

Nursing care guide for the indigenous population with cancer in the Amazon context

*Guia de cuidados de enfermagem à população indígena
com câncer no contexto amazônico*

*Guía de cuidados de enfermería para la población indígena
con cáncer en el contexto amazónico*

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ABSTRACT

Objective: To develop a nursing care guide for the indigenous population with cancer in the Amazonian context.

Method: Methodological study with a qualitative approach, conducted from March to July 2023. It was carried out in two stages: 1. A focus group with 18 nursing professionals working at an Oncology Reference Unit in Amazonas, aimed at gathering experiences in caring for the indigenous population with cancer; 2. Development of the guide, based on Madeleine Leininger's Theory of Culture Care Diversity and Universality. Data were processed and analyzed using Descending Hierarchical Classification.

Results: The content obtained from the focus group resulted in four thematic dimensions: educational, policy, care/assistance, and multidisciplinary. The guide outlines various aspects of indigenous health, oncological data in this population, audiovisual resources that complement the theme, reflections on the implementation of differentiated care, and nursing care actions based on decision-making levels, according to the theoretical framework.

Conclusion: The guide was developed with culturally differentiated content for indigenous people, based on the experiences of oncology nursing professionals in the Amazonian context, and can be used to inform and train professionals in indigenous transcultural care.

Descriptors: Indigenous Population Health; Neoplasms; Nursing Care; Oncological nursing; Teaching Materials; Educational Technologies.

RESUMO

Objetivo: Construir um guia de cuidados de enfermagem à população indígena com câncer no contexto amazônico.

Método: Estudo metodológico, com abordagem qualitativa, realizado no período de março a julho de 2023. Foi desenvolvido em duas etapas: 1. grupo focal com 18 profissionais de enfermagem que atuavam em uma Unidade Referência em Oncologia no Amazonas, para levantamento das experiências no cuidado à população indígena com câncer; 2. construção do guia, sustentado na Teoria da Diversidade e Universalidade do Cuidado Cultural, de Madeleine Leininger. Os dados foram processados e analisados a partir da Classificação Hierárquica Descendente.

Resultados: O conteúdo obtido no grupo focal resultou em quatro dimensões temáticas: educação, política, assistencial/cuidado e multidisciplinaridade. O Guia elenca aspectos diversos da saúde indígena, dados oncológicos nesta população, recursos audiovisuais que complementam a temática, reflexões sobre a efetivação da atenção diferenciada e ações para o cuidado de enfermagem baseadas nos níveis de decisões, de acordo com o referencial teórico.

Conclusão: O Guia foi construído com conteúdo culturalmente diferenciado aos indígenas, a partir da compilação das experiências de profissionais de enfermagem oncológica no contexto amazônico e pode ser utilizado para informar e capacitar profissionais ao cuidado transcultural indígena.

Descritores: Saúde de populações indígenas; Neoplasias; Cuidados de enfermagem; Enfermagem oncológica; Materiais de ensino; Tecnologias educacionais.

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RESUMEN

Objetivo: Desarrollar una guía de cuidados de enfermería para la población indígena con cáncer en el contexto amazónico.

Método: Estudio metodológico con enfoque cualitativo, realizado entre marzo y julio de 2023. Se llevó a cabo en dos etapas: 1. Grupo focal con 18 profesionales de enfermería que trabajaban en una Unidad de Referencia en Oncología en el Amazonas, con el objetivo de recopilar experiencias en el cuidado de la población indígena con cáncer; 2. Elaboración de la guía, basada en la Teoría de la Diversidad y Universalidad del Cuidado Cultural de Madeleine Leininger. Los datos se procesaron y analizaron mediante Clasificación Jerárquica Descendente.

Resultados: El contenido obtenido en el grupo focal resultó en cuatro dimensiones temáticas: educación, política, atención/cuidado y multidisciplinariedad. La guía detalla diversos aspectos de la salud indígena, datos oncológicos en esta población, recursos audiovisuales que complementan la temática, reflexiones sobre la implementación de una atención diferenciada, y acciones para el cuidado de enfermería basadas en los niveles de toma de decisiones, de acuerdo con el marco teórico.

Conclusión: La guía fue construida con contenido culturalmente diferenciado para los indígenas, a partir de la compilación de experiencias de profesionales de enfermería oncológica en el contexto amazónico, y puede ser utilizada para informar y capacitar a los profesionales en el cuidado transcultural indígena.

Descriptores: Salud de la Población Indígena; Neoplasias; Cuidados de Enfermería; Enfermería oncológica; Materiales de Enseñanza; Tecnologías Educativas.

■ INTRODUCTION

The plurality of Brazilian indigenous populations is expressed through their 305 ethnic groups, 274 dialects and 73 indigenous lands demarcated by the National Foundation for Indigenous Peoples (*Fundação Nacional dos Povos Indígenas* - Funai). Approximately 1,693,535 Brazilians are self-declared indigenous, equivalent to 0.8% of the country's population, mostly in communities in the North Region, where approximately 753,357 self-declared indigenous people (44.48%) live. The State of Amazonas has the largest number of indigenous people, with approximately 490.9 thousand (28.98%), with Manaus being the city with the largest population, with a total of 71,713 people (approximately 3.48%)⁽¹⁾.

The significant number of indigenous people in Amazonas alerts health services to consider in their planning specific demands of this population and to train healthcare professionals to care for them, in response to the recommendations of the National Policy for Health Care for Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos indígenas* - PNASPI), established in 2002. This document highlights the importance of establishing and strengthening dialogue to ensure differentiated attention addressing the health conditions affecting this population⁽²⁾.

Among the most diverse problems that affect indigenous populations, Chronic Non-communicable Diseases (NCDs) stand out, especially cancer, caused by changes and sociocultural, environmental, nutritional and economic transformations over the last years, which have led to shifts in the epidemiological profile⁽³⁾.

The national epidemiological scenario for indigenous populations highlights that the most common neoplasms for females are cervical, stomach, leukemia,

liver and breast cancer, showing divergent profiles when compared to the non-indigenous population. As for males, the most common neoplasms are stomach, liver, colorectal, leukemia and prostate cancer⁽⁴⁾.

In the process of providing care for indigenous populations affected by NCDs, especially cancer, nursing represents as the largest health professional category working with these populations. However, there is still a lack of preparation and insecurity in decision-making and conduct, which has an impact on the quality of care. Therefore, there is an urgent need for initiatives that permeate the construction of individual and collective knowledge capable of fostering personalized and intercultural care⁽⁵⁾.

Given the need for culturally strengthened care, Madeleine Leininger's Theory of Culture Care Diversity and Universality (TCCDU) emerged, reinforcing the influence of cultural and social factors on health-disease processes and nursing care, thus providing differentiated care⁽⁶⁻⁷⁾.

Leininger indicates in her theory, based on the Sunrise Model diagram, the analysis of the nursing approach in three forms of action: preservation/maintenance, aiming to maintain the culturally based phenomenon, providing actions that can maintain beliefs and values; accommodation/negotiation, constituting the culturally based act, allowing to seek combinations of different cultures; and cultural repatterning/restructuring of care, to foster practices that can lead clients to modify, rebuild or alter their own health models⁽⁸⁾.

The choice of developing a technical-technological guide was made with the intention of supporting reflections for nursing care actions for indigenous populations with cancer, with a view to providing access to relevant content, presented in text, image and sound format,

which can serve as support for the search for knowledge about indigenous peoples and decision-making, in addition to nursing actions based on intervention approaches in light of TCCDU to become congruent and beneficial. Thus, the objective of this study was to develop a care guide for nursing care for the indigenous population with cancer in the Amazon context.

■ METHODS

This is a methodological study ⁽⁹⁾ in which an educational technical and technological product was constructed, developed in two stages. This construction was preceded by a qualitative stage ⁽¹⁰⁾, in which the experiences of nursing professionals who provide care to indigenous cancer patients were assessed, and these experiences guided the content used in the educational technology.

The research was conducted at a reference institution for cancer control and treatment, which is part of the specialized care of the public network of the Unified Health System (*Sistema Único de Saúde - SUS*) of the Amazonas State Health Department (SES-AM), whose actions and services offered are of medium to high complexity, related to cancer treatment and control.

Stage 1: Survey of nursing professionals' experiences

In this first stage, the experiences of nursing professionals were surveyed in the months of February and March 2023, through the focus group technique, which is a group interview based on communication and interaction. Its main objective is to gather information capable of providing an understanding of ideas, impressions, beliefs and attitudes about a specific topic, product or service ⁽¹¹⁾.

Eighteen nursing professionals participated in the focus group, including six nursing technicians and twelve nurses who met the inclusion criteria, which was having more than 30 days of experience with direct care for indigenous patients in the oncology unit. Including experienced professionals and others with a short period of experience in the study setting is justified by the high turnover of employees at the institution and because the experience of newly hired professionals in caring for the indigenous population is

considered important, as well as including them in the collective construction of the Guide through questions that encouraged reflections from the participants of both groups on care for the indigenous population with cancer.

The participants were invited in person after an agreement with the management of the Institution, ensuring that the focus groups could be held in a private environment for study participants only, during the period in which the groups were held, to obtain the greatest participation of professionals who were on duty during the data collection period.

Two focus groups were conducted in the auditorium of the reference institution for cancer control and treatment and were promoted via WhatsApp. The groups were mediated by one of the researchers and included three researchers, who contributed as observers, responsible for observing behaviors (facial expressions), controlling entry and exit from the auditorium, response time for each question, and recording the speeches of both groups. The statements were recorded after participants' consent in both groups, using three cell phones placed at different points to guarantee good audio quality.

The two focus groups were carried out using three trigger questions on the topic of indigenous health, namely: 1. What are your experiences in caring for indigenous people with cancer? 2. How do you plan and carry out care for indigenous people with cancer? and 3. What are the main nursing care practices used for indigenous people with cancer? The time used to conduct the groups lasted on average one hour and thirty minutes for the focus group with nurses and approximately one hour for the group of nursing technicians.

For data analysis, the software *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ®) was used, which is based in the R software and allows different forms of analysis. The textual *corpus* was constructed from data collected from the focus group, according to the professional category (nurses and nursing technicians), transformed into a single unformatted text file.

The Descending Hierarchical Classification (DHC) or Reinert Analysis was used to group text segments and form a hierarchical class scheme. The DHC's function

is to classify parts of the text according to the vocabularies, segmenting them according to their similarities and differences⁽¹²⁾.

After the analysis and categorization performed by IRAMUTEQ®, the focus group transcripts were performed. It is worth noting that the classes resulting from the previous analysis of the software were read again with a close look at the statements and categorized based on the researcher's reflection, in light of TCCDU and PNASPI.

Leininger's TCCDU provided a robust theoretical support for the four dimensions of the care guide: Educational Dimension; Policy Dimension; Assistance/Care Dimension and Multidisciplinarity Dimension. In Leininger's model, the forms of action in nursing are distributed into three approaches: cultural preservation, cultural accommodation and cultural restructuring of care, represented in the fourth level of theory. Therefore, each dimension of the Guide has the three forms of action, proposing reflections so that the decisions and actions of nursing professionals can be based on culturally congruent aspects, or can be adapted to the cultural and health needs of indigenous people, contributing to more effective and meaningful care.

The study was approved by the Research Ethics and Committee (REC) of the Amazonas State Oncology Control Foundation (*Fundação Centro de Controle de Oncologia do Estado do Amazonas - FCECON*), under Opinion No. 5,877,824 and CAAE 64315022,3,0000,0004.

Data collection occurred after guidance on the research objectives and method, and the signing of the Informed Consent Form (ICF) by the research participants, adhering to the requirements to respect the rights of individuals involved in the study, in compliance with the Resolution of the National Health Council (*Conselho Nacional de Saúde - CNS*) No. 466/2012 on research with human beings. The study participants were identified by the acronyms "NUR" and "NT", followed by numbers, therefore: NUR – 1, NUR – 2, NT – 1, NT – 2 and so on.

Stage 2: Developed Technological Product

The guide was designed and developed based on thematic sessions that responded to the analyzed content, illustrations and adequacy of the formatting. Meetings were held with the Design professional to

make a final decision on the design, audiovisual, imagery and graphic aspects, based on the researcher's criteria. The document consists of 54 pages, including mandatory pre- and post-textual elements, with the four main dimensions resulting from the categorization performed by IRAMUTEQ and the researcher analysis, namely: educational, policy, assistance/care and multidisciplinarity, with a comic strip at the beginning and end of the product.

For each thematic axis, a regional song from the *Garantido* and *Caprichoso bois bumbás* was chosen with the aim of approximating cultural elements through sound, with illustrations that represent important features of indigenous cultures, as well as videos and links to publications, to complement the theme and provide a Technical Technological Production, characterized as didactic and instructional material, in digital format, with the potential to support nursing professionals within the context of this research.

In addition to the focus group, bibliographies related to indigenous health were also used, such as the PNASPI, the Federal Constitution of Brazil of 1988, Law No. 9,836/1999, ordinances of the Ministry of Health that address aspects of indigenous populations and data from the Brazilian Institute of Geography and Statistics (*Instituto Brasileiro de Geografia e Estatística - IBGE*)^(1,13,14).

With the aim of providing an entertaining understanding of the path taken by the indigenous population in the healthcare networks, including the Indigenous Healthcare Information System (*Sistema de Informação da Atenção à Saúde Indígena - SIASI*) and the SUS, as well as aspects recommended in the PNASPI, the guide starts and ends with a fictional comic strip story that tells the story of an indigenous woman with cancer, her therapeutic itinerary, her community relationships and her admission into the hospital environment.

As this is a digital version, the guide was developed in Portable Document Format (PDF) to facilitate its sending and sharing. The guide was registered with ISBN 978 6500 722314 to guarantee intellectual property. The document is available free of charge and with open access on the website of the Graduate Nursing Program—Professional Master's Degree, of the *Universidade Federal do Amazonas*, in the technical productions section, at the following URL: <https://ppgemp.ufam.edu.br/producao-tecnica.html>.

■ RESULTS

For this study, the textual *corpus* was constructed using data from the focus group and the subsequent IRAMUTEQ® analysis, according to the professional category (nurses and nursing technicians); then transformed into a single text file. Regarding the analysis of the nurses' responses, the *corpus* was created using data collected from the 12 participants, with command line generation for each participant and each interview converted into a text. In the software, the 12 texts were divided into 125 text segments (TS). The analysis of the processed content generated three classes, described below: Class 1, containing 62 TS (49.6%); Class 2, with 60 TS (48%) and Class 3, with 3 TS (2.4%).

For the nursing technicians, the textual *corpus* was created from the responses of six participants, then the command line was generated for each one, with each interview converted into a text. Within the software, the six texts were divided into 48 TS. The analysis of the processed content generated three classes, described below: Class 1, containing 10 TS (20.83%); Class 2, with 33 TS (68.75%) and Class 3, with 5 TS (10.42%).

In total, six classes were generated, however, after a reanalysis by the researcher, a thematic overlap between them was observed, which could generate content redundancy during the guide's construction. It was decided to regroup the content of two classes, thus reaching four classes, which then formed the thematic dimensions: Educational, Policy, Assistance/Care and Multidisciplinarity, so that the content of the care guide would be directed to the entire nursing team.

Educational Dimension

This first dimension highlights the inherent difficulties in providing care to indigenous cancer patients, as well as the importance and need for continuous health education actions in the hospital setting that address this issue and can equip the nursing team to provide care that is consistent with indigenous cultural diversity. This can be observed on statements of the research participants.

The institution does not provide guidance. Like someone to guide the team on how to deal with indigenous people, that does not exist here. (NT – 1)

The institution does not provide guidance or training for the team to deal with indigenous people. Since I started here, they have been talking about adapting a ward to receive these patients, but it has never been implemented. (NT – 5)

It would be good, because in the same way they do with the course to apply wound dressings here in the auditorium, I think it would be very good to adapt the team to serve these people. (NT – 6)

The statements also highlight the gap in the education and training of nursing professionals regarding care to the indigenous population, especially since they are in the Amazon region, given the number of these populations and their cultural specificities:

One suggestion for the undergraduate course in the curricula would be to implement a subject, even if it were optional, on indigenous dialect, since we do not have direct contact with their culture [...] we are in the Amazon region, if it were like in the Northeast, Southeast or Central-West it would not be necessary, but here it is unjustifiable. (NUR – 11)

I see this lack of training since undergraduate studies. We are part of the Amazon region, where there is the greatest contact with indigenous classes. This should happen from the introduction in undergraduate studies and continue throughout the training, but we in the Amazon region should be well trained on this subject [...] when you search online, you find a lot about their culture but very little about health, especially in nursing field. (NUR – 10)

Based on the mentioned excerpts, there is a need to intensify efforts aimed at carrying out educational activities that address the health of indigenous peoples, which must be aligned with the PNASPI guidelines, while also considering the specific characteristics and needs of local communities.

The city of Manaus stands out as the capital with the largest number of indigenous people in its population, when compared to the capitals of other Brazilian states⁽¹⁾. Given this fact, it is urgent the training of qualified nursing professionals to assist Indigenous populations at all levels of healthcare.

Promoting spaces for learning and discussion on issues related to the health of indigenous populations is essential for the effective implementation of public policies and for strengthening the autonomy of these communities, as it ensures that their cultural and health-care needs are respected and appropriately addressed.

As a result of the educational dimension, some specificities of the Amazonian indigenous populations are presented, including the territorial distribution of the seven Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*- DSEI) in the State of Amazonas, and information on cancer prevalence in Indigenous populations, and associated risk factors.

Three forms of nursing action were proposed according to the TCCDU, with a view to implementing differentiated care for indigenous populations with cancer. Differentiated care is a widely discussed concept in public health studies, as it refers to actions and policies that aim to respect and address the specific cultural and social needs of different populations.

Policy Dimension

The policy dimension reveals aspects related to the lack of knowledge regarding the role of the institutions that make up indigenous health, as well as the path to the reference unit, as can be observed below:

They have difficulties with language, transportation, everything... They depend on CASAI, so these logistics end up delaying treatment. (NUR – 9)

The women's network against cancer, the child support group that they use provides everything, but for indigenous people, what we have is just CASAI. We don't have a support group, you know, where we can do work there so that they can help us with the work. (NUR – 6)

So we realize that basic care for this population is also vulnerable and very deficient, so this already affects all our attention here in specialized care. (NUR – 11)

The professionals' statements also bring aspects related to the physical structure of the hospital setting in the process of welcoming and hospitalizing the

indigenous population. They also point to the prior submission of the indigenous patient to hospital rules and routines, revealing particularities regarding the environment, food, comfort and communication, as can be seen in the following excerpts:

Both for them and for us, in this issue of the environment, food, the patient's speech... I think these are the biggest obstacles we have in relation to indigenous culture. (NUR – 6)

Later, we even spoke with the institution's manager about how we could implement an environment for them, with an adapted ward. (NUR – 10)

[...] the biggest obstacle is the language. They have difficulty communicating, they feel withdrawn and embarrassed, as the colleague said, they feel diminished, embarrassed. For a person who is not indigenous, the hospital environment is already difficult, imagine an indigenous patient who lives in a totally different village [...]. (NUR – 3)

In short, the second dimension addressed the policy aspects. Thus, the main legal frameworks of indigenous health were presented, as well as the actors involved in healthcare for indigenous populations, the procedures required to refer indigenous people with cancer to the oncology unit and the importance of the hospital environment.

Knowledge about the political dimension is essential to understanding rights, ensuring the implementation of appropriate public policies and better coordination and effectiveness of healthcare for these populations. Furthermore, the hospital environment provides respect for cultural specificities, which promotes greater adherence to treatment and well-being for indigenous patients.

Assistance/Care Dimension

The professionals' statements pointed out aspects related to the nursing care and practices related to hygiene, nutrition and rest of indigenous patients and how these differ from what is routinely observed in the hospital setting, as noted in the statements of nurses and nursing technicians:

They have their own culture, they have a totally different life and come to a place where they don't know where they are, they don't have the hammock they like to sleep in, and they have a lot of difficulty sleeping. (NT – 1)

I once had a child on the ward and, despite having cancer, she had her own desires, one day she wanted lemon, another day she wanted fish [...]. (NUR – 12)

Their religious aspect is very important, I remember that when I got here, she was already very thin and her tumor was already exposed. She asked the shaman of her village tribe if he could go and say a prayer, because she knew she was nearing the end and she needed to make, as she said, her "passage" to the spiritual realm. This sensitivity that the nurse has to have, the team, because each one has their own particularity, whether it be nutritional or religious [...] they also have their own particularities, hygiene needs to be prioritized, especially wound care. (NUR – 8)

Regarding the aspect of interculturality, concern was expressed regarding the reception of indigenous patients in the hospital environment, with recognition of the difficulties related to habits, customs and culture. Participants also recognize that care for this population is provided in an imposed manner, without considering their worldview, and point out the importance of planning that allows the nursing team to connect with the hospitalized indigenous patient, as observed below:

[...] because our tendency is to bring that person into our culture and we limit ourselves to entering their reality, that's the barrier. There should be a plan so that we can enter the universe of this patient, understand what they expect, what they understand from here [...]. (NUR – 1)

As for their culture, we have to find a middle ground. You also can't be totally radical, because you will banish them, push them further away, and create a wall. (NUR – 7)

[...] respect their culture, explain better, and guide them so that they accept the procedures. They are more resistant due to lack of knowledge. (NT – 2)

In the assistance/care dimension, the challenges faced by indigenous cancer patients on their way to the reference center were addressed, with aspects related to self-care, both on an individual and collective level (bringing considerations about spirituality, communication and hygiene procedures).

Understanding the obstacles in the treatment path of indigenous cancer patients is essential to effectively provide appropriate care that respects diversity. Spiritual elements, for example, are fundamental to the daily experience of these populations, and the distance from their practices often makes it difficult to accept and adhere to treatment. Additionally, communication difficulties can hinder the understanding of medical instructions, while hygiene practices specific to their culture can influence the acceptance of hospital care.

By understanding these issues, it is possible to adapt care and improve its effectiveness, as well as promote respect for the cultural particularities of indigenous patients and their rights.

Multidisciplinary Dimension

The presence of a multidisciplinary team was also mentioned by participants regarding demands related to care for indigenous cancer patients. In this context, it was possible to perceive that there are situations that go beyond the scope of nursing and require more holistic and interprofessional approaches, which reinforces the relevance of multidisciplinary:

[...] So, within humanization with psychology, with the doctors and us [...]. (NUR – 7)

We have to pay attention to these particularities of this population, and we ask social services to work together. (NUR – 8)

So, we can count a lot on professionals in psychology, nutrition, social services, which are also very active, they help us a lot, we have already managed to return patients home at the end of life. (NUR – 2)

The construction of the multidisciplinary dimension was conceived through the visual representation of a web, in which all professionals and their knowledge are interconnected, thus generating differentiated and more complete care.

Multidisciplinary is crucial to the effectiveness of indigenous health care, as it provides care services that considers the various dimensions of patient well-being. Professionals from different areas can collaborate to address not only the physical needs but also the cultural, spiritual, and social aspects of indigenous people. A holistic approach facilitates understanding and respect for cultural specificities, reduces communication difficulties and creates more welcoming care environments, with direct impacts on treatment adherence and satisfaction.

■ DISCUSSION

The literature about differentiated care, particularly in the indigenous context, often mentions the fundamental role of respect for cultural practices, traditional knowledge and the autonomy of peoples, in defense of an approach sensitive to ethnic diversity⁽¹⁴⁻¹⁵⁾. Furthermore, the practical application of differentiated care and specific policies and care indicate that the health system may be adapted to the specificities of indigenous populations, in which differentiated care includes both the preservation of their cultural practices and integration with traditional medicine⁽¹⁶⁾.

This perspective broadens the vision of TCCDU, by including the role of public policies and healthcare professionals in creating spaces for intercultural dialogue. Based on this premise, differentiated care transcends the idea of merely adapting health practices, requiring an effective inclusion of cultural elements in health policies, which results in more effective and culturally relevant care, as pointed out by Leininger and complemented by other authors discussing indigenous health^(7,8).

The gaps in professional training and education were highlighted in this study as being the responsibility of healthcare institutions, as they do not favor the preparation of the team for the care for indigenous populations. It is essential to emphasize that curricular teaching in the training of healthcare professionals, especially nurses, on care for indigenous populations needs to be encouraged and incorporated into the curriculum content of nursing education in Brazil.

This process of curricular integration can promote more complete training, which considers the cultural, social and health specificities of indigenous populations. A study conducted with students in Amazonas⁽¹⁷⁾,

highlighted the importance of including topics related to indigenous health in the curriculum, considering cultural diversity as a fundamental aspect for promoting comprehensive and humanized care. By including care for indigenous people in the curriculum, educational institutions can contribute to training professionals who are better prepared, not only technically, but also culturally, which is crucial for the effectiveness of care and assistance practices for this population. Thus, the educational process in indigenous health becomes a responsibility not only for professionals and management but also for educational institutions, which are responsible for promoting adequate preparation from initial training⁽¹⁸⁾.

As shown in the statements of the nursing professionals interviewed, national studies reinforce the importance of bringing up discussions regarding the teaching processes of indigenous health for the development of cultural aspects, observing regional contexts and revealing the historical need for professionals prepared from the undergraduate level for the intercultural context, in view of the needs of indigenous populations^(5,17-19).

Regarding the teaching of indigenous health, it is noted that Higher Education Institutions are meeting the proposals of the Ministry of Health, by offering undergraduate and graduate courses with themes of indigenous health, ensuring that in this way the in-depth study of the theme is encouraged at the level of teaching, research and extension, both for technical and higher education. These actions aim to train qualified professionals to work in providing care to indigenous populations. However, the professionals' statements reinforce the perception of practices that contrast with those recommended by the Ministry of Health^(13,14).

As nurses and technicians pointed out, there was a clear lack of knowledge regarding the role of institutions such as Indigenous Health Houses (*Casas de Saúde Indígena* - CASAI) when it comes to providing extra-hospital care to indigenous populations. However, this role is well established in two studies conducted in the cities of São Paulo and Manaus^(20,21), in which the institution presented as a support and residence, especially for those undergoing longer-term monitoring and who require services that are often unavailable in their places of origin.

It is worth mentioning that there are more than 15 CASAI units throughout the state of Amazonas. However, the main healthcare units with diagnostic, treatment and monitoring centers are concentrated in Manaus⁽¹⁾.

The hospital environment was mentioned by nursing professionals, revealing the impact that this has during the hospitalization of indigenous populations. In this context, the reference institution for cancer control and treatment, the place of this study, initiated movements to create an appropriate environment, formulating some initiatives such as the nursing wards environment, the outpatient flowchart for attending to indigenous individuals in villages, and the navigation service, aimed at addressing the specific demands of this population⁽²¹⁾.

The culturally appropriate hospital environment should be considered an integral part of the care provided to indigenous populations, as observed in the prerogatives of the PNASPI through the training of culturally appropriate human resources, agreements with traditional indigenous systems, special nutrition adjusted to eating habits according to ethnic characteristics and enabling the presence of interpreters and traditional caregivers. The agreement between the various government bodies and hospital managers, aligned with financial transfers guaranteed by law, should also create culturally adapted environments^(13,22,23).

A study conducted with the Warao people of the state of Alagoas, showed the importance of a care plan based on Leininger's care decisions and actions, showing that it is possible to preserve cultural aspects, negotiate current care models and restructure existing standards to adapt them to a better reality. Even with several tools for improving the provision of care, it will often be necessary to seek alternatives beyond transcultural theory, as it will not be able to address all existing gaps⁽²⁴⁾.

Communication was cited by the vast majority of professionals as the greatest obstacle when it comes to providing care to indigenous populations in the hospital environment. A Brazilian study⁽²²⁾ points out that communication difficulties occur for several reasons, including the plurality of indigenous peoples and their numerous dialects. Therefore, it is important to whenever possible, to have an interpreter to facilitate

dialogue and exchanges between the healthcare team and users, aiming to strengthen healthcare practices.

Culture is widely related by nurses and nursing technicians when it comes to the context of indigenous health, especially when talking about the differences and the possible conflicts that arise. In a Brazilian study conducted with indigenous populations during the COVID-19 Pandemic, especially at CASAI São Paulo, it was highlighted that, in the relationship between healthcare professionals and indigenous patients, there is a natural factor between those who are in a position of power (healthcare professional) and those who are more submissive (indigenous individual), requiring extra attention to avoid depreciation of traditional indigenous knowledge, imposition of habits and routines without proper contextualization, and instead promote sociocultural appreciation^(19,20,25).

Interculturality emerges as a key element in respecting differences and understanding singularities, aiming at reflecting on the diversity of sociocultural identities, observing historical, social, political, cultural and economic contexts. Dialogue and interaction between knowledge are the ground of the intercultural perspective, which is essential for nursing to be able to provide the humanization necessary for its care and understand indigenous health from different perspectives⁽²⁶⁾.

The socioepidemiological profile of indigenous populations with cancer is often not accessible due to insufficient records and a lack of studies that aim to outline the characteristics of morbidity and mortality, revealing outdated data that hinder the development of public policies aimed at these populations.^(27,28)

When planning nursing actions, practices and customs should be considered, as well as ensuring differentiated attention and listening to the concepts of life, the world and their perceptions regarding the health and illness process.

Since this Guide is developed based on the local regional reality, the main limitation would be on the reality of nursing professionals who are in other regions of the country and who work with other ethnicities with distinct demographic and geographic characteristics.

It is important to emphasize that the Guide aims, through the presentation of its content, to encourage reflective attitudes for those who provide nursing care

to indigenous patients with cancer, with a view to responding to the needs of both nursing professionals and the indigenous populations that are the target of care.

■ FINAL CONSIDERATIONS

This study achieved its objective by enabling the development of the Nursing Care Guide for Indigenous Population with Cancer in the Amazonian Context, based on the understanding of the experiences of nursing professionals, based on aspects of TCCDU, Madaleine Leininger and publications in the field.

From the professionals' statements, the main difficulties emerged, related to the practice of care for indigenous patients with cancer and the need for continuing education actions directed at the nursing team in the intra-hospital context. It also revealed a lack of knowledge regarding the role of institutions working in indigenous health and the therapeutic path taken by indigenous populations to the reference center. Issues regarding the hospital environment for receiving these patients, as well as existing rules and routines, were listed. The presence of a multidisciplinary team appears as a complement to nursing actions, providing support for more culturally congruent care.

The Guide was composed of four central themes: Education, Policy, Assistance/Care and Multidisciplinary. Interconnecting aspects of indigenous health with oncology. It also covered various aspects of regional culture, emphasizing visual and sound elements that aim to bring professionals closer to the reality of indigenous populations. Thus, it can be used by nursing professionals in its entirety, providing directions for those who work in hospital units that care for indigenous cancer patients and for continuing education and health activities.

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■ Data and material availability

The datasets generated and/or analyzed during this study are available and can be accessed upon request to the corresponding author.

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