REGISTERED NURSES’ EXPERIENCES OF WORKING WITH INDIGENOUS PATIENTS IN REMOTE AREAS IN AMAZONAS, PERU

A qualitative interview study at health clinics in Loreto region

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ABSTRACT

Background
In remote areas of the Peruvian Amazon there is a high burden of communicable diseases, limited access to health care and a low distribution of registered nurses. Registered nurses are working with indigenous patients in the area, where traditional medicine and practice is common. In order to strengthen the relation between western and traditional practices, intercultural health has been implemented within the public health care.

Aim
The aim was to describe registered nurses’ experiences of working with indigenous patients in remote health care settings in Loreto region, Peruvian Amazon.

Method
A qualitative field study with semi-structured interviews was conducted at four health clinics in Maynas and Mariscal Ramón Castilla province. A qualitative content analysis was used when analyzing the data.

Findings
Three categories were identified in the analysis; Working environment in a remote area, Providing health care for indigenous patients and Including intercultural health in nursing practice. The participants’ daily work with few colleagues and high demand in remote clinics was described. Experiences of working with intercultural health, as well as opportunities and challenges of working with indigenous patients was found.

Conclusion
The registered nurses work in an area with a high workload, limited resources and geographic isolation. Intercultural implementations were shown to improve intercultural relations, autonomy and health. Challenges between registered nurses and indigenous patients related to communication and different cultures were described. In order to improve the situation and reach the UN Sustainable Development Goals, infrastructural and socio-economic improvements, more resources and health professionals are necessary.

Keywords: Registered nurses’ experiences, Indigenous patients, Intercultural health, Remote areas, Limited access
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BACKGROUND

Peru

Peru is a country located in the western South America and had in 2018 a population of approximately 31 million people. There are 72 different ethnic groups in the country, where the largest group is referred to as Mestizo, a mix between white and indigenous people (Central Intelligence Agency [CIA], 2019). The second largest group is the indigenous population, constituting one third of the entire population of Peru and includes the majority of the ethnic groups in the country (Sandes, Freitas, Souza & Leite, 2018). Most of the indigenous groups and communities reside in the rainforest of the Peruvian Amazon, all with their own history, traditions, language and customs (Yajahuanca, Diniz & da Silva Cabral, 2015). In the Amazon there were over 60 different ethnic groups and 13 different local languages in 2013 (Orellana, Alva, Cárcamo & García, 2013).

Indigenous people

One absolute definition of “indigenous” would be misleading since there is not one indigenous person or indigenous culture, but millions of different people living within indigenous cultures worldwide (WHO, 2019a). Instead of one absolute definition, WHO (2019a) refers to an indigenous person as someone who identifies - and is identified from their community - as indigenous, whose ancestors lived in the territory before states and borders existed and before other people moved there. The term further refers to a person who is part of a community with own political and social systems, and someone who maintains the community’s beliefs and traditions. Other terms which are used to refer to indigenous people are for example; first peoples, tribes and ethnic groups (WHO, 2019a).

The General Assembly of the United Nations adopted in 2007 The United Nations Declaration on the Rights of Indigenous Peoples (United Nations [UN], 2018). The declaration focuses on the respect for indigenous cultures, knowledge and traditional practices. Mentioned in the declaration is that indigenous people have the right to maintain traditional health practices and have the right to access national health care services. Indigenous people have equal rights to reach well-being, both physically and mentally as other citizens in the country. Furthermore, the declaration proposes that governments should invest in education for indigenous people and provide improved sanitation and access to food, especially for those living in rural areas, to contribute to health and well-being for indigenous people. The declaration claims that all of these actions should be taken without any form of discrimination (UN, 2018).

Health care in Peru

Health care on a national level

The health care system in Peru is divided between a public and a private sector where the public sector constitutes the largest part. The national health care system aims to ensure health care and social security in health for the entire population. The Ministry of Health (MINSA) is running most of the public health care facilities in the country. They are providing free first level health care for the most vulnerable population through the national health insurance; Seguro Integral de Salud (SIS) (Pan American Health Organization [PAHO], 2017). Peru is aiming to reach a universal health coverage and had in 2017 reached a coverage by 83 percent, a steadily increasing number strongly linked to the adoption of the SIS-insurance (Organization for Economic Co-operation and
Development, 2017). Health care facilities and services in Peru are unevenly distributed over the country where specialized care and hospitals are mainly located in the capital, Lima. Health care services in the private sector are used mainly by high-incomers (PAHO, 2017).

Registered nurses
The International Council of Nurses (ICN) (2019) defines a nurse as someone who completed nursing education and is authorized to practice nursing within the country of the authorization. Included in the nursing practice is to promote health, prevent illness and care of both physical and mental illness, given to all people of all ages in all forms of health care. Nursing is seen as autonomous and collaborative care of all individuals, sick or well, disregarding settings, age or community. Nurses should assist the patients to restore and maintain health and functions (ICN, 2019).

To become an authorized and registered nurse in Peru it takes five years of education, resulting in a bachelor’s degree. On a national level the number of graduates has increased over the past years (Jiménez, Mantilla, Huayana, Mego & Vermeersch, 2015). Professional responsibilities as a registered nurse in Peru includes; protecting human life, providing integral health care for all and contributing to the improvement of the country’s sanitary and socio-economic problems (World Health Organization [WHO], n.d).

The distribution of registered nurses within the country is uneven, with a higher workforce in urban areas and a lower density in the rural parts (WHO, n.d). According to the study by Jimenéz et al. (2015), registered nurses were 15 times more likely to take an urban position than work in a rural area. Investments have been made to improve the density of registered nurses in the rural areas by implementing a system of a one-year rural service for new-graduates (SERUMs). Meaning new-graduates are deployed in rural clinics and thereby strengthening the workforce for permanent nurses working in the area (WHO, n.d). To gain employment as a registered nurse in the MINSA public sector it is mandatory to go through one year of SERUM-service (Jimenéz et al., 2015).

Loreto region

Region background
Loreto is Peru’s largest region and is located in the Amazon rainforest. The region covers one-third of the country’s land area and had in 2014 approximately one million inhabitants. The main city is Iquitos, only accessible by boat or plane. Outside urban areas, around 55 percent of the population lives along the Amazon river with its tributaries in more than 2000 remote villages, most of them one can only access by boat (Brierley, Suarez, Arora & Graham, 2014). The rural villages and communities consist of both indigenous and mestizo people (Williamson, Ramirez & Wingfield, 2015).

During the past decades the remote parts of the Amazon and Loreto region have not had the same economic growth as the rest of the country. This has led to the fact that people living in the area in 2013 were to a greater extent suffering from poverty, low educational levels and illness related to limited access to healthcare and infrastructure than the rest of the country (Orellana et al., 2013).

The high levels of illness in the area is connected to high burden of communicable diseases, such as malaria, dengue fever and tuberculosis together with sexually transmitted
infections and diarrheal diseases with outbreaks of cholera. Overcrowded housing, lack of food and poor sanitation are factors which increases the prevalence of these diseases as well as the infant mortality rate. Because of poverty and food insecurity, malnutrition and anemia are common issues in the rural areas (Williamson et al., 2015).

**Access to health care in Loreto region**

**Health services in the region**
The health services in the rural parts of Loreto mainly consists of health posts and health centers. They have the role of providing basic health care for the diverse population in the area, focusing on prevention, early diagnosis and treatment. Apart from first level care, the region had three hospitals in 2015, able to provide more specialized care and treatment. The health centers and health posts are often located along the rivers in remote areas of the region, sometimes only accessible by boat, while the hospitals are located in the cities (Yajahuanca et al., 2015).

Loreto has one of the lowest distributions of health professionals in the country (WHO, 2019b). Jimenéz et al. (2015) shows that there was a big gap between the health professionals accessible in the area and the number needed. The study showed that the region had a deficiency of 486 nurses and 468 physicians in 2013 (Jimenéz et al., 2015).

**Contributing factors to limited health care access**
According to the study by Brierley et al. (2014) the main reasons for poor health care access among the population in the area was poverty and long-distances to health facilities. Due to long waiting times and great distances to health care facilities, which required hours or several days of travelling by boat, many people refrained from seeking health care. Provision of the health care services in Loreto are limited due to lack of infrastructure and resources, some health clinics is staffed by one or two registered nurses, with their closest colleagues further down the rivers (Williamson et al., 2015). Annual flooding and draining of the rivers are environmental changes affecting the communities, connected to access and damages on houses and crops (Williamson et al., 2015).

It is inevitable to link the differences in health care access and socio-economic prerequisites between indigenous communities and mixed, urban communities to the history of colonization and discrimination of indigenous groups (Browne et al., 2016). These differences can be seen as higher rates of maternal mortality, malnutrition and infectious diseases within indigenous communities than non-indigenous (Sandes, Freitas, Souza & Leite, 2018).

**Application of the UN Sustainable Development Goals in Loreto**
Access to health care are mentioned in both goal 3 and goal 10 of the United Nations Sustainable Development Goals, to be fulfilled by 2030 (UN, n.d). Good health and well-being, describes that sufficient density of health professionals, access to medicines and proper health services are important factors to increase health. This way infant- and maternal mortality rates can be reduced, as well as the prevalence of communicable diseases (UN, n.d). Good health and well-being is one goal that the government in Peru has focused on during the past years (UN, 2017). Goal 10; Reduced inequalities, focuses on decreasing disparities to health care access among the population and to provide resources to marginalized populations. Another link between Loreto and the UN Sustainable Development Goals is goal 6; Clean water and sanitation for all. The lack of clean water,
basic sanitation and good hygiene increases the diseases related to water and sanitation (UN, n.d).

Health knowledge and perceptions in rural areas of Loreto

Health knowledge
WHO (2019a) defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

WHO’s (2019a) definition of health has a holistic approach which sees health as something more than the absence of illness or disease. Indigenous groups often share the holistic view on health by seeing harmony between individuals, communities and the universe as important factors affecting health and healthiness (WHO 2019a). Health is a flowing concept and underlying cultural beliefs and values can influence how health, illness and disease is perceived by a group or individual (ICN, 2013).

Espinosa (2009) explains that different perspectives of medicine, illness and healing occurring between indigenous patients and health professionals might lead to communication gaps. Williamson et al. (2015) describes that patients in their study to a high extent did not fully understand their diagnosis or treatment provided by the health professionals, and they desired to get more information. For example, it was not uncommon that indigenous patients had little or no knowledge about the etiology of malaria, HIV or tuberculosis, something few health professionals took into consideration in their clinical work (Williamson et al., 2015).

The lack of health knowledge among indigenous groups experienced by health professionals might be related to different health perspectives. The traditional medicine in the area holds an ancient knowledge regarding medicinal plants and healing, a knowledge that might not get recognized in the same way as knowledge regarding western medicine (Yajahuanca et al., 2015).

Traditional medicine in the Amazon
Traditional medicine is based on a holistic and multidimensional view, focusing on spiritual, natural and physical entities. Healers and shamans are trained practitioners of traditional medicine, contacted for diagnosis and treatment of both physical and spiritual illnesses. The treatment is based on medicinal plants, either provided by the healer or self-medicated (Wolff, 2014). Many of the plants have curable effects, being both antibacterial and antiparasitic (Brierley et al., 2014). The prevalence of the use of traditional medicine in Loreto is not known, but more than 80 percent of the participants in the study by Brierley et al. (2014) had during the year of 2011 sought help from a shaman or used traditional medicine.

Factors affecting the health care of rural populations
According to Espinosa (2009) the public health care in the remote Amazon is built on western beliefs regarding medicine and treatment. The health professionals working in the area are often people from urban areas with a higher status than the rural population due to higher income and education. Coming from other backgrounds might lead to that the health professionals disregard ethnic or spiritual beliefs since they are not familiar with the local practices, something that complicates the possibilities to provide care built on respect, trust and exchange of knowledge (Espinosa, 2009). Browne et al (2016) continues that health
professionals who come from other backgrounds might foresee underlying factors of historical and social disparity in the area. Therefore, health professionals caring for indigenous people need to adjust the care to the needs of the patients. An awareness of the underlying factors that might cause or contribute to physical and mental illness is needed (Browne et al., 2016). In order to be able to transfer health knowledge from theory to practice, these factors need to be taken into consideration and be adapted to the local context. It is needed to learn more from the rural communities to decrease health inequities in Loreto. Patient education is one key in decreasing inequities, infections and other types of diseases (Williamson et al., 2015).

**Intercultural health**

Interculturality can be seen as an interaction between cultures built on mutual respect, creating opportunities for cross-cultural sharing (United Nations Educational, Scientific and Cultural Organization [UNESCO], 2015). According to Yajahuanca et al. (2015), seeing something from an intercultural view is to value and respect differences between cultures as well as lightning common factors between them. Interculturality is not about integrating one culture into another, but combining, sharing and respecting both sides (Villa Pesantes, 2014). The term “culture” is described as factors shared within a group or society, such as behaviors, norms and values. These factors can be seen as something people transmit from one another, creating knowledge necessary to be able to function within a specific group or society (Hruschka, 2009). Culture can also be seen as behaviors of a group that has been affected by their habits, norms, language and geography (MacKenzie & Hatala, 2019).

The concept interculturality emerged in Latin America in the 1970’s after political activism from indigenous groups, addressing the discrimination and inequities they were facing in society (Menéndez, 2016). Intercultural health started as an attempt to strengthen the relationship between patients in indigenous communities and health professionals, as well as strengthening the pursuance of traditional medicine and create health systems where traditional and western medicine exist on equal terms (Menéndez, 2016). Monteban, Yucra Velasquez and Yucra Velasquez (2018) describes intercultural health as a way to combine and build bridges between traditional and western medicine. Through intercultural health, different perspectives on health and wellbeing co-exists without claiming that one is better than the other (Monteban et al., 2018).

**Registered nurses and intercultural health**

Villa Pesantes (2014) writes that in order for registered nurses to work interculturally both knowledge regarding intercultural health and cultural competence is necessary. Cultural competence can be seen as the ability of health professionals to create functional interpersonal relationships that supersedes cultural differences (Mobula et al., 2015). Smith (2013) describes that working with cultural competence means working patient-centered within the patient’s cultural context. Being culturally competent means taking the patients personal experiences, including their families and communities social and political aspects, into consideration while caring for the patient (Blanchet Garneau & Pepin, 2015).

The International Council of Nurses (2013) state that being culturally and linguistically competent is one of the nurse’s responsibilities. A culturally competent nurse accepts that there might be differences in cultural beliefs and health perceptions, respects cultural differences and adapts the information and the care of the patient according to their cultural
needs (ICN, 2013). They further state in their ethical code for nurses (ICN, 2012) that the care should be culturally appropriate in order for the patient to receive accurate care, given with respect for human rights, values and spiritual beliefs. Every person has the right to get culturally appropriate care and by showing respect and understanding for the person’s culture, a trustful encounter can be created (ICN, 2013).

Using intercultural communication is one way in achieving a good quality health care built on trust. Intercultural communication involves accepting and respecting differences in health perceptions and practices as well as maintaining an equal balance between them and the people practicing them. There is a need for more courses during health professionals’ education that involves intercultural health and cultural adjustments to rural contexts, including indigenous communities (Yajahuanca et al., 2015). Monteban et al. (2018) agree that the education for health professionals should involve an intercultural health strategy.

**Intercultural implementations in Peru and Loreto region**

An intercultural health legislation was established in 2016 by the Ministry of Public Health (Monteban et al., 2018). The legislation says that health is a human right and should be provided for indigenous people regardless of healthcare levels. Further should intercultural health be included in the health systems and traditional medicine be recognized (Monteban et al., 2018).

Investments has been made in Peru and the Peruvian Amazon to improve both indigenous peoples’ health and the position of traditional medicine. These investments have for example been in forms of providing education for health professionals regarding different health practices and local languages, as well as providing education for traditional health practitioners. The intercultural investments have aimed to increase indigenous communities' involvement in the health care planning (Villa Pesantes, 2014). Despite these investments toward intercultural health, several studies from the area (Villa Pesantes, 2014; Yajahuanca et al., 2015; Espinosa, 2009) show that there are still existing barriers between traditional and western medicine and health professionals and indigenous patients. These barriers can be seen in forms of different perceptions of health and treatment, lack of understanding and respect between health professionals and patients, difficulties in communication and lack of trust (Villa Pesantes, 2014; Yajahuanca et al., 2015; Espinosa, 2009).

**Research area**

Registered nurses at health clinics in remote areas of the Amazon rainforest work in a resource-poor environment, sometimes being the only registered nurse or health professional at the facility. Due to limited infrastructure, the remote clinics are in many cases only accessible by boat, which due to long-distances can take hours or days to reach. The patients are vulnerable due to socio-economic inequities, communicable diseases, malnutrition and maternal mortality, poor sanitation as well as limited health care access.

Intercultural implementations have been made in Loreto region, aiming to strengthen the relation between traditional and western medicine. Intercultural health is included in the registered nurses work field in Peru, this to create acceptance and respect towards different health perceptions and practices within the health care systems. Despite the intercultural implementations, the few studies carried out on the topic show that barriers still exist between health professionals and patients.
Research shows that there is limited knowledge about the experiences and perspectives of registered nurses working in rural parts of Loreto. This leaves a knowledge gap regarding the reality the registered nurses face in their everyday work with indigenous patients with limited access and resources.

AIM

The aim was to describe registered nurses’ experiences of working with indigenous patients in remote health care settings in Loreto region, Peruvian Amazon.

METHOD

Design

A qualitative interview study was conducted at remote health clinics in Loreto. Qualitative design focuses on the understanding of human experiences and their lived realities (Polit & Beck, 2017). The study was made through an inductive approach, which according to Priebe and Landström (2017) means that the researchers are looking at a phenomenon through the participants descriptions and not based on an existing theory. This design was chosen because it was the best suitable design for the aim of this study; to describe nurses’ personal experiences. The interviews were semi-structured, which according to Henricson and Billhult (2017) lets the participants express themselves freely and thereby contribute to a wider understanding of the subject.

In this study’s aim, ‘experience’ is referred to as “(the process of) getting knowledge or skill from doing, seeing, or feeling things” (Cambridge University Press’, 2019).

Sample

The sample consisted of registered nurses working at public health facilities in Loreto region. The sampling method used in this study was convenience sample. Convenience sampling is a suitable sampling method if the participants are recruited from a specific clinical setting, which in this case was a remote health care setting (Polit & Beck, 2017). Further, convenience sample is used when participants who are the most readily available are selected (Polit & Beck, 2017), which was suitable for this study due to limited time and resources. The participants were chosen based on that they had experienced what the study requested; working as a registered nurse at a facility in the area.

Selection criteria

The inclusion criteria were that the participants had to be registered nurses working at a public health facility in the region where the study was conducted. To avoid limitation of the thesis, since there were few registered nurses working in the area, there was not any further criteria except those stated above.

Recruitment process

To get in contact with the registered nurses at the health facilities, an American-Peruvian non-governmental organization by the name Project Amazonas was contacted. Project Amazonas work in Loreto region mainly with provision of medical services to the most
remote parts of the Amazon, in cooperation with MINSA. Through them, contact with three of the four public health facilities included in the study was established and information about the purpose of the study, as well as letters of introduction, was sent out. The health clinic that was not contacted beforehand was approached on site and received the information about the study simultaneously. Through Project Amazonas, a formal agreement was signed with the MINSA regarding the study, which was handed out to the directors of the facilities when visiting them, see Appendix A. After getting permission from the director, the registered nurses on duty were asked if they wanted to participate in the study.

Study participants
The registered nurses were both SERUMs and locally employed nurses working at health centers in larger villages and health posts in remote areas further away. The participants came from different areas of the country and were of different ages. There was a diverse range of working experience among the participants, from one to 26 years as registered nurses. Six women and two men participated in the study.

Data collection
The data collection of this study was made possible thanks to a Minor Field Studies scholarship from the Swedish International Development Cooperation Agency (SIDA).

Eight interviews with registered nurses were performed at four health facilities in Maynas and Mariscal Ramón Castilla province, Loreto region. The interviews were held together with an interpreter. The interpreter came originally from the region and spoke Spanish and English, assigned to this study through Project Amazonas. According to Al-Amer, Ramjan, Glew, Darwish and Salamonson (2014) using an interpreter from the local context is positive for the study. The interviews were interpreted between English and Spanish. All of the interviews were audio-recorded with the participants consent.

Interview setting
The interviews started with a personal presentation of the interviewer and interpreter. The participants were given written and verbal information about the study, aim and informed consent, which was signed if the participants wanted to participate. The overall frames of the interview, regarding length and the information of how the interview would be conducted together with the interpreter was covered (Danielsson, 2017a). The interviews took place during the participants working hours in a secluded part of the clinic, if possible. In some cases the clinics’ access to secluded areas were limited which led to that the interviews sometimes were interrupted by people who needed to access the room. The authors of this study did four interviews each, all together with the interpreter. The interviews lasted between 30 and 60 minutes.

Topic guide
During the interviews, a topic guide was used, see Appendix B. The topic guide contained topics of interest for the study that had been planned and send to the interpreter beforehand. The questions in the topic guide were arranged as Price (2002) suggests with easy going questions in the beginning and the end of the interview, and deeper, more sensitive questions in the middle. This to get a flow in the interview and at the same time be responsive to the needs of the participants (Price, 2002). As Danielsson (2017a) suggests, the topic guide was used as a tool of direction to keep the questions and answers
around the subject. This way the interviewer could ask open questions and let the participant talk freely around the topic but still get the information needed (Danielsson, 2017a). The participants had not been given the topics of the interview beforehand, leading to spontaneous answers from the participants since they were unaware of the direction of the interview. The order of the questions from the topic guide was adjusted according to the participants answers, this required flexibility from the interviewers as Polit and Beck (2017) describes.

Pilot interview
A pilot interview was conducted in order to, as Danielsson (2017a) suggests, examine the quality of the questions, interview technique, and other technical matters. No adjustments in the topic guide were made after the pilot interview, although some adjustments regarding the translation technique was made together with the interpreter. As the pilot interview contained information that corresponded to the purpose of the study, it was included in the analysis process.

Transcription process
As Polit and Beck (2017) suggests, the audio-recorded interviews were listened through as soon as possible to make sure that the whole interview was taped with enough quality. The interviewers themselves listened through the interviews, which Danielsson (2017a) describes as an advantage in order to hear nuances in the participants descriptions and to maintain a broader meaning from what has been said. The interviews were thereafter listened through together with the interpreter, taking Polit and Beck’s (2017) advice of improving the interview technique until the next session. Due to insufficient translation during the interview sessions the interviewers and interpreter listened to the audio recordings and from them translated the interviews verbatim into English. In the transcriptions the interviewee was defined with (I) and participant with (P), as Danielsson (2017a) suggests. Pauses and incomplete sentences was marked with three dots, non-verbal sounds such as laughter and sighs were noted. The transcriptions of the recordings were divided between both authors of this study.

Data analysis
The data was analyzed through a qualitative content analysis with an inductive approach. The qualitative content analysis is used in qualitative research in order to find patterns and themes from the collected data (Polit & Beck, 2017), why it was chosen for this study. An inductive approach is recommended if there is limited knowledge about the phenomenon described (Elo & Kyngäs, 2008).

After the transcriptions were completed, the text was processed by first reading it several times to get an overall understanding of the collected data. Thereafter, the authors separately broke down the data into smaller meaning units containing of sentences and words, which were divided into codes of interest for the study, as suggested by Graneheim and Lundman (2004). After this was done, the codes were compared and discussed between the authors, resulting in mutual codes. The codes were then divided into subcategories and in final categories. The data was analyzed word by word focusing on the manifest content of the data, meaning the analysis was based on the literal, obvious and visible content (Graneheim & Lundman, 2004). The CAQDAS-software NVivo was used as a tool during the analysis process.
Table 1. Example of the analysis process.

<table>
<thead>
<tr>
<th>Meaning unit</th>
<th>Code</th>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>“The traditional and western medicine can work together.”</td>
<td>Opinions about intercultural health</td>
<td>Intercultural implementations</td>
<td>Including intercultural health in nursing practice</td>
</tr>
</tbody>
</table>

The data-analysis resulted in a total of seven subcategories and three categories which are a summary of aspects corresponding to the aim of the study. An incidental finding emerged during the data-analysis, which was included in the findings separately as it was not directly corresponding to the aim. The findings are presented with quotes from the transcriptions, selected as they were mirroring the essence of the findings. The results’ purpose is to create a bigger knowledge around the subject as well as an understanding of the phenomenon (Elo & Kyngäs, 2008).

Table 2. Subcategories and categories from the data analysis.

<table>
<thead>
<tr>
<th>Subcategory</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work environment</td>
<td>Working environment in a remote area</td>
</tr>
<tr>
<td>Lack of resources and support</td>
<td></td>
</tr>
<tr>
<td>Access to health care</td>
<td></td>
</tr>
<tr>
<td>Experiences of caring for indigenous patients</td>
<td>Providing nursing care for indigenous patients</td>
</tr>
<tr>
<td>Increasing health knowledge and compliance</td>
<td></td>
</tr>
<tr>
<td>through patient education</td>
<td></td>
</tr>
<tr>
<td>Traditional medicine as a first-hand choice</td>
<td>Including intercultural health in nursing practice</td>
</tr>
<tr>
<td>Intercultural implementations</td>
<td></td>
</tr>
</tbody>
</table>

Ethical considerations

It is important to reflect about ethical considerations throughout every part of the study and to be aware of the autonomy and integrity of every person as well as every human’s equal value (Kjellström, 2017). While conducting a field study there is a risk that the participants are of the impression that their decision to participate might come with positive or negative consequences, depending on their will to participate (Helgesson, 2015). Before deciding to participate in this study, the participants were given prerequisites to make an autonomous decision. To make an autonomous decision the participants need to be competent by having relevant information regarding the study and its aim and method. The more competent, well-informed and free in the decision-making the participant is in the given situation, the more autonomous the decision becomes (Helgesson, 2015). To prepare the participants, a letter of introduction was sent out so they could consider their will to participate. This was sent to all the clinics except from one that was contacted on site. Further on, an informed consent about participation, both written and verbally, was used, see Appendix C. As Polit and Beck (2017) suggests the consent included information about the study, the ability to end participation at any moment without consequences as well as information regarding their anonymity in the results.
The confidentiality of the participants can be secured by changing their names and other characteristics or create an ID-code unique for every participant (Polit & Beck, 2017). In this study the confidentiality of the participants was maintained by using passwords on technical devices, storing confidential papers in locked rooms as well as creating unique ID-codes for the participants. Further on, the exact names of the clinics are not mentioned in order to avoid connection between the participants and their workplace. According to Dalen (2015) the interpreter works by the same secrecy code as the researchers and therefore the interpreter in this study signed a secrecy form before the data collection started, see Appendix D.

According to the Declaration of Helsinki (World Medical Association, 2013) it is essential to question in whose interest the aim will be fulfilled and to consider the need for the study to be made versus the well-being of the participants. Further on, the Council for International Organizations of Medical Sciences (2016) points out in International Ethical Guidelines for Health-related Research Involving Humans that promoting people’s health should be the main intention in these types of researches. This study can illustrate the challenges that might come with lack of access to health care for both patients and professionals in rural areas. Since there are still few researches made on the topic the study can contribute to a wider understanding of the nurses’ work field in the Amazon.

FINDINGS

The findings of this study are presented under the following three categories; Working environment in a remote area, Providing health care for indigenous patients and Including intercultural health in nursing practice. Incidental findings are presented in the end.

Working environment in a remote area

In this category the findings regarding the everyday work as a registered nurse at a remote health clinic are presented. The subcategories Work environment, Limited resources and support and Access to health care were found during the data analysis.

Work environment
All of the participants explained that their work field included control of children’s growth and development and most were responsible for vaccination. Other areas of work described were connected to the patients’ main health issues and reasons of contact, such as respiratory infections, diarrheal diseases, vector borne-diseases, anemia, malnutrition, maternal care, snake bites, pneumonia, TBC and HIV. Many of the participants worked directly with providing first level health care for indigenous people, while a few of the participants worked in mestizo communities, providing only emergency and maternal care for indigenous people. Most of the participants handled emergency cases, either during their regular working hours or being on call aside from their usual work shifts.

“In emergency cases, if I get off at one, anytime, it doesn’t matter if it is eleven or twelve in the night or at dawn, they call me, the hour doesn’t matter, attend deliveries, immediate care of the newborn. This is our routine, every day.”

Some of the participants described that they were the only registered nurse in their clinic, something being expressed as working twenty-four hours a day and being unable to leave the area during their free time in case of an emergency. Most of the participants described
their workload as heavy with limited resources and support, a participant expressed that sometimes they were not able to provide proper care due to lack of time and high number of patients.

“(Sigh). The workload? It is heavy, they ask a lot.”

Many of the participants expressed how they experienced their work using words such as love, best, knowledge and interesting. Several participants pointed out that giving care to the children was the best part of their work.

“I love my job. I love to be with the patients, all the time, I like to help persons until they get better.”

The participants confidently expressed that they had sufficient knowledge and competence to perform their work in a professional way, disregarding work experience, workplace or pre-knowledge about the area. Some of the participants shared that they had earlier experience from the area while others described that they knew little or nothing about the area, before being deployed there as SERUMs. Most of the participants had either started working in the area as SERUMs or were doing their SERUM-service at the time of the study.

Limited resources and support
Several of the participants expressed that there was a shortage of health professionals, something expressed especially by the registered nurses who were working alone in the clinics together with a nurse technician.

“Look, how can I know if I have some problems, if the district has 17 000 inhabitants, for these inhabitants there are only two physicians, four registered nurses, it is not good for this population. It is wrong. We need more professionals.”

Due to lack of capacity and equipment, some of the participants described that they were unable to perform surgeries or provide more advanced care at the clinics. For serious emergency cases, the routine described was sending the patient to a larger clinic or hospital after consulting with the doctors there. The available means of transportation were speed boats and airplanes and pregnancies, deliveries or life-threatening conditions were most prioritized. A participant described the possibilities to send patients from a remote health post to a larger facility.

“Minimal. To be honest, you have to know a lot about general medicine, the Peruvian government don’t accept sending [the patients] from here to there if they are not seriously ill.”

The lack of equipment and medication for emergencies in the health clinics was highlighted as leading to a limitation in the provision of emergency care. Several mentioned better equipment and infrastructure as important areas in need of improvement and development.

“Ah yeah, start with everything. [The rural health post] is different to [the larger society], it is a village. To get to the post, the road, the building of the health post is lousy, also, the service, /.../”
Access to health care
All of the health clinics were only accessible by boat if the patients did not live within the village or area where the clinic was located. Participants expressed that indigenous communities in the area had limited access to health care. The main reason for limited access described by the participants was the distance, that the communities were located far away from the health clinics.

“Clearly the indigenous communities are far away. With the “engine 40” that we have it takes more or less one hour to get there. In our boat, but in their boats, they are called “pekepeke” [local canoe, with engine] it takes four hours. Four.”

“Here the problem, the limitation, is the transport, the distance from one community to here, the health center. When, also, another problem is when the level of the river is high or low.”

As pointed out, the environment in the region with recurring flooded and dried rivers also affected the accessibility to health care. The situation in the area compared to a more urban one was described.

“The indifferences, the government doesn’t want to invest, doesn’t want to give, the community is marginalized, far away /.../ we need major health investments, because the health centers are not accessible as in Lima, where you can take a bus to get to the health center. Here it is different, you have to spend hour by hour waiting.”

High poverty rates within indigenous communities was expressed by a participant as another contributing factor to limited access. According to several participants, the high poverty rate was something affecting the possibilities to buy fuel and boats, which was needed in order to reach the health clinics. A participant expressed that the lack of fuel could lead to the fact that the patients could not make the journey to their appointments. Some of the participants mentioned that many of indigenous people did not have a health insurance, something which affected the access to health care.

Providing health care for indigenous patients
In this category the findings regarding registered nurses’ experiences of providing care for indigenous patients are presented. This category includes the subcategories Experiences of caring for indigenous patients and Increasing health knowledge and compliance through patient education.

Experiences of caring for indigenous patients
Several of the participants expressed that they found it challenging to provide care for indigenous patients in remote settings. One prominent factor described by the participants was that indigenous patients had other customs and cultures than themselves.

“Well, actually the customs of the indigenous people are completely different in our reality, no? Well, what I see in my experience is that in the indigenous communities, there are many kids with anemia, malnutrition, they live in their own world.”
Another challenge described by some of the participants was connected to the fact that they did not speak the local languages spoken by indigenous patients, leading to communication barriers regarding diagnosis and treatment. The majority of the participants described that sometimes they experienced that indigenous patients did not understand them, regardless of language. The lack of understanding unrelated to language was expressed to be connected to the different customs, or something that the participants were unable to express.

"[Laugh]. I don’t know. I don’t know why they don’t understand. They are custom that way."

“For us it is a challenge to arrive to the people, we are using simple words. They are very shy people. They have other customs, very rare. They sometimes obey, sometimes not. They believe in their ideas. It is very complicated, a little bit. Sometimes when I ask, they don’t answer, they are just watching [laughing].”

In order to increase the knowledge, the professionals at a health center had attended a course where they learned about customs of indigenous groups. A desire to learn the languages spoken in the communities was also expressed, as it was seen as a missing part in the nurse education.

Participants shared polarized opinions surrounding indigenous patients’ experiences of care; some experienced a reluctance towards the health care provided from the health clinics. Other participants experienced that indigenous patients were satisfied with the provided care and left contented. It was emphasized that despite challenges, caring for indigenous patients was an opportunity.

"It’s an opportunity because we can know more about these people. Their needs, and see how to help them."

Increasing health knowledge and compliance through patient education
Several of the participants experienced that indigenous patients were unfamiliar with the causes of the most common diseases, something a participant referred to that many of the patients had not completed elementary school. Other participants expressed that the patients’ health knowledge covered the most common diseases in the area.

“No, no they don’t have a lot of knowledge about the causes, they just know that they have the diseases, but they don’t know what the causes are.”

Compliance to treatment among indigenous patients were experienced by some of the participants as low as they experienced that the patients did not follow the recommended treatment. In order to improve the patients’ compliance it was described that instead of letting the patient bring the medicine home, they had increased the compliance by letting the patients come to the health clinic every day to receive the medical treatment.

“The majority bring their medicines home, but after that they abandon the treatment. This is the problem here.”

All of the participants explained that they worked with patient education, something that some of the participants mentioned had increased the patients’ health knowledge and
health-seeking behavior. They described that they gave workshops in indigenous communities about different diseases, symptoms, food, hygiene, pregnancies and family planning. Several participants described that they used descriptive images and when there was language barriers they used bilingual images, signs and mimics.

“We provide health programs for indigenous people. We have raised awareness of that the deliveries were at home, they now come to the health post. /.../ we have raised awareness of how people can drink the water, not the river water but rain water.”

Some of the participants expressed that they were adapting the information given during the workshops according to what they believed was understood by the patients. The adaptation was described as avoiding technical terms, using simple and regional words often used by the patients.

Including intercultural health in nursing practice

In this category the findings regarding registered nurses’ experiences of working with traditional medicine and intercultural health is presented. This category includes the subcategories Traditional medicine as a first-hand choice and Intercultural implementations.

Traditional medicine as a first-hand choice
All of the participants experienced that their patients in some extent also used traditional medicine. Participants expressed that indigenous patients both went to local shamans for traditional treatment or treated themselves at home. Traditional treatments for fever, malaria, bleedings, pregnancies, hepatitis and mal-aire [evil air] was mentioned. Several participants expressed that indigenous patients had a high belief in traditional medicine, practice and practitioners.

“Because the first they do, people of the Amazon, is to cure with medicinal plants. If they don’t feel better they come here to the health center.”

Several participants brought up that the patients came to the health clinics after they had tried to cure themselves with traditional medicine. In some cases this led to that the patients came to the clinics seriously ill, due to the late contact with the health clinics. A participant mentioned that they tried to respect traditional medicine as much as possible, but expressed that use of traditional medicine had led to cases of deaths due to the late contact.

“They come here seriously ill, many times to the health post, they believe a lot in the curiosos, shamans. They blow around their bodies. Blow the mapachu [cigarette used in traditional medicine], we call it that, they think it cures the person.”

Opinions regarding the use of traditional medicine among the participants were mainly build on respect for indigenous customs and beliefs, some of the participants highlighting the traditional medicine’s importance and function.

“Traditional medicine is very important because there are medicinal plants that can cure.”
Other participants expressed a respect for the ancient traditional medicine and were of the opinion that it was good to use from time to time, but needed to be complemented with western medicine from the clinic. None of the participants used traditional medicine as a base in their health practice, but a couple of the participants expressed that they sometimes were combining traditional and western medicine. By recommending both the traditional medical root malva and paracetamol to patients with fever, the patient used to traditional medicine could be met halfway. A participant described how knowledge about malva was obtained.

“A lot of mothers teach me, it’s better to crush malva to cool the child with fever. I can’t say stop to that, on the contrary, it’s a part of our care. We give counseling, prescribing traditional medicine /.../ The malva has to be mixed with pomegranate and the fever is lowered, it’s antipyretic, lowering the fever [laughing].”

Intercultural implementations
All of the participants were familiar with the term intercultural health and most of them worked with it in some way. Several participants expressed intercultural health as something positive and that it was a helpful tool in the care of the patients. Intercultural health was seen as a strategy while working with indigenous patients, since indigenous communities were not used to western medicine. It was pointed out that intercultural health contributed to a safer maternal care.

“Ah, it is good because there are many cases of when they feel more safe so they come here to give birth. Because mostly we are working with that, the majority want to give birth at home. And we can avoid complications to decrease the rate of maternal mortality, in Loreto it is high.”

Several of the participants expressed that intercultural implementations had been made within their working area. The use of bilingual posters in educational workshops was one of the implementations.

“We apply intercultural health at the health post. We apply, in the post for example we have a lot of indigenous communities. [Showing pictures]. The words are in our local language. These images are in Yagua language. [Reads in Yagua]. We use them to give... food, hand wash /.../ the youngest from 0 to 6 months, pregnancies /.../”

Another intercultural implementation was to work with a health promoter within the communities. The health promoter was described as a link between health clinic and community and handled the contact with the patients and their treatment, able to speak the local languages. The health promoter either worked together with a nurse technician at the health post or alone in the communities which were far away from the health post.

“The health promoter knows two languages, we talk with him on the phone, to see if the patient is following prescription, if it is not that way, the patients feel abandoned, and they abandon the treatment.”

A maternal house with possibilities to give birth through vertical birth, the traditional way of giving birth by standing or semi-sitting and grabbing a rope, had been implemented.
Autonomy was brought up, by giving patients chances to choose which kind of care they preferred, for example regarding deliveries. It was also possible to collect medical plants from a biofarm which had been implemented at one of the health centers.

Many of the participants emphasized that respect for diversity of customs and health beliefs was an important part of the care even if they did not share the same belief.

“But in my spirituality I have another belief, I respect other persons with other believes. I respect everything. Well, they believe in passing eggs around the body for mal-aire. I don’t believe in that. I respect everything. But I don’t suggest that. I respect.”

Experiences of working with intercultural health was shared.

“It can work together. According to my experience, I have two or three years from the Amazon basin. The traditional and western medicine can work together.”

Incidental findings

There was a tendency among participants to stereotype indigenous people and ways of living. Indigenous people were generalized by some of the participants as shy, very special, that they saw everything as an emergency and that their customs were rare. Furthermore, indigenous people were referred to as rebels, that they did not look after their kids, that they did as they wanted and that they lived in their own world. Several of the participants mentioned that the information given to indigenous patients had to be adjusted, mentioning it had to be lowered to their cultural level in order for them to understand.

“They don’t wash their hands, they are playful, the native children don’t wash their hands. They are connected with the natural, they are not as from the city. They go to the jungle, when their bread falls down they pick it up and eat it, no problem. For their culture, aah. They don’t wash their hands. They eat everything. [Laughing].”

DISCUSSION

Discussion of Findings

This study examined registered nurses’ experiences of working with indigenous patients in remote health care settings. The main findings that emerged are connected to the registered nurses work field, including challenges and how to work with patient education as well as intercultural implementations.

The participants working as registered nurses in Loreto seem to be in a particularly demanding position. The study found that the participants had broad experiences of nursing care with indigenous people in the remote clinics. This can be linked to the fact that they were working either alone or with a limited amount of colleagues or with limited possibilities to send patients to more specialized care. High workload was related to the high numbers of patients, long working hours, insufficient resources and staffing levels. These findings are supported by Peñarrietade De Córdova et al. (2012) who found the same reasons for high workload in their study of nurses’ work situation in Peru. Lack of
resources, material and infrastructure was further described by Newman and Shapiro (2010) as reasons of dissatisfaction amongst health professionals in Loreto in 2009. This shows that the main reasons of dissatisfaction remain unchanged ten years later. The average of 4250 patients per nurse in one of the studied districts can be compared to the national level in Peru with the distinct lower number of 781 patients per nurse (WHO, 2017). This confirms the lack of nurses in the region found in the study by Jimenéz et al. (2015). OECD (2017) points out that in order for Peru to reach universal health coverage, primary health care in rural areas must be strengthened regarding available health professionals.

The participants were almost exclusively working in the area due to a present or post SERUM-service. Mirroring the positive impact of the SERUM-service in the area by strengthening the workforce and thereby enabling improved access to health care. Although limited pre-knowledge about the area, the level of experienced competence was unisonly high, related to earlier work experience or education. Considering the work experience in some cases being less than one year, the high level of experienced competency was a surprising find. The high level of competence might have been connected to the overall work tasks and practice, leaving an unawareness of how the competence was experienced connected to specific fields. Yajahuanca et al. (2015) points out that competence connected to for example indigenous traditions and customs was lacking among earlier inexperienced health professionals in the area. Intercultural health is included in the registered nurses work field in Peru, and all the registered nurses should have the competency to provide it.

Poverty and long distances to health care facilities were the main issues for poor health care access among the patients in the area. The same issues were found in the study by Brierley et al. (2014) as well as in the study by Nawaz et al. (2001), conducted in the same area almost twenty years ago. Although all of the Amazon population are entitled SIS with free health care, transportation expenses are not covered in the insurance, meaning contacting the health care is not free in the area after all. This was shown in the results as patients not showing up to their appointments since they could not afford buying fuel, not able to get the free health care they were entitled to. Differences between the area of the study and more urban ones were emphasized in the results, differences that Browne et al. (2016) link to the history and discrimination of indigenous groups. While spending time in the country, socio-economic differences were observed between urban areas and the area of the study with mostly indigenous communities, pointing to that inequities between ethnic groups are still present in Peru.

The challenges in providing health care for indigenous patients was seen mostly in the inability to foresee cultural differences regarding customs, languages, behaviors, and perceptions. Browne et al. (2016) stresses that the focus, when working with cultural diversity, should lie on changing and adapting the culture within the health care, instead of focusing on cultural diversity as the source of challenges. Smith (2013) points out that to see the patients as individuals within their cultural context is a way to work culturally competent. For health professionals working in culturally diverse regions such as Loreto, it is especially important that education to become more culturally competent is provided. If the participants had had more education and experience regarding cultural competence, the experienced challenges might have been of a different character. Although, as emphasized by Villa Pesantes (2014), there is a risk to generalize the customs and habits of a specific culture when educating in cultural competence. Instead of changing attitudes and adapting
the care to cultural needs, intercultural health is then reduced to just what one should or should not do while meeting people with other cultures (Villa Pesantes, 2014).

Browne et al., (2016); Espinosa, (2009); Villa Pesantes, (2014) point out that limited understanding of the area can lead to negative consequences related to language barriers and limited knowledge regarding local history, customs and practice. According to Espinosa (2009), miscommunication can occur when diverse customs and perceptions of medicine, illness, healing and health beliefs meet. Miscommunication was seen in the results connected to both language barriers and customs. Despite the participants’ lack of knowledge in the local languages, there seemed to be a low interest in learning them, even though communication barriers were expressed widely. Courses in local languages seemed to be something that could be more occurring in the nurse education. Villa Pesantes, (2014) points out that health professionals who speak the language spoken in the community plays an important role in providing health services that are culturally appropriate. This is strengthened by MINSA (2006), who describe the importance of health professionals learning the languages in order to be competent to provide intercultural health. This shows that the participants level of competency can be questioned since they were not familiar with local languages and customs. Browne et al. (2016) argue that health professionals working with indigenous populations should be recruited based on values of equity and motivation to work within the given area. The situation is not easy; there is an urgent need for more professionals, and at the same time it is of great importance that the professionals are suitable and competent to provide equal care for indigenous patients.

Patient education was included in the participants responsibilities, given both at the clinics and directly in indigenous communities. The patient education was seen as something increasing the patients’ health knowledge and compliance. The campaigns and workshops held in the communities were described as being adapted to the patients regarding study material and information, using bilingual and descriptive images and pamphlets. By using locally adapted and culturally appropriate patient information, Williamson et al., (2015) state that it can have a positive impact on the health knowledge and prevalence of disease. Yajahuanca et al. (2015) continues that patient education becomes ineffective if interculturality and local health knowledge is ignored. Cultural adapted patient education is one way for the registered nurses in the area to fulfil their responsibility of preventing disease and maintaining health in an endemic area (ICN, 2019). By adapting the patient education, the registered nurses can provide care that takes local knowledge and tradition into consideration.

That the patients came to the clinics in life-threatening conditions and sometimes too late was expressed with feelings of frustration. The patients’ late contact with the health clinics was something the participants referred to that the patients first of all tried to cure with traditional medicine. Torri and Hollenberg (2013) found that late health seeking behavior within indigenous groups was affected by other reasons than the preference of traditional medicine. Financial restraints, distrust in the western medicine due to ineffectively provided treatment, work and family responsibilities was mentioned as contributing factors for not seeking help at the clinics (Torri & Hollenberg, 2013. The participants described that they were explaining symptoms, warning signals and when to seek health care as a part of the patient education, which is an essential and valuable beginning in promoting health. To improve the situation even more and avoid unnecessary life’s lost, the underlying causes for not seeking help from the clinics should be investigated.
Strategies to improve the experienced compliance had been implemented with reported positive effects, due to increased contact and information given to the patients. In the study by Williamson et al. (2015), the patients did not understand their diagnosis and wanted to get more information. This might be something that was affecting the compliance in this area of the study too, before the strategies were implemented and therefore leading to abandonment of the treatment. As the participants working with the strategies insinuated, the patients were not dismissal to treatment, but rather sought support from the health promoter and health professionals and were fulfilling the treatment after proper information had been given. Gianella et al. (2016) explains that low compliance can be an effect of that the provided information is insufficient. The participants did not mention underlying causes for the experienced low compliance, but Espinosa (2009) explains that health beliefs and practices might affect the views on treatment. The study brings up the example of that indigenous women who according to their beliefs could not administer medicine to anyone during their pregnancy or menstruation period, a fact the health professionals were unaware of, leading to a misconception of the compliance level (Espinosa, 2009). Therefore, a suggestion for the registered nurses working in the area is to keep investigating the underlying factors to low levels of compliance and adapt the work thereafter, and not dismiss the behavior as lack of understanding or unwillingness from the patients. Since the aim of the study was to examine registered nurses’ experiences, the opinions in these matters from the patients’ perspectives was not covered in this study.

Traditional medicine, beliefs and practitioners had a high position among the patients, where it seemed to be commonly known that especially indigenous patients cured with traditional medicine first of all. This shows a reality where traditional and western practices are coworking and functioning together at the same time, with or without intercultural implementations. This reality was something the participants had to adapt to, regardless personal views in the matter. It could be seen in their everyday work with recommending both traditional and western treatment simultaneously, as well as gaining knowledge of traditional medicine and their function from the patients. Working across the borders of traditional and western medicine means the participants are respecting and recognizing traditional medicine as an alternative, adopting an intercultural view (Monteban et al., 2018).

Regarding the areas of interests of this study it was a positive find that the term intercultural health was well-known and expressed in positive terms. Showing that Peru’s attempts to include intercultural health within the public health system has been at least somewhat effective. Ways of working interculturally and with various intercultural implementations shows that the public health care in Loreto is recognizing traditional medicine and is working toward a system where traditional and western medicine exists on equal terms (Monteban et al., 2018).

The implementation of the vertical birth was expressed as lowering the maternal mortality rate in the area as well as increasing the trust and safety of the mothers coming to the health centers, compared to before the implementations when women in greater extent gave birth at home. Rural parts of Peru had in 2009 one of the highest maternal mortality rates in the country. The vertical birth was implemented in the public health care in order to lower it and improve the situation for indigenous women (Guerra-Reyes, 2009). In addition, the implementation is a way to decrease the gaps in maternal mortality between
indigenous and non-indigenous communities (Sandes et al., 2018). The implementation in the area meant that women were given the opportunity to choose between traditional and western way of giving birth, becoming involved in their health care as well as having their traditional health practice accepted. The vertical birth was given in specially adapted maternal houses, designed to be similar to the houses in indigenous communities. Studies show that before the implementation of the vertical birth, indigenous women refrained to give birth at the health centers. Apart from limited access, it was also related to how they were treated by health professionals as well as how the procedures of the western way of giving birth threatened their health, autonomy and traditions (Guerra-Reyes, 2009).

To have bilingual and local health promoters as a link between the practices in the communities is a valuable implementation towards achieving intercultural health. The health promoter is someone coming from the same community where they work and is educated in both traditional and western medicine (Villa Pesantes, 2014). The implemented system by calling the health promoter and in that way follow up on patients’ condition and treatment was something that seemed to work well and contributed to improved health among the patients. That the health promoter was bilingual was something that could help reduce the communication barriers and gaps between health professional and patient. As described by Gianella et al. (2016) a problem with the implementation is when the health promoters are mainly being used as translators and mediators between health professionals and indigenous patients. The knowledge from health promoters towards the health professionals regarding the traditional view is then gone missing. How knowledge between health professional and health promoter was further exchanged did not emerge in the findings.

Every person has the right to receive respectful and cultural appropriate care (ICN, 2013). Intercultural implementations, such as the vertical birth, can be one step closer to guarantee that this right is maintained. Gianella et al. (2016) describes that culturally acceptability in health implementations is extra important when providing care for people with a history of discrimination and marginalization. In line with the country’s intercultural health legislation and ICN:s ethical code for nurses, respect towards indigenous peoples health beliefs, customs and traditional health practices were present among the participants. Yajahuanca et al. (2015) point out that obstacles for enabling exchange and cross-cultural sharing is when one practice is seen as superior to the other. In order to enable cross-cultural sharing built on mutual respect and trust, traditional medicine and practice needs to be seen as equal to western by the health professionals working in the region. Further, in order to improve the situation in the area, the care has to be based on the local views and beliefs, getting to know the patients and care for them based on who they are and not on preconceptions or generalizations.

In order for Peru to reach the UN Sustainable Development Goals, the situation needs to be improved, but the responsibility does not lie on the very individuals working in the area. With the high workload and limited resources, it is understandable that working alone or with few colleagues makes it difficult to find the time to develop the care, although it needs to be pointed out that some of the participants did manage to do so. This might contribute to difficulties for the participants to investigate underlying factors for low compliance and miscommunication, as well as the possibility to learn a new language. In this environment, the medical part of the work and to get the job done gets prioritized, together with the need to recover while not working. Therefore, this study suggests that national investments in order to improve the density of health professionals, as well as the
infrastructure and socio-economic situation for indigenous people is needed. National investments, especially for the population in rural areas, are also supported in the UN Declaration on the Rights of Indigenous Peoples (UN, 2018). As a participant pointed out, it is important to learn more about the needs of indigenous people and focus on how to help them.

**Discussion of Method**

The qualitative design was used since it was believed to be able to answer to the aim of this study; examining personal experiences. It was further chosen because it is a useful method when examining a phenomenon that there is little knowledge about (Polit & Beck, 2017). A quantitative design was not chosen since it was not considered being able to answer to the aim, because quantitative research mainly originates from objective realities examined through numerical and statistical analysis. A literature review aims to describe the studied phenomenon, which could have answered the aim of this study, if there would have been enough relevant data found on the topic (Polit & Beck, 2017). This study had an inductive approach, because it intended to look at the phenomenon unconditionally and analyze it directly from the collected data. Using a deductive approach could have affected the way the data was analyzed and interpreted (Priebe & Landström, 2017).

Convenience sampling method was chosen since there were few registered nurses in the area, why other sampling methods might have limited the number of study participants as well as being too time consuming in the planning of the study (Polit & Beck, 2017). Critique has been directed toward convenience sampling in terms of that the participants might not provide the richest information about the subject, since the people available at the moment are chosen (Polit & Beck, 2017). Although, given the specific situation, almost all of the registered nurses working in the area participated in the study and they had all experienced the studied phenomenon, meaning another sampling method would have provided with more or less the same participants. Finding participants who have experienced the phenomenon is one way in achieving credibility (Graneheim & Lundman, 2017).

The sample size in qualitative research with semi-structured interviews is decided by the richness of the data, where the researchers’ aim is to collect enough in-depth data of the phenomenon (Polit & Beck, 2017). Therefore, the sample size was not decided beforehand, also related to the unawareness of the number of registered nurses in the area. The selection criteria were adapted to the study area; more criteria would risk the aim not being answered due to the inability to recruit participants who matched the criteria, especially considering the limited pre-knowledge of the area regarding people working there.

Including different clinics made it possible to collect enough data, since there were only one or few registered nurses working at each clinic. After conducting eight interviews from total four clinics it was estimated that enough data coming from various participants was gathered, concerning the time frame, size and level of this study (Graneheim & Lundman, 2017). The participants were of diverse ages, gender and had various experiences and backgrounds. According to Henricson and Billhult (2017) variation in sampling is desirable in order to reach a broad understanding of the studied phenomenon, something the different experiences of the study participants as well as their different workplaces was able to contribute with. Variation increases the credibility of the sample selection as well as increases the transferability of the study (Henricson, 2017).
The study was conducted in a specific context, with registered nurses providing care for indigenous patients in remote areas with limited access. The specific context might create difficulties to transfer the findings to other settings and groups. To increase the transferability a detailed description of sample method, selection criteria, study context and descriptions about study participants are presented in the method section (Polit & Beck, 2017).

Collecting data through interviews was seen as the most suitable way to collect information about personal experiences of the phenomenon. Semi-structured interviews were chosen in order to make sure that topics of interest was covered in the interviews, but at the same time let the participants talk freely around the subject (Polit & Beck, 2017). By selecting the most appropriate data collection method, it contributes with credibility to the study (Graneheim & Lundman, 2004).

There was a conscious choice that only one of the interviewers was in the room during the interviews. This to avoid imbalances and confusion since there, apart from the participant, were already two persons, the interviewer and the interpreter, present (Danielsson, 2017a). All of the participants consented to be audio-recorded after given both written and verbal information and therefore it was not needed for the second interviewer to be present and take notes. The interviews were conducted at the clinics during the participants working hours at a time and location chosen by the participants. Although it might have been stressful to leave the work especially since there was a lack of professionals, this way the interviews did not take up their already limited free time and they could choose the most suitable time for the interview during their work hours. Due to limited space at most of the clinics, the locations were not always filling up to the criteria of being private, protected against interruptions and adequate for recording (Polit & Beck, 2017), a fact that both interviewers and participants had to accept and adapt to, focusing on conducting the interview (Danielsson, 2017a).

One factor affecting the trustworthiness of this study is that the interpreter had inadequate English level and lacked earlier experience of interpreting. This was something unknown before conducting the study and the possibilities to assign another interpreter during the data collection was minimal, due to the isolated location in the Amazon and a restrained time schedule. This was affecting the interview sessions in the sense that the translation of the interviewers’ questions and participants answers were insufficient. Meaning follow-up questions in some cases were left out, and sometimes leading to misunderstandings, resulting in a less deep data. In order to get the correct translation, the audio recordings were listened through multiple times together with the interpreter. The content was discussed between the interpreter and interviewers, actions taken in order to gain trustworthiness (Al-Amer et al., 2014). The final translations did in the end turn out adequate, although the quality of the interpretation was not excellent, something that might have affected the result of this study (Al-Amer et al., 2014). Despite challenges, the interpreter came from the region, speaking the same dialect as many of the participants and was familiar with the local slang, terms and cultural context, which helped in the interpretation of the data by explaining local phenomena and traditions. According to Al-Amer et al. (2014), an interpreter who is familiar with the local context and language is one way in understanding the correct sense of the data and gaining trustworthiness. By being transparent when describing the translation process the credibility is increased (Al-Amer et al., 2014).
Other methodological restraints were the researchers’ limited experience of conducting a research study, as well as conducting it in a different language. If the researchers had had a higher Spanish level and conducted the interviews without an interpreter, a closer relation to the participants and a wider understanding during the interviews could have been possible. The researchers would also have been able to take part of scientific articles on the subject written in Spanish.

Before the interviews, the interviewers had gone through the topic guide several times in order to get comfortable with the questions (Danielsson, 2017a). By knowing the material and using the topic guide as a support, the interviewers were able to be flexible without having to remember the topic guide by heart, in order to stay focused on the ongoing interview. As mentioned earlier, there were difficulties regarding follow-up questions connected to misunderstandings. Nevertheless, the interviewers were more or less adapting the questions according to the participants answers, not letting the questions in the topic guide steer the interview. The interviewers were also paying attention to what questions the participants had already covered and were adapting the questions accordingly (Polit & Beck, 2017). Only one of the interviewers held a pilot interview due to limited time. By discussing the pilot interview afterwards regarding topic guide, translation and technique, the other interviewer was prepared. Although, conducting two pilot interviews would have been ideal in order for both interviewers to get familiar with the research role.

An inductive content analysis was chosen since it is a helpful method in finding mutual patterns and themes of the data (Polit & Beck, 2017). By presenting how the data was analyzed and presenting the findings with quotations, it increases the transferability, transparency and trustworthiness (Graneheim & Lundman, 2017). When using an inductive analysis, the pre-understanding about the subject is set aside (Henricson & Billhult, 2017). Since the researchers had no previous personal experience from the area, it may have contributed to a larger openness toward the subject and a more neutral approach than if studying a well-known subject. The researchers have been aware and open about their pre-understanding, something that helps creating credibility to the study. Being more than one researcher also helps gaining dependability, since it is possible to discuss the interpretations and analysis of the data, something that has been done in every step of the analysis process (Graneheim & Lundman, 2017). Credibility and confirmability can further be gained if the analysis process and result is peer-reviewed by others (Henricsson, 2017). In this study, the analysis process and result have been peer-reviewed by a supervisor and a supervisory group, making sure the analysis and results were based on the collected data.

The actions planned in order to keep the participants confidentiality were fulfilled and an ethical approach has been present throughout the study. One ethical aspect is that Project Amazonas, a well-known organization in the area, provided the contact with the clinics. This might have affected the participants answers and decisions to participate, since the interviewers and the interpreter were indirectly connected to the organization. In order to avoid connection between the study and the organization, information was given to the participants about the neutrality and aim of the study. Another aspect is the fact that one of the health clinics was contacted on site and therefore the participants were not given the same time in advance to consider their participation. Although, the researchers handed out information about the study and the formal agreement one day ahead to create prerequisites to make an informed consent (Helgesson, 2015). In addition, the researchers were flexible when the best suitable time was if anyone wanted to participate. That the interviews
sometimes were interrupted is something to reflect about, the interviewers sometimes paused the interview and, in some cases, observed the participant and considered the questions sensitiveness, sometimes letting the participant continue talking. The interruptions might have created less in-depth answers and higher levels of stress, unfortunately these interruptions were inevitable, as explained before. The researchers’ interest in fulfilling the study was never bigger than the interest of the participants’ well-being, something that was considered during the course of the study and is in line with the Declaration of Helsinki (WMA, 2013). Most of the participants expressed positive thoughts regarding the study being conducted and they saw a need of research within the area and wanted to share their experiences.

Conclusion

This study has contributed to decrease the knowledge gap regarding registered nurses’ experiences of working in Loreto region, by listening to some of their stories. The findings revealed a broad work field with a lot of responsibilities, performed in an area with low prerequisites because of a high workload, little available resources and an isolated location. Experiences of including intercultural health in practical work was shown. Intercultural implementations in forms of patient education, the vertical birth and working with health promoters appeared from the descriptions, shown to improve intercultural relations, autonomy and health. Challenges related to communication and diverse cultures was described to be recurrent between registered nurses and indigenous patients. To improve the situation, a bigger change than individual efforts are necessary. National investments to provide more resources and health professionals, improving the infrastructure as well as the socio-economic situation for indigenous people are needed in order to reach the UN Sustainable Development Goals until 2030.

Further research

This is one of few qualitative research studies made on the experiences of registered nurses working in the area, why more research is needed to create a bigger understanding of the subject. Suggestions for future research is to collect in-depth data of the different areas that this study has only touched. In addition, indigenous patients’ experiences of intercultural health and implementations is a missing voice in research.

Clinical importance

The study gives an insight in how registered nurses can work with cultural diversities, something occurring in health care settings all over the world. Respecting the patients’ cultural needs was seen as an important factor in providing culturally appropriate care, especially when caring for vulnerable populations. However, the small scale of this study needs to be complemented by further research in order to gain more clinical importance.
REFERENCES


25 abril 2019

Estimado(a) Director(a) del Centro de Salud,

Es mi placer presentar dos estudiantes de enfermería de Sofiahemmet University College en Suecia:

Srta. Siri Fjellman (identificado con pasaporte sueco 95173570)
Srta. Linnea Berglund (identificado con pasaporte sueco 94512130)

Ellas piden su permiso de visitar su establecimiento de salud y entrevistar al personal, en particular las/los enfermera(o)s. Las dos estudiantes están auspiciadas por la Asociación Civil Proyecto Amazonas que cuentas con un convenio con DIRESA-Loreto para colaborar en varias modos para mejorar el salud en zonas rurales de Loreto, Perú.

Sin otro particular, agradecemos su gentil apoyo a las señoritas Fjellman y Berglund.

Devon Graham
President/Scientific Director
Project Amazonas, Inc.

US cell: 001-786-232-2674
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APPENDIX B

The aim is to describe registered nurses’ experiences of working with indigenous patients in rural health clinics with limited access in Loreto region, Peruvian Amazon.

Background

- For how long have you worked as a nurse? How many years at this clinic?
- How come you decided to work here? (SERUM?)
- What did you know about the area before you started to work here?

Work situation

- Can you describe a normal work day here at the clinic? (What tasks do you perform?)
- In general, how do you experience your workplace?
- Which are the main issues or diseases the patients are seeking for?
- How do you experience your workload here at the clinic?
- What kind of backup is available for you if you would need it? By backup I mean in forms of personnel, resources, support from other clinics etc
- How are the possibilities for you to send patients to more specialized/inpatient care?
- Do you feel that you have sufficient training and competence to perform your work in a professional way?

Working with indigenous groups

- How do you think the health care is affected by that it is mostly indigenous groups residing in the area?

How does the location of the clinic affect your work and the care of the patients?

- How do you experience working with indigenous patients in a rural setting?
  - Opportunities, challenges?
- We have read that intercultural health, a combination of traditional and western medicine, as an approach within health care has been implemented in the region – what do you think about these implementations?
- Do you work with intercultural health at this clinic?
  - If yes, how and why? Why not?
- From your experience - to which extend do the patients use traditional medicine? What is your opinion about that?
-How do you work with patient education? (regarding health knowledge?)

-In your opinion, how is the knowledge among indigenous patients about the causes of the most common health issues?

-According to you, how is the compliance to treatment among the indigenous patients?

-How do you think the indigenous patients are experiencing the care/clinic/health system?

-If you had the chance to improve something at the clinic, what would that be?

-Is there anything that I have omitted to ask that you think is relevant to the research subject?

Thank you for participating in this interview.

-How did you experience this interview?
APPENDIX C

Information about the research study

To the participant,

Our names are; Linnea Berglund and Siri Fjellman, we are two student nurses in our final year at Sophiahemmet University in Stockholm, Sweden. We are in Peru between 28th of March to 27th of May 2019 to write our Bachelor thesis.

The aim of the thesis is to describe registered nurses’ experiences of working with indigenous patients in rural health clinics with limited access in Loreto region, Peruvian Amazon.

The population living in rural parts of Loreto have limited access and long-distances to health care services. There is a high prevalence of communicable diseases in the area. In comparison to urban areas, the population is affected by inadequate water and sanitation, limited infrastructure as well as high rates of poverty. Many indigenous communities with knowledge of traditional medicine and practices are living in the area. Intercultural health, a combination of traditional and western medicine, as an approach within health care has been implemented in the region. It is of great interest to us to explore if and how intercultural health is applied in the health care clinics. Research shows that there is limited knowledge about nurses’ perspectives and experiences of working with indigenous patients in areas with limited health care access and resources in the Amazon. Therefore, we would like to contact registered nurses who have experience of working in the area and gain knowledge of their experiences.

We will conduct a qualitative study with semi-structured interviews with registered nurses working at different health clinics in Loreto. We estimate that the interviews will take around 45 minutes. The interviews will be audio-recorded if you agree, in order to help us with transcription and analysis. The recordings will be treated confidentially and will be deleted after they are analyzed.

Your answers are going to be kept confidential and will be anonymous in the study result.

You have the right to end your participation in this study at any time without any consequences.

We would like to thank you for your time and engagement,

Linnea and Siri

To contact us: Linnea Berglund
linnea.berglund@stud.shh.se
+51 982 192 946
Siri Fjellman
siri.fjellman@stud.shh.se
+51 994 934 230

To contact our supervisor at Sophiahemmet University: Marie Tyrrell
marie.tyrell@shh.se
+46 840 628 78
Informed consent

I have read and fully understood the information given to me about the study with the aim to describe registered nurses’ experiences of working with indigenous patients in rural health clinics with limited access in Loreto region, Peruvian Amazon.

I understand that my participation is voluntary and I can end my participation in the study at any time without any consequences.

I hereby consent to participate in the study

__________________________________________________
Date and Place

__________________________________________________
Signature

__________________________________________________
Printed name
Información sobre el estudio de investigación.

Al participante,

Nuestros nombres son; Linnea Berglund y Siri Fjellman, somos dos estudiantes de enfermería en nuestro último año en la Universidad Sophiahemmet en Estocolmo, Suecia. Estamos en Perú entre el 28 de marzo y el 27 de mayo de 2019 para escribir nuestra tesis de licenciatura.

El objetivo de la tesis es describir las experiencias de las enfermeras registradas de trabajar con pacientes indígenas en clínicas de salud rurales con acceso limitado en la región de Loreto, en la Amazonía peruana.

La población que vive en las zonas rurales de Loreto tiene acceso limitado y largas distancias a los servicios de salud. Existe una alta prevalencia de enfermedades transmisibles en la zona. En comparación con las áreas urbanas, la población se ve afectada por el agua y el saneamiento inadecuados, la infraestructura limitada y las altas tasas de pobreza. Muchas comunidades indígenas con conocimientos de medicina tradicional y prácticas viven en el área. La salud intercultural, una combinación de medicina tradicional y occidental, como un enfoque dentro de la atención de salud, se ha implementado en la región. Es de gran interés para nosotros explorar si y cómo se aplica la salud intercultural en las clínicas de atención médica. La investigación muestra que existe un conocimiento limitado sobre las perspectivas y experiencias de las enfermeras al trabajar con pacientes indígenas en áreas con acceso y recursos limitados de atención médica en la Amazonía. Por lo tanto, nos gustaría contactar a las enfermeras registradas que tienen experiencia trabajando en el área y obtener conocimiento de sus experiencias.

Realizaremos un estudio cualitativo con entrevistas semiestructuradas con enfermeras registradas que trabajan en diferentes clínicas de salud en Loreto. Estimamos que las entrevistas tomarán alrededor de 45 minutos. Las entrevistas serán grabadas en audio si usted está de acuerdo, para ayudarnos con la transcripción y el análisis. Las grabaciones se tratarán de forma confidencial y se eliminarán una vez analizadas.

Sus respuestas se mantendrán confidenciales y serán anónimas en el resultado del estudio.

Usted tiene el derecho de terminar su participación en este estudio en cualquier momento sin ninguna consecuencia.

Nos gustaría agradecerle por su tiempo y compromiso,

Linnea y Siri

Para contactar con nosotros: Linnea Berglund Siri Fjellman
linnea.berglund@stud.shh.se siri.fellman@stud.shh.se
+51 982 192 946. +51 994 934 230

Para contactar a nuestro supervisor en la Universidad Sophiahemmet: Marie Tyrrell
marie.tyrell@shh.se, +46 840 628 78
Consentimiento informado

He leído y entiendo completamente la información que se me dio sobre el estudio con el objetivo de describir las experiencias de las enfermeras registradas de trabajar con pacientes indígenas en clínicas de salud rurales con acceso limitado en la región de Loreto, en la Amazonía peruana.

Entiendo que mi participación es voluntaria y puedo finalizar mi participación en el estudio en cualquier momento sin ninguna consecuencia.

Por la presente consiento en participar en el estudio.

________________________________________________________________________
Fecha y lugar

________________________________________________________________________
Firma

________________________________________________________________________
Nombre impreso
A letter of agreement

To the interpreter,

Our names are; Linnea Berglund and Siri Fjellman and we are two student nurses in our final year from Sophiahemmet University in Stockholm, Sweden. We are writing our bachelor thesis in Peru and will be collecting data through interviews at health clinics in Loreto region between 20th of April and 1st of May 2019.

The aim of the study is to describe registered nurses’ experiences of working with indigenous patients in rural health clinics with limited access in Loreto region, Peruvian Amazon.

The interviews will be held between English and Spanish, or any other language spoken by both you and the participants.

All the information gathered during the interviews must be treated confidentially to keep the integrity of the participants of this study, therefore we would like you to sign this form.

I agree in my position as a translator in this research project that the information I receive from the study participants will be treated confidentially and will not be divulged to others

________________________________________________________________________

Date and Place

________________________________________________________________________

Signature

________________________________________________________________________

Printed name