, there were a total of 43 professionals (Table 1) covering both EMSIs. As often happens at this time of year, many professionals such as the IHAs and the physician had their contracts terminated, awaiting a new selection process. The IHAs, as well as other members of the two EMSIs, continued working despite this situation.

Table 1 – Composition of the Multidisciplinary Indigenous Primary Health Care Teams (EMSIs). Xapecó-SC, Indigenous Reserve, December 2010/February 2011

	EMSI 1		EMSI 2	
EMSI Member	**Fem. (n)**	**Male (n)**	**Fem. (n)**	**Male (n)**
Indigenous Health Agent	8	2	7	-
Indigenous Sanitation Agent	-	1	-	1
Indigenous Nursing Technician	1	4	1	1
Indigenous Nursing Aide	2	1	-	-
Non-Indigenous Nursing Technician	1	-	-	-
Assistant Dental Consultant	2	-	-	-
Nurse	5	-	1	-
Dentist	1	1	-	-
Nutritionist	1	-	-	-
Physician	-	2	-	-
Total	**21**	**11**	**9**	**2**

The empirical study was qualitative, descriptive, with data collected by field research based on ethnographic methods (interviews and participant observation). The ethnographic method is a way of constructing a narrative about a group in order to "establish relations, select informants, transcribe texts, raise genealogies, map fields, keep a diary and so on", developing a "dense description".[11:15] The ethnographic framework, therefore, was used to capture an unexplored context and weave interpretations that enabled revealing how the participation of these workers in the Indigenous health care services is taking place.

The survey was conducted between December 2010 and February 2011, in the three health centers located in Ipuaçu and one of the centers in Entre Rios. The researcher took up residence in the main village in the IR, where she observed and monitored the daily activities of the EMSI. In the other three health centers, she stayed there for two days to two weeks, after the period in the main village (the shortest stay was at a station located in Ipuaçu, which only had a nursing technician and an IHA, with sporadic visits from the physician and the nurse). In the participant observation, the nursing technicians and aides were included, while they carried out everyday activities in the EMSI, as well as patients assisted by them. The inclusion criteria for the interviews were: working in the nursing field as a nursing technician, aide or registered nurse; having participated as a teacher or coordinator in training courses for nursing technicians and aides; and being a user of the health services. Overall, the respondents, considered as key informants, were seven nursing technicians and three indigenous nursing aides, a non-indigenous nursing technician, a nurse, a teacher and a course coordinator, and two patients. The guiding questions were about training and the activities developed. Sociodemographic data on the Indigenous nursing technicians and aides were also collected. All of them signed the Informed Consent Form. The ethnographic data were recorded in the field diary and, whenever permitted, the interviews were recorded.

Data analysis focused on the identification and interpretation of meanings emerging from the interviews and the participant observation, systematizing the converging points. The differences were analyzed from the context of the speech and the speaker, paying attention to the location and status of participant observation and interviews. During the execution of the ethnographic method, documents relating to training courses were also consulted, in order to support the interpretation of data.

The research was conducted in accordance with the required ethical standards, complying with Resolution No. 196/CNS/1996; Protocol No. 626/2010 from the Human Research Ethics Committee of the Federal University of Santa Catarina (UFSC); and Protocol No. 540/2010 from the National Commission for Ethics in Research. The researchers also received an authorization for entering the Indigenous Reserve as per Protocol No. 90/AAEP/2010, from the National Indian Foundation. The names of the participating subjects were changed.

RESULTS

Who were the indigenous nursing technicians and aides?

At the Xapecó IR there were 16 indigenous staff members trained in mid-level nursing (three nursing aides and thirteen nursing technicians); four were unemployed (not included in Table 1). Most were between 31 and 50 years of age. Among the informants (seven nursing technicians and three nursing aides), most were married or living together with a partner, they had up to three children and were Kaingáng, yet not speakers of the language. Three nursing technicians had completed higher education in diverse health areas: one worked as a technician, one always worked in the administration of the covenant between Non-Governmental Organizations and FUNASA and the third had taken another higher education course. There were ten Indigenous contractors in the function compatible with the training (seven as nursing technicians and three as aides, as per Table 1), most receiving between 1.4 and 2 minimum wages; two technicians worked in other roles (one as an IHA, shown in Table 1 in this function, and the other in general services, not informed in the same table).

Training and qualifications of the Indigenous nursing technicians and aides

Mid-level Indigenous nurses carried out their training through free professional training courses. The Supplementary Professional Course for Nursing Aides, offered in 1993-1994, especially to the Indigenous population, was promoted by the Catholic Church, together with the Lutheran Church and the Indigenous Missionary Council. According to a religious woman from the Catholic congregation, who was the course coordinator, the program included 480 hours of internship in the hospital and health center, a month of lectures in Braga, Rio Grande do Sul, and practical activities in the students' villages of residence, totaling 1,300 hours. The Indians Paulo, Lucas, Tereza and Anastácia took this course.

According to the religious woman, the training of indigenous people would provide better service in the villages: *most nursing assistants on the indigenous land were white and did not understand the Indian culture. And the indigenous nursing assistant knew the community, the teas, the culture and knew the people better* [...]. *The Indigenous nursing aide accompanies most patients. He knows the community to be able to work with home remedies* (Sister Sara). One of the central issues of the course was teaching about medicinal plants, because some of the Sisters considered the "rescue" of traditional indigenous medicine as important. Nevertheless, the contents generally did not include information on the socio-cultural economic and political context of the Indigenous people who live in this IR.

The Worker Professionalization Project in the Nursing Area (PROFAE)[12] was divided into two modules: I) Technical Qualification – Nursing Aide from the Nursing Technician Course, with 1,250 hours (400 hours in internship), offered in 2003; and II) Specialization in Nursing Technician, with 1,800 hours (600 hours in internship), offered in 2004. Module I (Nursing Aide) was performed by the Indians Simas, Luana and Lucrécia, whereas Module II (Nursing Technician) was completed by Anastácia, Paulo and Francisco. In this course, there was no specific content related to the Indigenous reality, as it was more general and related to the Indigenous aspects of this IR.

The "Pioneer Project" of UFSC, aimed at Indigenous people, was offered in two modules: I) Nursing Aide, with 1,110 hours (400 hours in internship), offered in 2002-2003; and II) Nursing Technician, with 1,800 hours (690 hours in internship), which took place in 2004-2005. The Indians

Gabriel, Carlos, Fernando, Pedro, Amanda, Carla, Gabriela and Alexandra took both modules; Lucas and Luana, who had taken the Nursing Aide Course through the Supplementary Course and through PROFAE, respectively, completed the Nursing Technician Course at UFSC. Module I included the discipline "Regional Studies" on "local customs and habits" in the Xapecó IR. For these classes, older indigenous people from the IR were called, along with Sister Sara. Module II was directed towards the hospital environment, in order to prepare these professionals to receive and offer care to Indigenous patients in this site. According to a teacher who worked on this "Project", *it was not a university initiative, it was the response to a specific demand from the Indigenous people.* [...] *very important, because this group was then consolidated, which was only one group of students in this class* (Professor Claudia).

Nursing technicians and aides manifested positively in relation to the training courses carried out, stressing that there is a need for Indigenous people working in health and for a more advanced qualification, as expressed by one Indigenous nursing technician (INT), with a college degree in a different health area: *there is a lack of trained Indigenous professionals. There are colleges for training Indigenous people only in the area of undergraduate degree, and not for health. This is needed in the health area* (INT Anastácia).

The free training courses offered were uncommon, grounds for complaint by the indigenous people. Most of the training courses organized by FUNASA and in the counties of Ipuaçu and Entre Rios, in the period between 2000 and 2010 were attended by all the Indians of the EMSI. The themes were about prevention of sexually transmitted diseases and AIDS, oral health, fighting drugs and alcohol, food and nutrition surveillance, among others. The update through training courses was seen as important to the work, as indicated by an Indigenous nursing aide (INA): *I wanted more training, so as not to stand still* (INA Lucrécia).

Activities developed

In health centers in the Xapecó IR, mid-level nursing staff (Indigenous or non-Indigenous) carried out the same activities, such as: hosting the patient, performing triage and pre-consultation, scheduling tests and appointments, assisting nurses/physicians in emergency cases, administering medicines by intravenous route, delivering and taking care of the stock of medicines, performing dressings and inhalation/nebulization, preparing/cleaning the dressing rooms, sterilizing materials, carrying out and assisting the team in home visits.

After the consultation, the patient received, mainly from the nursing technician or aide, medication and/or treatment prescribed by a physician. Even when there was no physician present, they hosted the patient and helped out with their demands. In the need for a more complex intervention, they called the nurse. Nevertheless, when this was not present, or even depending on the severity of the situation and the time of the incident, the patient was referred to another village's health center or to the reference hospital.

In the daily work, supervision of Indigenous nursing technicians and aides was more frequent when compared to non-Indigenous ones. According to one nurse, the Indigenous people demonstrated to be insecure, especially in invasive processes: *they are not very secure, they are a little more dependent.* [...] *they do everything, sometimes they have difficulty doing something, but then we help, and then they do it very well after we show them* (Nurse Laura).

Before the implementation of the SASI in the Xapecó IR, health care at the health centers was given by the nursing aides and attendants, with the possible presence of physicians and dentists and mobile health care teams. Thus, the activities carried out were different from those currently implemented, as one INT noted, who has already worked as an attendant and an aide: *at the time you had the nursing attendant to teach you how to perform sutures, deliveries, you did everything. Not today, but at that time it was like that. The attendant was the physician, there in the countryside. At that time a pregnant woman came and we did not take her to the hospital, first, because there was no hospital nearby, and also because there was no car and the road was terrible. Today we have a good road, there is a car, there is a hospital, but at that time there wasn't, so we 'hospitalized' her at the health center and assisted her there. I performed childbirth, gave medications, performed drips, looked after patients* (INT Carlos).

For this technician, he has less responsibilities today, because there is a sharing of the activities according to the function performed: *we have been working this way, but since that Law, from the Nursing Council, which has the discussion from there in 1988, which says an aide is an aide, a technician is a technician and nurse is a nurse, it prevents us from doing procedures that we did before, we did a lot more stuff, we had more responsibility. Today it is the nurse who has this responsibility* (INT Carlos).

Another important factor that negatively affected the work process and the relationships within the team was the turnover of professionals, as highlighted by one INT: *I always had plenty of rapport with the health care team, it was just that we have a problem that changes a lot, not the nursing technicians, but the registered nurses who come from outside. Because it always involves politics, and we have always had problems with the covenants* [a contract between FUNASA and Non-Governmental Organizations]. *I would have had an opportunity to do an entrance exam* [public] *and go to the city* [Entre Rios], *because here every contract is difficult, and my husband is in politics, but I didn't want to do it because I like it here, and they also like my work* [...]. *The changing of Indigenous health agents is a difficult thing, everything has to start all over again, we train them, empower them, and then everything changes again when there is a change of chief* (INT Amanda).

Some Indigenous nursing technicians get involved with practices related to medicinal plants, with vegetable gardens in at least two of the villages in the IR. Nevertheless, activities related to medicinal plants were not constant, not only due to operational difficulties (maintenance of vegetable gardens, procurement of raw materials for preparation of medicines), but also because the natives did not feel very confident, despite having received training on the subject. The use of plants was well regarded by non-Indigenous professionals, who saw them as rescuing the culture. On the other hand, one INT emphasized the limitation of plant remedies to treat health problems, a situation that, according to her, should be known by all of those working in health centers: [...] *plants have the effect of healing, but with the Indians now eating processed products, not food from the forest/natural anymore, there is a need to heal with medicine from the pharmacy as well as teas, because their diet has changed and now only the medicines from the forest don't help on their own, they also need anti-hypertensive medication and medicine for diabetes* [...] *if someone is at the health center and has no knowledge of this Indigenous community they suffer for not knowing* (INT Anastácia).

Two Indigenous nursing technicians were active in social control, both of whom had been presidents of the Local Indigenous Health Council and one was also a member of the Southern Interior Indigenous Health District Council. The perspective of one of them on the work of indigenous professionals emphasizes their responsibilities: *whoever does a good job is professional, whoever makes things happen depends on each one of us, but it doesn't cost, for instance, I do not get mad if they tell me to work another way to see if anything changes.* [...] *we have to be open to change, to get better.* [...] *we have to stop and evaluate. Here at our wee health center we have a lot of difficulty, I have to take care of the health center, medication, filing, playing the role of a laborer* (INT Fernando).

Indigenous nursing technicians and aides performed very different activities from the IHAs. According to one INT, who had already been an IHA: *IHAs have to be together with the community and technicians are more oriented towards disease prevention, lectures and attending folks at the health center. I like the two professions, but the difference in salary made me choose to be a technician. I like the technical actions such as dressings, injections, checking pressure. The coolest thing about the profession is the pleasure in working with people, seeing them opening up and helping. In the beginning there is fear, trepidation and then trust* (INT Gabriel).

The Indigenous nursing worker even assumed the role of facilitator and mediator between the health care team and the community. The staff perceived him as the mediator of medical, curative recommendations, as well as the desires and fears of patients towards medical procedures. The Indigenous nursing technician and aide intervened to assist the patient and/or their caregivers in accepting and fulfilling the medical recommendation. He valued the role of mediator, because he saw himself as the "caretaker" of the community, realizing the importance of his explanations or intervention. The community, in turn, considered him accessible, obliging, ready to exercise care; he was a family member on the team, who could be demanded whenever necessary, facilitating access to some resources, such as medicines.

DISCUSSION

At the Xapecó IR, research[3-4,7] shows that, since the implementation of SASI, the physical and personnel structure of health services has increased, which was observed in this study from the identification of the composition of the two EMSIs. Nevertheless, one of the biggest problems has been the turnover of its members,[3-5,7,13] which occurs regardless of employment periods. In the case of Indigenous nursing technicians and aides in that IR, unlike other professionals (especially physicians, nurses and IHAs), there was a significant turnover, and some of them worked in health care for many years. There

was dissatisfaction with the constant hiring and firing. Along with this, changes in the organization of Indigenous health, going from FUNASA administration to the Special Indigenous Health Department, causing uncertainty and concern, as salaries, specialist consultations, examinations, purchases and payments, by the administrator of the covenant, had been suspended to await the transition that should have occurred within 180 days from October 2010,[14] a deadline later extended to 31st December of 2011.[15]

Another point to highlight regarding the composition of the EMSIs concerns the unemployment of nursing technicians and aides (25%). One of the reasons for this situation involved internal political alliances, which was similarly observed among the IHAs,[4,7] in other words, nursing technicians or aides without a connection to indigenous leaderships had less chance of being employed. A report published in 2003,[16] about the assessment of the impact of PROFAE in 17 Brazilian states, revealed that among students from the nursing aide class, 19.7% were unemployed, 54.5% worked in nursing and 25.8% exercised other functions, i.e., at the Xapecó IR there was a similar context, compared to other scenarios, in the level of unemployment and in the insertion of Indigenous people in the nursing labor market.

In Santa Catarina, between 2002 and 2005, 3,165 nursing technicians and 2,434 nursing aides graduated through PROFAE,[17] a proportion of 0.06% and 0.05%, respectively, in relation to the State population,[18] whereas in the Xapecó IR the proportion of indigenous people with a degree in nursing was 0.33%, considering the total population. An analysis[19] of the graduation process for Indigenous nursing aides in Mato Grosso-MT pointed out the professionalization of 117 Indigenous people between 1997 and 2000. According to the study, the aides want to become technicians seeking a higher status, taking courses with Indigenous and non-Indigenous people. At the Xapecó IR, the professionalization of the Indigenous people has meant an opportunity for qualification, similar to other non-Indigenous contexts.[20-22] From the perspective of continuing their training, the Indigenous people aspire to a university degree, particularly in medicine (nursing and psychology come in second and third places, respectively). The community also hopes that the Indigenous people look for more specialized training.

Among the three courses performed, two of them were specifically for Indigenous people, the first (1993-1994), also absorbing content on medicinal plants and the other (UFSC) bringing, in one of the modules, a theme on customs and habits in the IR; in the third (PROFAE), the Indigenous people shared with non-Indigenous students, without any space for local specificities. Official documents[1] and authors[4-5,7] have placed importance on contemplating training and qualification that is more sensitive to the Indigenous socio-cultural realities, including topics on knowledge and practices involved in the health-illness-care process, which are broader than the use of medicinal plants or a list of habits and customs of a group of people. On the other hand, the Indigenous people, when searching for mid-level training in nursing, aspire to access biomedical knowledge, thus increasing performance possibilities at the EMSI. In a similar vein, the Indigenous people who took the Projeto Xamã course[19] claimed courses geared towards non-Indigenous people, as they felt less capable than other members of the EMSIs, since they had not performed a hospital internship, which they named as the "reality of the city".[19:67]

According to the legislation,[23] the activities of these workers are varied. Analyzing the activities performed by the Indigenous nursing technicians and aides in the Xapecó IR, they actually do not differ, as indicated above, highlighting that their work process is found at the primary care level. If there was division of work, it occurred by affinity and not by professional category. In a study[24] conducted in three hospitals in São Paulo, "a lack of distinction between the work of the nursing aide and the nursing technician"[24:428] was observed, leading the authors to question the pertinence of such a division. When we compare the activities of the Indigenous nursing technicians with those of the non-Indigenous technicians, we can observe that there was no differentiation, unlike what was observed at the Indian Health Support House of the DSEI Tapajós, where the Munduruku nursing technicians had different attributes than the non-Indigenous nursing technicians.[25]

The role of facilitator and mediator of nursing technicians and aides allowed the establishing of links with the assisted population, which is a positive factor where primary care is concerned, a fact also observed in other realities, such as among primary care nursing aides staff in Distrito Federal[26] and São Carlos-SP.[9]

Despite the importance of the link and the role of mediator, the activities developed had an eminently individual character, based on the clini-

cal curative model, as shown in other studies.[8-9,13,26] The work process based on individual and curative intervention, on the biomedical logic, did not allow spaces for dialog and the construction of collective local practices, nor the articulation with Indigenous knowledge, the basis for differentiated attention.[1] This situation is a reflection of technical training (for both Indigenous people and other professionals) and of the bureaucratized, hierarchical and service-producing organization. On the other hand, the Indigenous nursing technicians and aides from the Xapecó IR did not have an ambiguous role in the care model, different from the IHAs from this place.[3-4,7] The role of mediator was strictly in the field of biomedical activities and the conflicts and tensions experienced by the staff involved aspects linked to the coordination and execution of daily tasks, but no charges of a possible professional exercise articulated to Indigenous socio-cultural specificities.

FINAL CONSIDERATIONS

Although this study was conducted in an Indigenous Reserve, among several existing in the country, the results expose a particular context, poorly explored and recorded in literature. Some of the studies consulted address the role of the IHAs at SASI, without emphasizing the Indigenous nursing staff. Thus, further research in other Indigenous realities, considering the socio-cultural heterogeneity of the Brazilian people, will help to understand how the Indigenous people, included in an EMSI, perform faced with the demands of the service and the population served.

The data collected suggest that the Indigenous people aspire to a higher qualification in health (and are actively pursuing it) as a way to improve their earnings, with institutional recognition of their role, and access to knowledge that provides prestige in relationships among their peers. Nevertheless, this study points out some challenges, whether at the local level or further afield. The dynamics of health centers, the workers and the population served need to establish relationships that include Indigenous knowledge and practices. More broadly, the new Special Indigenous Health Department needs to consider the Indigenous nursing technicians and aides and not only the IHAs in the organization and operation of services, as well as promoting greater coordination with vocational courses in order to restructure the curricula in accordance with local and regional specificities.

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