Historical and cultural aspects of the provision of care at an indigenous healthcare service facility

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Abstract *This case study aimed to interpret the underlying historical and cultural aspects of the provision of care at an indigenous healthcare service facility. This is an interpretive, case study-type research with qualitative approach, which was conducted in 2012 at the Indigenous Health Support Center (CASAI) of the State of Mato Grosso do Sul, Brazil. Data were collected by means systematic observation, documentary analyses and semi-structured interviews with ten health professionals. Data review was performed according to an approach based on social anthropology and health anthropology. The anthropological concepts of social code and ethnocentrism underpinned the interpretation of outcomes. Two categories were identified: CASAI, a space between streets and village; Ethnocentrism and indigenous health care. Healthcare practice and current social code are influenced by each other. The street social code prevails in the social environment under study. The institutional organization and professionals' appreciation of the indigenous biological body are decisive to provision of care under the streets social code perspective. Professionals' concepts evidence ethnocentrism in healthcare. Workers, however, try to adopt a relativized view vis-à-vis indigenous people at CASAI.*

Key words *Healthcare, Indigenous health, Social code, Ethnocentrism*

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Introduction

Health services are social settings in which actions and individual attitude are guided by codes, that is, people also act according to the organization and the social rules of their location[1]. Health users (patients) and their families will be more engaged in the care process at health institutions that value autonomy and participation of subjects of care – users, family and workers[2]. In bureaucracy-ridden facilities, for example, there will be fewer opportunities to build the autonomy of professionals and users[2,3]. Interpretation of the social environment and its codes is relevant to analyze the conduct and actions of those involved[1] and to identify the type of care provided in health services – including indigenous health.

Indigenous health attention is a peculiar care setting. In Brazil and other regions of the world, such as Canada and Africa, indigenous care methods are based on different values and rituals directly linked to nature and religion[4-7]. However, many of the indigenous health care services have a service rationale based on the biomedical approach to health issues, focusing on the biological body[8,9].

Non-indigenous and Amerindian health professionals who work in indigenous care facilities are faced with the indigenous cultural diversity in a social environment of the health service guided by a biomedical logic care[3,6-8]. In addition to these aspects, in health's work place, another key element in the type of care delivery is how the people involved in the care process perceive each other[9]. Particularly in the case of indigenous people, preconceived and stereotyped concepts can negatively influence health staff's attitudes during care. It is important that the health care providers understand the illness as a sociocultural process and consider the experiences of people receiving care[5].

Indigenous health attention is a borderline area that produces processes of intercultural communication and interaction that must be studied and understood, focusing on different perspectives[3,4]. This should be taken into account, since Brazil lacks systematic production on health issues that includes ethnic and racial aspects, particularly on indigenous people[3,4,8,10,11].

Given the aforesaid and in order to get closer to the practice of care provided to indigenous people in health services, we raise the following questions: how do we outline the guiding code of workers' performance in the social setting of indigenous health care? Do workers' concepts about indigenous people influence the production of health practices in this social environment? From these enquiries, this study aims to interpret the cultural and historical aspects underlying the social framework in which care is built on the indigenous healthcare context, in the light of the concepts of social code and ethnocentrism.

Theoretical framework

This paper is an anthropological interpretive-qualitative research. It is a case study conducted among healthcare workers. The theoretical framework of this study sought the support of authors linked to Social Anthropology[1] and Health Anthropology[5,12-14], in order to understand the cultural and historical aspects of the investigated context. Two important anthropological concepts served as a basis for reflection in this study: social code and ethnocentrism, as described below.

Social codes: home, streets and the other world

"Home-based", "Streets-based" and "from the other world" concepts were developed by Da Matta[1] in his studies on the urban / semi-urban Brazilian society, which does not necessarily reflect the daily lives of indigenous people. These concepts are part of the framework adopted in this study, as they enable dialogue and discussion on health care to indigenous provided by professionals of urban origin in health services facilities located in an urban setting.

In the different areas of society as in health services[13], the role of individuals is guided by social codes. The social code and where it materializes are imbricated[1]. To understand a certain setting, one must consider the social relations and values, as well as the historical, political, economic and cultural aspects inherent to the context in question[1,15].

The concept of space is linked to the notion of time because "we live in fact within and in a transition from one social group to another, and we feel time as something concrete and the transformation of space as a social important element"[1], and it is determined by historicity. Social settings are spheres of social significance, where individuals express views and behave according to the current code[1,16].

In Brazilian society, there are additionally three types of ethical / social orders: home-

based, streets-based and from the other world. The home-based rationale is related to fraternity, reception, balanced reality among peers and personal loyalty. It is averse to change, individualism and economy[15,16].

The streets-based code is about impersonality, individualism, hierarchy and injustice held by the totalizing discourse that naturalizes and reifies concepts and relationships in which no one is capable of changing his/her social place.

From the other world rationale refers to the abdication from the world in which we live in, with its suffering, struggles and falsehoods to the detriment of equality[1,16]. Take, for example, a father who is respected in his home. If unemployed, in the streets, he can be treated as a miserable and helpless person. The same individual is subjected to different social logics by crossing through different social environments[1].

Whereas health services can be understood as cultural phenomenon resulting from a social reality in which they are inserted[9], the social relations in this space are influenced by the prevailing social code[1]. Health services' current code can influence the production of different types of care and the person-centered care, as in approaches that value individual diversity and autonomy. They also impact on the procedure-centered action, as in the biomedical model[1,13].

Social settings with a code "from the other world" in the context of healthcare would be propitiated by health models with a holistic view of the human being. They would be environments encompassed by the "idea of resigning from the world and its pain and illusions, and in so doing, attempting to synthesize the other two [codes]"[1].

The resignation from pain and illusions can mean the shedding of personal values and perspectives for the construction of a biocultural reality-centered care[1] of the user's health-disease-care complex. Thus, there would be a meeting of subjectivities between those who care and are cared for, without imposing a single knowledge to the patient / sick person / user.

The guiding code of health professionals' work would be the empathic and multidimensional perspective of the process of becoming ill[1,13]. In this setting, there would be no prioritization of this approach in the actions of professionals that medicalizes social problems[10]. By abdicating, while not entirely, from their point of view about illness and considering the beliefs and values of users, health workers would facilitate the construction of care of and with others[1,13]. As a result, care practices would be person-cen-

tered. There would be a greater chance of light technology jobs such as relational tools (respect, attachment and affection), therapeutic listening and narrative enabling access to the illness experience[2,13].

Ethnocentrism

Ethnocentrism refers to the elimination of cultural differences. It is the tendency to judge individuals from other cultures from own culture's point of view. It considers that own culture is better and superior than the others and, therefore, culturally different individuals are seen as inferior and less civilized[1,17].

Since the health-disease-care process is determined by biological, social and cultural factors[13], health action ethnocentrism may occur as well. In health, an ethnocentric practice covers the capture of subjectivities in favor of the appreciation of technicality, biological body and disease that affects[1,9] the biological body[4].

Centrality is at the heart of knowledge of the health professional, whose values are common to the system of meanings that permeate the political, social and cultural scenario of care, which is the Unified Health System (*Sistema Único de Saúde*-SUS). In turn, this system's operationalization is predominantly based on the biomedical model of health care[8,18].

Ethnocentric practices in health can be avoided through relativization, which is aligned with decentralized health approaches to disease that appreciate the diversity of values and types of health care. Thus, professional conduct will be guided by the social rationale from the other world[14,17].

The intercultural perspective in the approach between individuals with different cultures[14] and with divergent views on the health-disease-care process is important. Interculturality refers to the recognition of own identity and dialogue to build agreements with a view to accepting and appreciating different cultures as something positive and enriching to the social environment[14,17].

Methodological process

Study setting

The study setting was the Indigenous Health Support Center (*Casa de Apoio à Saúde Indígena*-CASAI) of Mato Grosso do Sul, Brazil. The institution receives daily about 40 indigenous

and companions from eight ethnic groups of the Special Indigenous Health District. Nursing staff consists of nine technicians and a responsible nurse. The nursing service operates around the clock, with 12-hour shifts and 36-hour rest scheme.

The organization of care to Brazilian indigenous people is based on Districts[11], as recommended by the National Indigenous Health Care Policy. In Brazil, the Special Indigenous Health District is organized according to cultural, demographic and indigenous territorial characteristics. Currently, there are 35 districts in Brazil and one of them is the Mato Grosso do Sul, located in the state bearing the same name.

At each District, the service network consists of health facilities located in villages where health actions are most often directed to primary health care. When requiring a specialized procedure, the indigenous is referred to middle and high complexity services referenced by the SUS[11]. CASAI is normally located in large cities. It provides care to the indigenous people under treatment and/ or recovery and to family members and companions.

Indigenous Health Support Centers is responsible for the articulation of indigenous care at District and other SUS services and nursing care[3,11]. Support Centers of Mato Grosso do Sul District are referred to as regional; however, they also serve indigenous people of the north[3]. Currently, there are about 50 institutions in Brazil, of which four are national Indigenous Health Support Center, located in São Paulo, Brasília, Curitiba and Goiânia.

Study participants

The study participants were 10 nursing workers who worked at CASAI from January to February 2012, when data collection was performed.

Data collection process

Systematic observation techniques, document analysis and semi-structured interviews were used. Nursing professionals were informed about the presence of the researcher in the field in question. Data was collected between January and February 2012. Each participant was individually made aware of the objectives of the study and the researcher's observation to understand

CASAI operations. Given the above, the professionals agreed to carry out the observations in their own working context.

Observations recorded in a field journal explained how indigenous people are received and screened at CASAI, their origin, the reason for seeking service, who performs care activities, how workers react during the relationship with indigenous people, as well as knowledge and practices developed before individual health needs.

The lead investigator through a script conducted interviews individually. Two interviews of acculturation were previously held. Interviews of acculturation is the most appropriate term to be used in qualitative research, replacing the pilot-interview denomination[19].

Therefore, two nursing professionals working in indigenous health, but not at the CASAI studied were selected in order not to limit the number of participants in the survey, namely, a nurse and a nursing assistant working at an Ethanol Plant of the State of Mato Grosso do Sul, where the majority of workers are indigenous.

Interviews held at the CASAI were directed by the initial questions: What does it mean for you to work here in this place? How is it for you to work in nursing care to the indigenous people? Interviews took place after at least a first contact, a conversation with each participant in order to establish a comfort zone between interviewer and respondent. Before interviews, it was emphasized that participation in the survey would be voluntary.

Outcomes review

Data collected in the study were submitted to interpretative analysis, from which meanings units embedded in the theoretical framework adopted emerged. Impregnating horizontal readings were performed, followed by a cross-sectional elaboration in order to understand and interpret data[20,21].

Ethical Aspects

The research project that led to the study was submitted to the Research in Human Beings Ethics Committee, Federal University of São Carlos, and approved. Participants were informed about the research and signed the consent form. There are no conflicts of interest.

Results and discussion

CASAI – A place halfway through the streets and the village

Nursing staff reports and observations showed the professional's perspective on the indigenous cared for seen as being shy, wary, arriving at the CASAI retracted. The following excerpts highlight this idea:

They already feel a difference as they [indigenous] *leave their habitat.* (E.10).

We imagine that they have another routine in the village, and they come here and get scared, because they live there in the forest. They have no contact with us. (E. 3).

They come here retracted, until they get to know people well; we keep on talking with them. (E.5).

The following field journal excerpt reiterates some peculiarities mentioned by respondents:

An indigenous woman came in today with her 2-month old baby brought by the driver. She [indigenous] *brought her son to remake the heel prick test. In conversation with the nursing assistant, the mother could not precisely explain the reasons to perform again this test. When they arrived, it was possible to notice the humble attire, her fear and distrust.* (Field journal).

When indigenous people come to CASAI, from the perspective of health professionals, they seem withdrawn in an institutional context with characteristics of an urban center. Such a view leads to study findings[5,11] which indicate that indigenous people have a strong sense of belonging to a place and a particular social group. Thus, while part of the indigenous health care model, from the perspective of professionals, CASAI is a reality not belonging to the indigenous people treated at the institution.

Indigenous people find themselves away from their homes, their customs and family. In their village, these same individuals may be active, imposing and respected people; however, when away from their own communities, they can feel deprived of these conditions and not belonging to that environment.

CASAI organizational structure seems to reinforce this idea. The institution studied has a work routine permeated by a bureaucratic organization. Respondents characterized the excessive nursing registration as one of the critical points of CASAI's bureaucracy. Filling various forms is a CASAI standard, as pointed out in the following extracts:

There has to be paperwork, this is everywhere. There's more here, since it is about documents and documentation. All patients who came here have something documented (E.1).

This is the standard here. In addition to writing, you still have to provide care to the patient. This is the rule. (E.8).

Considering the social setting's encoding[1], data from interviews and observations indicate that, at CASAI, indigenous people stripped and detached from their status with the emptying of the feeling of belonging, feel and act according to the logic of the streets[1]. In the perspective of professionals, the conduct of indigenous people is to guard and feel suspicious, without expressing their intentions and needs.

Indigenous people remain impersonal, which can be a result of the procedure- and disease-centered care. That is, care and where it is built acquire a streets' ethic, which depersonifies and reduces the individual to the biological body and compliance of rules, with capture of subjectivities for both the user and the professional. The following statements and field journal excerpt illustrate such situation:

The first thing we do is prepare the 7h00 a.m. medication. We give the medication and check the vital signs. (E.2).

We do not have time to talk properly [with the indigenous]*, we have to comply with the rule, which is what is scheduled in our agenda for the day.* (E.3).

I have been noticing for a while now that technicians are writing down nursing procedures in the nursing report book and medical records. They show signs of boredom. (Field journal).

The biological body is valued when the professional affirms the need to perform the technical procedure and the measurement of vital signs, for example. This aspect contributes to the low appreciation of the individual and his/her history[12,13,18], as reiterated by the claim of the worker, who says that he cannot even *talk properly* to users.

Statements of respondents, which reveal a perception that indigenous people coming to CASAI have exhausted all spiritual treatment possibilities in their villages, strengthen the passive indigenous people view:

In fact, they come from the city already with some hope of treatment that their own ritual there could not solve. Here would be the last resort. (E.5).

Seeking alternative solutions to their problem, indigenous people reach for high complexity health services and, while under treatment, they remain at CASAI. In these settings (CASAI

and other health services), from the perspective of health care providers, indigenous people seem to accept what they receive, expressing certain passivity in the unknown and complex health care biomedical network. The following statement illustrates this idea:

Many indigenous people do not speak. If you ask anything to them, they just nod their heads and say that everything is fine. (E.9).

One can see a strong convergence between the social code of the street and CASAI service that shows some biomedical care features. The biomedical perspective differentiates body and man and health professional work (mainly or solely the doctor) should be on the biological body affected by an ill, namely, the disease[12]. The individual is perceived impersonally, without considering the social and symbolic elements of the disease process. The life story of the patient and his family is also expropriated[22].

This reductionism and reification of disease propitiate *depersonification* with individual *subjection* or *objectification* and submission to the rules, procedures and institutional routines[13,23], in addition to the *technification* of the caregiving act[2].

These characteristics resemble the social rules of the setting, whose logic is similar to the streets, where the individual can lose his/her authority and *status*[1]. In health care streets logic-related environments, the respected cacique and the requested midwife, for example, are addressed to as a number and perceived by health workers as the disease they evidence.

Streets rationale is operating when the user submits to the long waiting time for a medical procedure, with his/her intentions and needs neglected by institutional routine, when their beliefs, values and rights are not respected and when targeted by a paperwork process that values technique and does not allow professionals to be attentive, empathetic and affectionate with someone who is ill, but also with a momentarily shattered happiness project[18].

The following field journal excerpt illustrates the relationship between the streets-based logic and CASAI's service, which, in turn, resembles certain health care settings centered on the biomedical model[23].

A CASAI worker said that, on one occasion, he accompanied two indigenous people to different health care centers. One of them stayed at the servicing facility, specifically in the waiting room. The professional explained to him that if he was called, he was to go and talk to the doctor. Meanwhile, he took the other Amerindian to a consultation at an-

other service. Upon returning, he realized that the doctor had left and the indigenous had not been examined; he was still sitting in exactly the same place in the waiting room. Without understanding why, he asked him why he had not been serviced. The individual said he had not been called, they called by saying 'next', and that is why he never went in. (Field journal).

The *next* case was permeated by impersonality, disrespect and disregard common to the streets-based code. An individual *depersonification* and *subjection*[20] is yet again clear. Da Matta[1] indicates that impersonality of the market, individualistic progress and linear historicity are in place in the streets. The indigenous individual treated as *next* was not screened and did not received a singularized care. The field journal excerpt also reveals another aspect inherent to the streets-based code, which is the subject's *petrification* by a totalizing discourse that does not allow him to reflect on his social place[1].

Regarding the totalizing ideology in health, it is worth noting the historical, cultural, social and political process of health demand production and the consequent naturalization of health needs[23]. In other words, health care, or treatment of diseases, increasingly requires biomedical care, therefore, biomedical health care needs are common, rising, compulsory and continuous[18,23], including among indigenous people[10].

Ethnocentrism and indigenous health care

The idea shared by professionals is that all indigenous people, as human beings, are similar, save for their differences, as suggested by the following statement:

It's like black and white individuals, I don't make any difference. Because someone is indigenous, because of this or that, and so forth. I do not see it that way. (E.6).

Interviews showed that, while saying they shared the idea of equality among human beings, workers evidenced in their statements a worker-indigenous people relationship power asymmetry, from the denial of what is said. The next reports portray this aspect:

You have to think that he/she [indigenous] *is a human being and needs us.* (E.3).

There's no difference, you know. Like every human being, there are some who are more hostile and others who are more shameful. (E.1).

[Indigenous people] *are equal, they do not differ from the Japanese with their crossbreeding, you know. They're just different.* (E.7).

Respondent non-indigenous workers had a Eurocentric vision, in which, according to the non-indigenous people, Amerindians lack certain qualities to be similar to Europeans[24].

Such denials occur particularly with respect to the customs, beliefs, ways of living and culture. Denials do not necessarily indicate native defects. It is noted that nursing workers live in the historical scenery of racist concepts of superiority and inferiority, which favors the development of the Eurocentric vision of others and the world[24].

To further elucidate the idea of indigenous culture's denial, one can use the example of the term "mestizo". Mestizo is the result of miscegenation, caused by the "union" between non-indigenous men and indigenous women who survived the conflicts of enslavement and were taken to Northeast hinterland's farms[24]. The descendants were called mestizos and, thus, a denial of the presence of indigenous people in the northeastern region was constructed. This fact was favorable to local farmers, whose possessions were expanded with the invasion of indigenous lands[24], whose real owners, with justification such as that of mestizos, were forgotten. Western nations, with the motto of colonization and development, historically subordinated indigenous people and still do it through asymmetrical power relations[8].

Statements of professionals reveal signs of ethnocentrism, represented by the denial of indigenous cultures. Such evidence may limit health actions and negatively influence the meeting of subjectivities and does not allow the worker to fully recognize the cultural differences (values) of the other in the care environment. The perception of retracted and passive indigenous people shown by CASAI workers corroborates this aspect.

As a global socio-cultural structure, these professionals reproduce practices and perceptions similar to those that they have been provided as a particular experience and interrelation experience in a specific historical context[13].

In Brazilian society, differences among its people (indigenous, Portuguese, Africans, Italians, among others) are naturalized and, thus, human groups establish relationships with other people, which, while ensuing an *eradication* of prejudice, convey the false idea of living together in perfect harmony[24].

Nursing staff, in general, fail to consider the knowledge and concepts different from those established by biomedicine, inherent to indigenous ways of seeing life[5-7]. In Amerindian societies, the explanation of a health need is linked to social and cultural rules, so it is important to relativize a vision on healthcare[4,25].

Participants recognized the ethnic diversity that exists among indigenous people they provide care to. They also pointed differences in behavior among Amerindians according to the culture of each ethnic group, as evidenced in the interview excerpts:

There's quite a difference, much difference. Here we try to treat everyone equally, regardless of ethnicity. (E.9).

The Terenas are not so withdrawn, they talk more, unlike Kaiwoás, which are more withdrawn, shy people. (E.4).

Kadiwéus are very unsociable (E.9).

Nursing workers distinguished individual behavioral characteristics of each ethnic group, which may have been favored by the continuous contact time among CASAI's nursing workers and indigenous people[5]. There are differences among ethnic groups, but the recognition of cultural needs of each individual was little observed during the research. This situation is enhanced by the bureaucratic work environment observed at the institution and the few permanent education actions[3], as can be seen in a highlighted record in the field journal.

The nursing assistant seems very busy. There are several scheduled events [in this context, procedures to which users will be referred] *that have been confirmed, but need to be inserted in the nursing report book. Such bureaucracy occupies much of workers' time, whose actions are focused on recording in different documents*. (Field journal).

CASAI's nursing workers adopt with little or more intensity a relativized look during care, in spite of the asymmetrical relationship between them and indigenous at CASAI, the predominant Eurocentric context in which we live and the bureaucratic work context[3], as reiterated by the following statement.

It is not only about administering oral, intramuscular or subcutaneous medicine. We have to talk to people, see how they are feeling inside as well. (E.2).

The construction of intercultural / relativized view concerns seeing and hearing the other, considering the cultural, experiential and social aspects underpinning the disease process and / or health need felt by the individual[17]. Disease requires an interpretation and performance in the socio-cultural environment and is not a static situation[13]. Considering that each individual has a unique vision of the world, cultural under-

standing enables the exposure of differences and specificities, and the appreciation of individual autonomy in the care setting[26].

Building a relativized / sensitive glance at these issues in indigenous health care is fundamental[17], mainly due to existing cultural differences, for example at CASAI, a place where the caregiver is usually not indigenous. Indigenous singularized health care can be positively impacted by workers' capacity to build the relativized / intercultural look, propitiated by the social care setting that enables understanding and appreciating users' knowledge and values.

Limiting factors

We emphasize that the lack of dialogue with the indigenous people was a limiting factor to this study. To better understand the current social setting code, it is important to consider the perspective of all stakeholders, including other workers. Due to the study's design, no other aspects that could determine the current social code and the production of health practices were observed, such as state political action and other political players.

Final considerations

The type of health practice exercised and the current social code are mutually influenced. In the space of care of the Indigenous Health Support Center studied, workers and users are operative and engendered by the current social logic of the streets.

From the perspective of professionals, the indigenous people's tendency is to guard and be suspicious, without expressing intentions and needs. Away from home and their customs, indigenous people may be, in their villages, active and respected people; however, when kept away from the communities to which they belong, they can feel deprived of this status and as not belonging to CASAI's environment.

CASAI organizational structure seems to reinforce this idea. Professionals value indigenous people's biological body. These factors are crucial so that care and the space where it is built acquire a streets' ethic, which contributes to the process of *depersonification* with *objectification* of the person people, who is the indigenous person in this case.

Professionals' conceptions are revealing the historical process of subordination / debasement of indigenous peoples, reflected in health actions. They are evidences of ethnocentrism in healthcare. It is worth highlighting that this process reveals collectivity and health care providers are spokespersons often unaware of the social discourse of a historically racist society. Nevertheless, workers also adopt in care a relativized look on indigenous treated at CASAI.

This review implies that practice contributes to the discussion on the classification of health services, especially those strongly marked by cultural issues, such as the indigenous people. It provides subsidies for development of public policies for the Amerindian people, as it reiterates the need for networks of symbols and meanings of indigenous care systems and the official system to be considered in the care of these people, especially the appreciation of the relativized look in care. There is a need for further studies to broaden the knowledge about the perspective of indigenous health services users.

Collaborations

AA Ribeiro and CIS Arantes worked on the design, design, analysis and interpretation of the data, as well as on the writing of the article and approval of the version to be published. DMR Gualda worked on the critical review of the article and approval of the version to be published. LA Rossi worked on data interpretation, article writing, critical review and approval of the version to be published.

References

1. DaMatta R. *A casa e a rua: espaço, cidadania, mulher e morte no Brasil.* 6ª ed. Rio de Janeiro: Rocco; 2003.

2. Merhy EE, Franco, TB. Cartografias do trabalho e cuidado em saúde. *Tempus – Actas de Saúde Coletiva* 2012; 6(2):151-163.

3. Ribeiro AA, Fortuna CM, Arantes CIS. O trabalho de enfermagem em uma instituição de apoio ao indígena. *Texto contexto* 2015; 24(1):138-145.

4. Novo MP. Política e intermedicalidade no Alto Xingu: do modelo à prática de atenção à saúde indígena. *Cad Saude Publica* 2011; 27(7):1362-1370.

5. Langdon EJ. Redes Xamânicas, curandeirismo e processos interétnicos: uma análise comparativa. *Mediações* 2012; 17(1):61-84.

6. Kurtz DLM, Sales T, Nyberg J, Moar D. Social Justice and Health Equity: Urban Aboriginal Women's Action for Health Reform. *The International Journal of Health, Wellness, and Society, Chamoaign* 2014; 3(4):13-26.

7. Migiro PS. Access to Health Services by Indigenous Peoples in the African Region. In: United Nation (UN). Department of Economic and Social Affairs of the United Nations Secretaria. *State of the World's Indigenous Peoples. Indigenous Peoples' United Nations access to Health Services.* New York: UN; 2015. p. 10-31.

8. Ferreira LO. A emergência da medicina tradicional indígena no campo das políticas públicas. *História, Hist. cienc. saude-Manguinhos* 2013; 20(1):203-219.

9. Rissardo LK, Molitermo ACM, Borghi AC, Carreira L. Práticas de cuidado ao recém-nascido: percepção de famílias Kaingang. *Cienc Cuid Saúde* 2011; 10(4):634-641.

10. Follér ML, González ME. Conocimiento, salud y derechos indígenas en la amazonía: introducción. *Anales Nueva Época* 2002; 5:9-19.

11. Coimbra CEA, Santos RV, Welch JR, Cardoso AM, Souza MC, Garnelo L, Rassi E, Follér M-L, Horta BL. The First National Survey of Indigenous People's Health and Nutrition in Brazil: rationale, methodology, and overview of results. *BMC Public Health* [serial on the Internet] 2013 [cited 2014 Nov 25];13(1):[about 9 p.]. Available from: http://www.biomedcentral.com/1471-2458/13/52

12. Le Breton D. *Antropologia do corpo e modernidade.* Petrópolis: Vozes; 2011.

13. Campos EA. Aspectos socioculturais e as práticas de cuidados em enfermagem. In: Nakamura E, Martin D, Santos JFQ, organizadores. *Antropologia para enfermagem.* São Paulo: Manole; 2008. p. 59-81.

14. Peru. Ministerio de Salud Publica. *Guía Técnica para la Atención del Parto Culturalmente adecuado.* Lima: Ministério de Salud Publica; 2004.

15. Freyre G. *Casa-grande & senzala: introdução à história da sociedade patriarcal no Brasil.* 51ª ed. Rio de Janeiro: Record; 2006.

16. Fazzioni NH. Entre a rua e o bairro: etnografia de um espaço em movimento. *Iluminuras* 2014; 15:287-307.

17. Castillo RAH. Entre el etnocentrismo feminista y el esencialismo étnico. Las mujeres indígenas y sus demandas de género. *Debate Feminista* 2001; 24:206-229.

18. Ayres JRCM. Sujeito, intersubjetividade e práticas de saúde. *Cien Saude Colet* 2001; 6(1):63-72.

19. Turato E. *Tratado da metodologia da pesquisa clínico-qualitativa: construção teórico-epistemológica, discussão comparada e aplicação nas áreas da saúde e humanas.* 5ª ed. Rio de Janeiro: Editora Vozes; 2011.

20. Thorne S. Toward methodological emancipation in applied health research. *Qual Health* Res 2011; 21(4):443-453.

21. Minayo MCS. Análise qualitativa: teoria, passos e fidedignidade. *Cien Saude Colet* 2012; 17(3):621-626.

22. Nötzold ALV. *O ciclo de vida Kaingang.* Florianópolis: Imprensa Universitária UFSC; 2004.

23. Camargo KRCJ. As armadilhas da concepção positiva de saúde. *Physis* 2007; 76(1):63-76.

24. Silva E. Os índios Xukuru e as ligas camponesas (Pesqueira-PE, 1961). *Revista Crítica Histórica* 2010; 1(2):101-114.

25. Gonçalves LJM. *Na fronteira das relações de cuidado em saúde indígena.* São Paulo: Annablume; 2011.

26. Pagliuca LMF, Maia ER. Competência para prestar cuidado de enfermagem transcultural à pessoa com deficiência: instrumento de autoavaliação. *Rev Bras Enferm* 2012; 65(5):849-855.