

INDIGENOUS COMMUNITY HEALTH AND THE NURSING STUDENTS' EXPERIENCE

EXPERIENCIA DE LOS ESTUDIANTES DE ENFERMERIA SOBRE LA SALUD EN UNA COMUNIDAD INDIGENA



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Abstract

The population of indigenous groups worldwide is directly impacted by the prevalence of chronic health conditions and disease. For the nursing student, this translates into a discovery of indigenous communities' health status and the nursing interventions that can impact their mortality and quality of life. Utilizing the educational framework of a community health nurse, a group of thirteen nursing students had the opportunity to take part in a community health, study abroad project targeted to the indigenous Kuna Indians of Las Nubes, Panama in June 2006 and 2007. Exploration into the nursing students' experiences, along with a literature review of the determinants of indigenous health, will provide insight into the role of the community health nurse and how the associated theories and applications can be applied to providing nursing care for indigenous populations.

Resumen

La población de los grupos indígenas en todo el mundo está directamente afectada por la prevalencia de condiciones crónicas de salud y la enfermedad. Para el estudiante de enfermería, esto se traduce en un descubrimiento de los estados de salud de las comunidades indígenas y las intervenciones que pueden afectar o impactar sobre su mortalidad y la calidad de vida de los mismos. Utilizando el marco educativo de la enfermería comunitaria, un grupo de trece estudiantes de enfermería tuvo la oportunidad de participar en un proyecto de salud en una comunidad indígena, el grupo de estudio fue conformado por los indígenas Kuna, de Las Nubes, Panamá en junio de 2006 y 2007. Los estudiantes de enfermería realizaron exploración de experiencias de salud, junto con una revisión de la literatura de los determinantes de la salud de los indígenas, que proporcionará información sobre el papel de la enfermera de salud en la comunidad y cómo desde las teorías y sus aplicaciones se pueden brindar o proporcionar cuidados de enfermería para las poblaciones indígenas.

INTRODUCTION

Along with Maurer & Smith community health directs its practice to promoting health and preventing disease of a community or population as a whole. Populations receiving health care delivered by community health nursing are those people in a common area or

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community, and/or are the group of people under statistical study (1). Stephens, Porter, Nettleton, & Willis, said that distinguishing a population of Indigenous peoples has been the cause of debate and controversy with no universally agreed definition identified (2). According to the World Health Organization, Indigenous peoples are distinguished by their social, cultural and economic conditions as descendants of the original inhabitants of the country at the time of colonization; are self-identified and groups recognized; and retain cultural, lingual and political institutions independent of the country in which they reside (3).

As stated by Maurer & Smith, the community health nurse's primary responsibility transcends individual needs to focus on the health of the entire population (1). Indigenous peoples are one such population that experiences extensive health disparities leading them to be the focus of many health and human rights projects, including the Las Nubes Mobile Health Clinic in Panama. Resolving to acknowledge "the precarious levels of economic and social development that indigenous people endure in many parts of the world, and the disparities in their situation in comparison to the overall population", the World Health Organization (WHO) along with the Pan American Health Organization (PAHO) and the United Nations have collaborated to adopt sustainable projects for indigenous groups (4). The formation of the Permanent Forum in Indigenous Issues, the declaration of First and Second International Decades of the World's Indigenous People, and the designation of August 9th to be observed as International Day of the World's Indigenous People every year are but a few of the initiatives.

After defining the target community, identifying the needs of the indigenous population being served is the second step to developing a plan of care that involves three levels of community nursing interventions: primary, secondary, and tertiary. In consistency with Maurer & Smith the primary level of intervention focuses on strategies to improve the health and well being of the community and include health education and immunizations (1). At the mobile health clinic, this was the most prevalent level of intervention identified by the students. "You could see how the importance of vaccinations was stressed as nurses and nursing students visited each family door-to-door to ensure children's records reflected current data. They (Kuna) had charts that informed the nurses of their medical background and everyone (nurses) educated the people on keeping them up to date"(5). Other education measures implemented include health pamphlets provided on malaria, tuberculosis, Papanicolaou (PAP) smears, water safety, and dental hygiene.

In accordance with Maurer & Smith, secondary interventions function to slow the progression of existing illnesses through screening programs of asymptomatic individuals and detecting illnesses in its early stages, and tertiary interventions function to limit disability and rehabilitation focused care (1). At Las Nubes, weights were taken of all the children in the community to monitor growth and development, blood pressure readings and blood glucose testings were provided for all, and PAP smears were performed on all the women willing. Tertiary level interventions included laboratory and dermatological referrals made to the local hospital located forty-minutes away from the village. Although the clinic sought to provide as much direct care as possible by having a doctor available for thorough medical examinations as needed, Kuna are known to have poor compliance with health care recommendations. As indicated by McConnel Poor compliance is often seen

when one culture is in dissonance with the health care values of Western medicine, with the resulting unhealthy behaviors existing in greater numbers among these communities (6).

The health fair operated to implement these interventions as various groups broke out to assess families in their homes and encouraged each person to walk to the mobile clinic area, located approximately 100 yards down hill from the residences, where doctors and nurses were providing health screenings and services such as weights, blood pressures, vaccinations, doctor's examinations and PAP smears. Visiting families in their homes to conduct "snap shot" assessments is a service community health nurses do not normally provide. It is more often seen with social workers assessing the environmental conditions of communities and families. These home visits had a great impact for many of the students as "we needed to literally invade a person's privacy and tell them what they were doing right or wrong and what changes needed to take place for their benefit" (7). However, making an assessment was just the tip of the iceberg for a community that required aggressive intervention to make the mobile clinic project truly successful as a means of delivering preventative nursing care.

During the study abroad trip to Panama, information was provided on the health status and culture of Kuna Indians for generalized educational purposes and in preparation for the health fair. Both chronic and acute public health conditions that defined the overall poor health status of the population were discovered. The chronic conditions affecting Kuna Indians include heart disease related to congenital abnormalities, hypertension, diabetes, and cervical cancer among women. The acute conditions include primarily malaria, dengue fever and lichenomysis. There are a number of risk factors preceding these conditions which ultimately influence the health status of indigenous groups. According to Montenegro & Stephens, Morrissey these risk factors were witnessed by the nursing students and are often reiterated for other indigenous populations world wide: ethnocide, resource exploitation, social deprivation, the failure of the health care system, cultural insensitivity, and language barriers (8; 9).

INDIGENOUS HEALTH DISCOVERED

Historically, the health traditions of indigenous ways of life have been endangered by European colonization and nationalist conquest of cultural practices. Said by Howe in 1919, Belisario Parros, then President of Panama, began a program to eliminate Kuna culture from the mainstream by prohibiting the female puberty ceremonies and women who bound their arms and legs and wore nose rings (10). The same author said that Chewing chicha mash used for general inflammatory conditions, picking lice out of hair, and burying defective newborns were also aggressively outlawed during Parros' term (11). However, today most Kuna could be readily identified by their traditional garments, molas shirts, nose rings, and bound arms and legs.

According to Ventocilla, Herrera, & Nunez as the apparent ethnocide of Kuna began to progress, the obliteration of land by colonist farming efforts and its inhabitant plants, food, and natural microorganisms that preserve the integrity of indigenous wellness, illness and disease ensued. The pure water springs Kuna are accustomed to have been replaced by barrels of water that function as breeding grounds for mosquitos and the malaria and dengue they carry. The ingredients common in their herb-based remedies and plant

pharmacology, such as *Sapindus saponaria* used to treat the common cold, and *Quassia amara* used to treat diabetes, are not available in Las Nubes (12). “Health for many indigenous peoples is not merely absence of ill health, but also a state of spiritual, communal, and ecosystem equilibrium and wellbeing” (13).

The majority of the Kuna population resides in a protected area of Panama called the Kunayala Islands, with Las Nubes being one of many transient communities on the outskirts of Panama City. Kuna Indians are known to migrate towards larger cities in search of food, fresh water, employment, and other resources that have become scarce in their native land. Orientation to the health fair made note of Las Nubes being rural and located on the side of a mountain, but rural defined and rural witnessed are two different perspectives. For one student, “the most significant difference [orientation versus the actual experience] was the unsanitary conditions and the amount of sheer poverty we experienced” (14).

Stated by Pan American Health Organization, Las Nubes is a mountain-side community of over 200 men, women, and children residing in hand-built shacks with 5 to 8 persons per one-room structure. Homes were constructed from scrap metal, cardboard, mud, twine, and what ever material could be harbored for building. The terrain was rocky, muddy, and slick and without defined paths for walking. And the mud seemed to permeate everything from the floors of the homes, to the water used for washing clothes and dishes, and to the faces of the children that ran through the village naked while their clothes hung on lines to dry. Within the first minute of arriving at Las Nubes, the initial image of the community’s destitution reflects the popular view of indigenous groups experiencing extreme poverty, a lack of land, and relative social deprivation in comparison with their non-indigenous counterparts (15). “The people in this community lived in shacks, have no running water, no air conditioning or heat, and nothing to even closely resemble a luxury item...the basic theme of the indigenous community was bare necessities” (16).

As indicated by Anderson, Smith, & Sidel, a finger is often pointed at the health care system for contributing to the lack of wellness among indigenous populations, but the health of the population is a matter of social concern that should be promoted through both individual and social means (17). Community-oriented care for Kuna addresses these disparities in a collaborative effort among Panama’s Ministry of Health (MOH) initiatives, the University of Panama School of Nursing, and a great deal of community support. It is a dynamic relationship as the MOH is responsible for approving in what settings indigenous community nursing care can be provided, the nurses determine when and how care is delivered, while the equipment and supplies are largely supported by donations from individuals and organizations. “The Panamanian model of community health is very proactive and interactive with the community as a whole in an effort to offer health care to everyone” (18).

The medicines offered to the Las Nubes community were donated by various sponsors as well and greatly appreciated by the professionals distributing them and the individuals in receipt. However, the drug therapy offered to Kuna did not consider the indigenous customary practices. Allegra and Prevacid, medications normally prescribed for rhinitis and peptic ulcers respectively, were a few of the medicines provided to treat symptoms of fever

and the common cold. “Most of the medicines provided during the health fair were not appropriate to each person’s condition and were given away just because they were free” (19).

Along with Stephens et al. cultural insensitivity, another risk factor for illness, can mean the difference between sustainability and extinction for indigenous communities that are already small in numbers. Performing a door-to-door visit of a man who resided in a single-room home with a one-year-old, a three-year-old and a four-year-old revealed his youngest child suffered from a respiratory infection. The father acknowledged he had known about his one-year old son’s illness for some time, but has not brought the child to the doctor. Unbeknownst to students, Kuna believe it is the woman’s responsibility to bring children for medical treatment and for that reason the husband refused to walk his child to the medical clinic. It required a nurse escorting the father and child to obtain a prescription for medications and a referral. A small numbers of deaths have a devastating effect on small communities (2). Without the nurses’ sensitivity to Kuna culture, the death of the child could have resulted in the loss of the sole male infant for the entire community. As a state by Montenegro & Stephens infant mortalities can have a devastating effect for small populations and lead to the destruction of entire generations (8).

The cultural differences did not deter the students or nurses from providing the best possible health care. “It wasn’t easy because a lot of the people that required nursing care had to be begged and coerced to walk down to the clinic” (20). At one point, a woman with a necrotic wound on her leg became the center of attention as a nursing student, nursing instructor, and a translator simultaneously tried to convince her to seek treatment from the doctor. Disappointingly, she never sought treatment. “We were tourists as well as nursing students. This made us less judgmental and more compassionate to the differences in ideas on health between us and the Kuna” (21).

During orientation provided by the University of Panama nursing instructors, cultural nuances specific to Kuna were discussed and suggestions made for tackling these factors affecting health care. There was a preconceived need for aggression when performing nursing assessments. One instructor’s suggestion for environmental evaluations was “do not ask if you can enter their home, just say ‘we need to see your home’ and walk in”. Our experience was different in that a polite request to enter someone’s home produced a welcoming response and no one seemed defensive to our request to assess the home. “The people were actually very friendly and warm. I got the sense that they appreciated us coming to help teach and heal them” (22). In line with Ryan, Twibell, Brigham, & Bennett While the brief introduction to Kuna culture did not prove to be helpful, it is still essential to know that a broad spectrum of cultural values, beliefs and practices must be recognized and understood in order to deliver culturally sensitive care (23).

Along with the idea of cultural sensitivity competence stems language barriers that also affect the health of indigenous populations. On the word of Howe the Kuna speak *Tule*, a language not found among the Spanish-speaking mainstream (11). Occasionally one would find a Spanish-speaking Kuna and Kuna-speaking Panamanians were more rare. This lingual obstacle “made it difficult to communicate serious topics effectively” (24). While the most wide spread method of education was through the distribution of pamphlets, all of

the educational materials were written in Spanish making most Kuna hesitant to accept them. “The hardest thing for me was difficulty communicating with non-English speaking people and then watching the nurses have difficulty communicating with non-Spanish speaking Kuna” (25). At its most extreme, the lack of linguistic sensitivity resulted in Kuna women who had received PAP smears at the mobile clinic believing they were receiving a form of birth control.

IMPLICATIONS FOR PRACTICE

In consistency with Wilson discovering the risk factors prevalent among indigenous communities has created a foundation for assessment, planning and implementation of appropriate care to be adopted by the community health nurse (26). According to McConnel instead of promoting the extinction of indigenous traditions, allowing for a bridge of knowledge between indigenous health practices and western medicine will help to close the gap of health disparities (6). It has been generally recognized by the Office of the High Commissioner for Human Rights that attempts to assimilate indigenous peoples into the mainstream are often counter productive (27). Nurses should be willing to incorporate the beliefs, practices and health priorities of communities into the delivery of their health care.

Montenegro & Stephens said that legal rights of indigenous communities should be guaranteed by the countries they reside in and Panama is one such country that recognizes the right to legislation that address indigenous health, the right to traditional practices, and the right to participate in the management of health resources (8). Rights of health care must also include rights to the protection of land if illness it to be successfully addressed and treated. The destruction of ecosystems and land inhabiting plants and animals remove an essential element of holistic approaches to health common among indigenous groups. Along with Montenegro & Stephens the Kunayala Islands are now a protected environment and in 2000, the Autonomous Institute of Traditional Medicine was created to ensure the Ministry of Health recognizes the existence, value and importance of traditional indigenous medicine (8).

According to Stephens et al. the social disadvantage of communities in new and unfamiliar settings can be addressed with the establishment of employment and education resources for displaced Kuna. Offering employment void of discrimination, instruction on the economic opportunities available, and information on health resources available are but a few ways social deprivation can be conquered. Making services available without financial, geographic and cultural barriers can encourage use by indigenous peoples who fear an environment that is preconceived to be prejudiced or unfriendly (2).

The health care system of countries inhabiting indigenous groups is also seen as discriminatory and uncompromising. In relation to Stephens et al. who said that indigenous peoples do not fit into the predominant lens of public health utilitarianism and efforts must be made to look outside the traditional biomedical model common in western medicine (2). Stated by Anderson et al. the World Health Organization declaration of “health for all” by the year 2000 diverges from the biomedical model and focuses on a view of social medicine that acts as a model for all health systems globally (17). Health care systems must provide “indigenous-friendly” environments that break the cycle of poor utilization and

inadequate health services.

Culturally appropriate health services coupled with culturally incompetent nurses are a combination proven to be detrimental to indigenous health. “It is important for community health nurses to examine their own cultural practices and ‘best practices’ to determine if they are culturally appropriate for patients” (28). According to Wilson using a language that can be understood not only allows for an amicable environment, but allows for the conveyance of respect for indigenous patients’ traditions and diversity (26). Recognizing cultural nuances of indigenous communities can mean the difference between an individual seeking needed care or succumbing to a deadly illness.

CONCLUSION

Participating in the Las Nubes Mobile Health Clinic, for all of the nursing students, was the highlight of the three-week, international, community health nursing program. Indigenous community assessment, cultural competency, and health system critique were a part of the learning experience that impacted all of the students in different ways. In sum, indigenous community health nursing is education, cultural sensitivity and disease prevention that must deal with family, their different practices, and diseases common to the population. It is learning to care for the family in their world, not ours.

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