DOI: 10.1590/1413-81232021269.2.22372019

Interculturality in the daily routine of primary health care: The case of the health model in Guainía, Colombia

Saidy Eliana Arias-Murcia (http://orcid.org/0000-0002-7015-8079) [1]
Cláudia Maria de Mattos Penna (https://orcid.org/0000-0001-5277-2860) [1]

Abstract *Colombia is currently implementing a new health model, which is being tested initially in a region of the Amazon, with the main objective of primary health care with an intercultural approach. It is a cut of a doctoral thesis outlined by the case study methodology, which aimed to understand the daily construction process of primary health care from the perspective of indigenous and health professionals in Guainía, Colombia. Twenty-two indigenous users and 26 health professionals participated in the study, as well as three key participants. The data were collected through semi-structured interviews and direct observation, and were later transcribed and analyzed by Bardin's thematic content analysis technique. The results show that interculturality, as a permanent process of negotiations and articulations present in the daily lives of indigenous and health professionals, is a fundamental part of the construction of primary health care in Guainía. In it materializes the encounter and exchange of heterogeneous forms of thinking-knowledge, that allow new interpretations and reinventions of knowledge and practices in health, although this process is permeated by conflicts, ambiguities, asymmetries and contradictions.*

Key words *Primary Health Care, Indigenous Health Services, Qualitative Research*

[1] Programa de Pós-Graduação em Enfermagem, Escola de Enfermagem, Universidade Federal de Minas Gerais. Av. Professor Alfredo Balena, lado par, Centro. 30130-100 Belo Horizonte MG Brasil.
seam-04@hotmail.com

Introduction

In 2016, in Colombia, the implementation of the Comprehensive Health Care Model (CHCM) began under the Comprehensive Health Care Policy (CHCP), as an initiative from the State to improve access and quality of health services at the national level. The implementation of the General System of Social Security in Health (GSSSH) in 1993, being a public-private system, brought important advances in terms of coverage of health services, reaching 95% of the population for 2015[1]. However, fragmentation and segmentation of the system accentuated some problems of financing, inequities and access to services, causing effects on the public health plan[2]. The separation and specialization of the management, financing and service provision functions, with the inclusion of different public and private agents, caused a disjointed attention between individual and collective actions, generating the accumulation of health risks[1,2]. Added to this is the late recognition of primary health care (PHC) as a care strategy within the GSSSH when considering "promotion and prevention" in 2001 and being conceptualized ten years later as "an intersectoral coordination strategy that allows comprehensive and integrated care from public health, health promotion, disease prevention, diagnosis, treatment, patient rehabilitation at all levels of complexity"[3].

CHCM emerges as a proposal by the Ministry of Health and Social Protection (MHSP), to resolve these demands and guarantee the Colombian population's right to health. The model advocates centrality in the person, a change in the biomedical paradigm, shifting the focus to care and comprehensive risk management, as well as strengthening PHC with a focus on family and community health as a central strategy. In addition, it suggests guidelines for differentiated care according to the particularities of three types of territories: those with an urban population, characterized by better conditions of access to health services given its centrality; territories with rural population, which offer restricted to low complexity care levels; and those with a dispersed population, with limited accessibility due to the lack of access routes and geographical barriers.

The state of Guainía was the first to start implementing the CHCM, being chosen by the MHSP as a model for territories with a dispersed population in the country[4]. In addition to the high rates of dispersion (0.5 inhabitants per Km²), Guainía is characterized by being the second state with the largest indigenous population in the Colombian Amazon (85% of the population), adding challenges to the differential approach brought by the model. Thus, health care in the region must respond both to geographical and epidemiological particularities, and to meet the own demands of ethnic and cultural diversity.

Thus, the CHCM for Guainía presents itself with the purpose of being a model "based on the principle of ethnic, cultural and territorial diversity, based on the PHC strategy"[5], which implies the implementation of a PHC with the family and the community and focused on an intercultural approach.

Authors such as Giovanella et al.[6] and Langdon and Garnelo[7] claim that the intercultural approach to health services and the articulation of traditional medicine among indigenous peoples have increasingly been part of the sanitary policies of most countries in Latin America. In the case of Colombia, years after recognizing the pluri-ethnic and pluricultural nature of the State, the Political Constitution of 1991, Law 691 of 2001 and subsequently the 326 Agreement of 2005 determined the adequacy of the health system for indigenous peoples within the framework of intercultural health care models, specifically for the subsidized health regime[8,9]. In addition, interculturality was considered one of the principles of PHC including, among other elements, "traditional, alternative and complementary practices for health care"[3] and seen as part of the essential components to guarantee the right to health and protection of indigenous peoples[10].

However, despite these considerations in the scope of legalization, advances regarding the articulation of indigenous health systems in PHC have been limited in terms of execution. These articulations have been reduced to specific cases, as products of autonomous initiatives by some indigenous communities or to specific projects developed by the political will of territorial entities. Thus, the CHCM for Guainía constitutes the first initiative from the Colombian State, within the scope of the GSSSH, which proposes a direct approach between Western health services and traditional indigenous medicine, through articulated work with traditional healers (traditional medical agents and midwives) and linking community managers as mediators between biomedical and traditional knowledge.

In this context, the social actors involved in the provision of PHC services in Guainía, who have experienced the implementation of the new guidelines incorporated by the care model, become essential and strategic.

Ciência & Saúde Coletiva, 26(Supl. 2):3683-3692, 2021

This article originates from a doctoral thesis that aimed to understand the process of daily construction of PHC from the perspective of indigenous and health professionals, in Guainía, Colombia. The results related to the issue of interculturality are presented as a key component of the daily dynamics of PHC in the region.

Methodological journey

It is a case study with a qualitative approach, under the theoretical perspective of Comprehensive Sociology of Everyday Life. The choice of the qualitative approach is guided by the nature of the object of study, which implied a comprehensive approach to a phenomenon of everyday experience to capture its subjective character. For Maffesoli[11], understanding requires an approach to the world as it is, without explanatory intentions, "describing what has been lived in what it is, content, therefore, in discerning the views of the different actors involved". In this way, the case study allowed to retain the holistic and significant characteristics of the daily structure of PHC and, according to Yin[12], "the preferred method when the focus is on a contemporary phenomenon in the context of real life". The choice of a single case corresponds to the particularity of the object to be studied and the context in which it takes place.

The research was carried out in the state of Guainía, located in the extreme central east of Colombia, in the northeast of the Colombian Amazon. The estimated population is 41,482 inhabitants, 85% of whom are indigenous, belonging to eight predominant peoples: Curripaco, Puinave, Piapoco, Sikuani, Tukano, Desano, Yeral and Cubeo. Health units, health centers and the hospital belonging to the public health care network were chosen as study scenarios.

Twenty-two indigenous users and 26 health professionals (9 indigenous and 17 non-indigenous) participated in this study, intentionally selected and whose participation was voluntary. The inclusion criteria for indigenous users were: being users of PHC services under the subsidized regime, over 18 years old; and health professionals: any member of the PHC team (doctor, nurse, dentist, bacteriologist, nursing assistant/technician, community manager or microscope specialist), with a minimum performance of six months in office. In addition, three key participants (a shaman, an administrative employee and an indigenous leader) were included who provided relevant information about the object of study.

The field research was carried out between February and June 2018. Data were collected through direct observation and individual interviews. Observation was carried out in the participants' environment (health unit, home, community) with their prior consent and focused on the unit of analysis. The record, identified as observation notes (OB), was made in a field diary, after the completion of each observation. The interviews were conducted using a semi-structured script and held in a predefined location with the participants. Whenever allowed, the responses were recorded in audio and later transcribed in full.

Data analysis used the thematic content analysis technique, following three chronological poles according to Bardin[13]: 1) pre-analysis; 2) exploration of the material; and 3) treatment of the results obtained and interpretation.

The research followed the ethical criteria for health research in Colombia established by Resolution 8,430 of 1993[14]. For access to the field, authorization was obtained from the Hospital Departmental, the Departmental Health Department and the *Asociación del Consejo Regional Indígena del Guainía* (ASOCRIGUA) as the highest authority representing the indigenous communities in the region. All participants signed the Free and Informed Consent Form and their anonymity was guaranteed, being identified by the initials: doctor - MED, nurse - N, nursing assistant - NA, community manager - CM, microscope specialist - MIC, bacteriologist - BAC, dentist - DEN and users - U, followed by a number related to the sequence of inclusion in the study.

Results and discussion

Understanding interculturality: the view of health professionals

For health professionals, interculturality is referred to as an element that converges a *variety*, whether of differentiated knowledge, practices or cultures. It is the point where diversity meets, coexists and relates in the same space. This coexistence perceived by them in a harmonious way is particular, with a two-way exchange on equal terms, which, taken in the field of health, focuses on the exchange that occurred between the indigenous and Western notions of care:

Interculturality is an exchange of knowledge, it means understanding how cosmology is, indige-

nous in this case, and understanding that in reality we are strangers and that we must adapt a lot to their culture, yes? and also to make this exchange that they understand, our customs and what we need (MED1).

It is expected that, as a product of coexistence between cultures, a comprehensive relationship will be established, in which the exchange of beliefs, customs and knowledge is possible without the presence of conflicts. This finding refers to one of the contemporary and conjunctural uses of the associated interculturality, according to Walsh[15], to the relational perspective referring to "contact and interchange between cultures, that is, between people, practices, knowledge, values and different cultural traditions, which could occur under conditions of equality or inequality".

In this sense, interculturality implies, for health professionals, the integration between two knowledge systems: the Western one brought by them and the traditional one of the users they serve. Thus, an "ideal" conjunction between these two types of knowledge is expected, an "amalgam of knowledge" as described by this participant:

It's like the integration and this conjunction between what we see in life and what they [indigenous people] see, I don't know, it's like that, how to do it as an amalgamation between knowledge, between ways of seeing between them and us (DEN3).

However, this approach presupposes an apparent "equity" in the way of valuing both types of knowledge, in addition to erasing existing asymmetries and inequalities. According to Walsh[15], interculturality understood from the relational level is problematic, as it carries with it the concealment or minimization of conflict and the contexts of power, domination and coloniality where such a relationship has been carried out.

In this way, the understanding of interculturality for professionals refers to the effort to conceptualize the "ideal" perspective, in a scenario of harmonious exchange between knowledge. Although this exchange actually occurs in the relationships established in the daily practice of PHC, through permanent negotiation processes, it is noted the difficulty of professionals in recognizing the power relationships immersed in intercultural processes, in which traditional and Western knowledge systems encounter asymmetrically positioned.

Tensions and convergences in (un)encounters with ***difference***

Most of the health professionals responsible for carrying out PHC actions in Guainía come from other parts of the country. Upon their arrival, the professionals carry with them questions that influence the initial encounters with the indigenous population, being, in part, convictions or principles brought from their own culture[16] or preconceived ideas about the region and the indigenous peoples:

We come with a lot... a lot of fear, a lot of prejudice about the indigenous population and when we give ourselves the opportunity to get to know them, we find a totally different world (N3).

The first immersions of health professionals in working with the indigenous population are marked by imaginary that are confronted with reality[16]. The idealized and homogenizing image of being indigenous, of their way of life and of their traditional medicine brought by professionals is in contrast with the indigenous that they encounter in reality and their otherness[17]. This, added to the first attempts to do a reading based on their own cultural values, generates a certain estrangement among professionals:

At first it was difficult because we come with another chip, really like the university does not prepare us for things of daily life and we are really shocked because sometimes we have the wrong concept that the indigenous is the one who wears the typical indigenous dress, and because the cultural part really wakes us up (N4).

However, the first experiences of contact, besides being conflicting and disturbing, can constitute critical moments of confrontation of truths and openness to new knowledge. After a certain rupture experienced in the first meetings with *the difference*, health professionals reflect on prejudices, pre-judgements and become more attentive to the cultural issues of indigenous users. *Cultural awareness* as it is called by Campinha-Bacote[18] allows professionals to build a distinction between indigenous communities and their health practices, while self-questioning their pre-established ideas.

Such process, however, in agreement with Martins' findings[16], is not without tension. Non-indigenous professionals are constantly being challenged by the different therapeutic concepts, health and diseases of indigenous users. Thus, when perceiving the insufficient ethnocentric discourse, they question themselves about their own "truths" and "assumptions":

Ciência & Saúde Coletiva, 26(Supl. 2):3683-3692, 2021

That was a big shock, because at the university they insert the chip that the medicines, that this is the mechanism of action... when they [indigenous people] talk about their plants and their prayers here, we have no way of say how it works in the body, and the fact that we realize that it works, we are like... that is, everything that has been teaching me at the university?... we start to doubt... it is how this shock of saying this is my truth and only my truth, and when we open our eyes and look around there are many ways to see it (N3).

The strangeness appears, in this case, as products of tension when confronting biomedical knowledge with "other" logic and rationalities that start from *difference* and go beyond its borders. However, even though it is a conflictive situation, the cracks produced in this confrontation seem to be spaces of opening for professionals to begin to question themselves about their own knowledge and, therefore, the limits of biomedicine. According to Pereira[19], health professionals who work in indigenous contexts experience unpredictable encounters with radical alterity, complex processes of limitations, mistakes and necessary and incomplete translations that make them question their own knowledge.

This question of limits on knowledge was also raised by indigenous users and professionals, but in a different way. Throughout their testimonies, indigenous participants described the distinction between indigenous and Western diseases. According to the participants, indigenous diseases, called "*postizas*", "*daños*" or "evils", require to be treated with traditional cures, while Western diseases with Western cures:

There are things that are natural that are not for the healer, such as surgery... and experienced personnel are required depending on the disease, because all diseases do not go to botany, nor to the curious [traditional healer], but go to a professional [Western medicine], or surgery (U12).

Although, as Langdon[20] warns, the relationship between cause and treatment is not reduced to etiological notions – since there are several factors that intervene in the choice of therapies – it can be inferred that, in order to understand the distinction between diseases and their treatments, the limits of Western and traditional knowledge are outlined by indigenous users.

In the case of indigenous health professionals, these limits were also considered during their training:

There [at the university] we see diseases as such [Westerners], here there are things that you see that the person is sick, but the diseases are from another environment (N1).

In this way, indigenous professionals experience encounters with otherness differently from non-indigenous health professionals. When they find themselves at the intersection of *differences*, indigenous professionals do not perceive Western and traditional medicine as two opposing, but complementary views.

In this sense, the questions brought up by the indigenous participants suggest that a clear delineation of the limits of self-knowledge and the need to open up to "other" knowledge[20], also looking at its limits, can minimize possible strangeness and, therefore, facilitate the convergences between *differences*.

Looking for a cure: practices and factors that influence the choice of treatments

The way in which indigenous users make choices relatively autonomously about the possible options for prevention, therapy and cure emerges as a fundamental part of the intercultural processes present in the daily life of PHC. In these deliberations a set of factors converge to be considered, which are presented briefly in Chart 1.

The family was highlighted by the participants as the first instance of decision-making about health care, being an important space in the daily practice of traditional medicine. In particular, many of the knowledge and practices employed in the family sphere – in addition to including the use of rituals and the preparation of remedies from the knowledge inherited by older members – mix resources from traditional knowledge (mainly herbal remedies) with resources from Western medicine (including medications self-formulated or formulated by Western doctors):

Yes, we do, that is, we even prepare the medicine... for diabetes, sometimes for tension, for kidneys, for ulcers... I have the plants around there are sown... tension and onset of diabetes I was told the last time I went to the doctor and they gave me some pills, but I already felt good, cholesterol was also high and already... I made the medicine myself, with the pumpkin leaf and with the pills they gave me (U17).

Thus, resulting from the integration of knowledge from different medical traditions, *home remedies* are one of the main resources with which the families of indigenous users solve the health or malaise of their members. Studies in the field of health anthropology confirm this finding[7], highlighting these elements of different forms of care available in the territory, adopted

Chart 1. Factors that influence the choice of treatments.

Family	-First instance of making decisions about health care. It helps to determine the severity of the disease and define the instance in the search for therapy (traditional healers and/or Western health services, hospital, health center, among others). - Provides traditional knowledge and practices for health care, inherited by older members. - Boosts *self-care* practices: integration of knowledge from different medical traditions (traditional/indigenous and biomedical) through home remedies.
Distinction between own and Western diseases and cures	- If the disease is identified as Western, it preferably requires Western treatment and, conversely, if it is own the disease itself requires traditional treatment.
Practicality and effectiveness of treatments	- Occasionally Western medicine resources are preferred because they are considered more practical when compared to traditional therapies. - Recognition of the value of Western medicine diagnostic tests and medicines. Claiming the right to access it.
Access to Western or traditional health services	- The ease in terms of availability, transport, and price influence the choice of the instance in seeking therapy. - Western services are limited in some remote indigenous villages. - Traditional medicine, through traditional healers, is limited in indigenous villages that do not have traditional healers.
Religious beliefs	- Indigenous communities with evangelical religious beliefs avoid attention through *shamans*.
The loss/transformation of traditional knowledge	- There is consensus on the compromise in the ways of transmitting traditional knowledge in health, which have affected the preservation of traditional medicine.

Source: Result of the analysis of research data. Elaborated by the authors, 2019.

and used by families according to their needs and priorities, as *self-care practices*, understood according to Menéndez[21] as "the representations and practices that population uses both individually and socially to diagnose, explain, attend, control, alleviate, support, cure, solve or prevent the processes that affect their health in real or imaginary terms, without the central, direct and intentional intervention of professional healers".

Likewise, the family plays an important role in determining the severity of the disease and in defining the instance in the search for therapy, being able to choose traditional healers and/or Western health services:

With the child too, my mother gives the child [medicine]... traditional doctor that we have here? No, this is no longer the same as that of the daddies of the people or the grandparents, of what they transmit to them, of the knowledge, they are the ones who give us the medicines, but then like this when we go [to the traditional healer], it is already when the disease is already very advanced or things like that, we need someone who knows (U20).

In this sense, it is evident how the users' families exercise their autonomy as to what to do, where and when to consult during the illness process, seeking therapy and prevention, regardless of what is prescribed by the system or by health professionals, which is also an issue stated by other authors[7,21].

Furthermore, decision-making related to the cure or prevention of diseases, in addition to being influenced by the distinction between diseases and their causes, is limited by other factors specific to indigenous groups or external to them, including: the practicality and effectiveness of treatments, access to health services (Western or traditional), religious beliefs and the loss/transformation of knowledge. Regarding Western treatments, participants report:

Western medicine for us is a medicine that acts fast, whereas traditional medicine is medicine that is slow, slower... that is, it will not react now, it will go slowly... when Western medicine is faster, that is, reactions are faster (U12).

Even though users recognize the existence of traditional treatments for certain events, some prefer to decide for biomedical resources, as they are considered more practical at a given time. Accordingly, Garnelo and Wright[22] observed that among the Baníwa in Brazil, the use of Western treatments represents a convenience when com-

Ciência & Saúde Coletiva, 26(Supl. 2):3683-3692, 2021

pared to traditional therapies, as it facilitates the resolution of diseases without making the restrictions inherent to traditional prescriptions.

However, access to Western services is sometimes limited in some indigenous villages due to the lack of nearby health facilities or the shortage of medicines, restricting the range of possibilities for choosing treatments:

In the case that we have no medicine at the health unit, or we cannot go to the hospital, as we must perhaps seek the shaman to get the medicine for us (U11).

In this case, users find themselves in the "need" to use traditional medicine resources, however, sometimes they are also scarce, since not all communities have traditional curators or those who have been appointed with CHCM are not recognized by all community members:

The traditional doctor? I don't know where he is, because I haven't heard anything, they named him, but he has never given us medicine (U17).

On the other hand, religion has emerged as another guiding factor in the choice of therapeutic alternatives. Users belonging to evangelical churches prefer to choose for Western health services, especially in specific cases where they require the attention of professional healers:

I'm an evangelical, I almost don't like it [shaman], I don't go there, yes, it's better here [health unit], it is to say what God has done for everyone (U3).

Apparently, when associating the figure of the shaman with the performance of rituals that include prayers, witchcraft or invocation of spirits, *the believer* users avoid resorting to these specialists (OB1). It is inferred, however, that this denial does not interfere with the realization of *home remedies* or the search for other types of healers (midwives or herbalists). As verified by Ghiggi Jr.[23] in his research with the Kaingang people, persons who attend evangelical churches continue to value herbal remedies as an important part of their traditional knowledge, regardless of religious creed.

Finally, some users revealed that they did not consider the knowledge about some traditional therapies, choosing for the use of biomedical resources:

Some indigenous people no longer know our [traditional] medicine, that's why I like to come to white people's medicine so much, so when I'm sick, I always run to the hospital, like that... others do know about indigenous medicine, but we do not (U2).

Concern about the "loss" and rescue of traditional medicine has often appeared in informal conversations. Most of the indigenous participants related this phenomenon to the arrival of religious missions or to the strong influence of contact with *whites* and their Western medicine (OB2), making evident the existence of a consensus on the compromise of the ways of transmission of traditional knowledge in health.

Thinking-knowledge strategies: the prescribed, the real and the expected

The data revealed several strategies for *thinking-knowledge* within PHC in Guainía, which, on the one hand, are proposed by the CHCM health model and, on the other hand, are the result of structures developed spontaneously by indigenous people and health professionals in the daily provision of services. These strategies will be approached from three perspectives: *the prescribed, the real* and *the expected.*

Regarding what was *prescribed*, the participants highlighted, in the first instance, the incorporation of traditional healers in primary care services. While non-indigenous health professionals highlighted positive aspects that this connection, in theory, could bring to the benefit of serving indigenous users, indigenous professionals indicated some difficulties:

This is stipulated in the project, of putting the shaman, that's why the new model was achieved here, but it is not working at the moment (CM1).

Although some traditional healers were appointed with the implementation of CHCM, many of them were still not providing their services in the indigenous villages or in health units or centers (OB3). An issue frequently associated with the cause of this phenomenon is the administrative difficulty in formalizing the payment of these specialists who are hired:

They [shamans and midwives], with this new health model, they want to work, but they also want an incentive, that is what they lack, there is no way to pay them, to compensate (NA6).

According to Ferreira[24], the remunerated employment of traditional healers is part of the struggle of these peoples for the recognition of traditional medicine before the State, but it is conditioned to the regulation of their trades, which would imply undertaking their professionalization to integrate them with health services.

The implementation of the figure of the community manager was another strategy mentioned by the participants:

Then they put the manager in the model, the community manager called him, but it was thought that it was for this, to mediate between the Western

and the traditional, to guide, but now he is collecting data, collecting things, only statistics (BAC1).

It highlights the difficulty that this professional must exercise his function of "knowledge articulator" as prescribed by the model, limiting himself to performing exclusively administrative actions. This question could be compared with the situation experienced by the Indigenous Health Agent in Brazil, whose role as mediator according to Diehl et al.[25] is marked by conflicts and ambiguities.

The *meeting of shamans and midwives*, an event that has been implemented for years by the government of the State of Guainía, with the aim of promoting the exchange of knowledge and strategies for community surveillance in health and interculturality, was also highlighted by the participants as an important part of projects that were strengthened with the implementation of the new care model.

In addition to these proposals established by official speeches, it was possible to identify other strategies operating spontaneously in the daily provision of services, this being the look of the *real*. Non-indigenous health professionals, on the other hand, articulate knowledge through negotiating responsibilities or establishing "concessions" for the use of certain traditional medicine practices:

In the hospital they [traditional healers] can also enter, because they come in to pray, say prayers and we allow them, what we cannot allow is that when the doctor says: 'nothing by mouth', it is nothing by mouth, because that would compromise us all (NA9).

However, many of these strategies start from the establishment of limits under biomedical parameters. Traditional practices considered harmful to the user's health – generally those that include drinking beverages – or that can alter the normal course of work activities, are not allowed by professionals. This attitude can be understood, according to Silva[26], not only based on imposing or restrictive reactions, but also by a historical situation that presupposes an analysis of power relations in this context.

It should be noted, however, the efforts made by some professionals to propose negotiation processes in terms of respect and "equality", despite the interlocution being subject to hierarchies and the exercise of powers.

In addition, it was possible to identify other strategies carried out by indigenous health professionals in their daily practice:

As my companion does, they always come [patients] when there is a disease among us indigenous people, so he immediately starts working on his traditional medicine, he knows massages and all that, he even knows some prayers, that is, when it does not end [the disease] we do anything, right there at the unit [health unit] (NA6).

Thus, in addition to indigenous health professionals performing the functions competent to their biomedical training, they try to respond to other demands from users, whether exercising traditional medicine practices, acting as intermediaries with other health professionals (usually doctors) or transgressing the imposed limits.

Finally, the data revealed that both users and indigenous and non-indigenous professionals have expectations about the *thinking-knowledge*, suggesting possible ways to make it work in practice. Some proposals regarding the approval of traditional healers by the community or about how to guide the user on the use of indigenous and biomedical resources were put forward by indigenous health professionals:

For me, the way would be through an intermediary, someone here [in the middle point] who evaluates both things and therefore must have both knowledge [indigenous and biomedical] (BAC1).

Therefore, they hope that it will be possible to implement a type of standardized "routes" to guide the user's conduct, either through the community manager in his/her role of mediator or determining Western medical services as the beginning of the consultation point.

Non-indigenous health professionals also expressed expectations about possible ways to implement the articulation of knowledge in the provision of PHC services:

It seems interesting to me that if it could be articulated with traditional medicine, that is, it is a work that I think is long, it is hard... it must have scientific support, so it is looking for this, that we do a joint research (DEN4).

Thus, for these professionals, the *thinking-knowledge* implies the scientific validation of traditional medicine practices, through research aimed at proving its effectiveness, safety and quality. In this perspective, science – as the only legitimate source – has the role of identifying the effectiveness of traditional therapies to be incorporated into health services. However, as Ferreira[24] points out, this process implies the purification of cultural aspects, beliefs and values that permeate these medicines.

Ciência & Saúde Coletiva, 26(Supl. 2):3683-3692, 2021

Final considerations

The issues addressed here contribute to the understanding of dynamics immersed in health care in interethnic contexts, which should be considered when driving intercultural objectives in health care models with a differential focus.

The look at the experience of the subjects involved in the provision of PHC services in Guainía, allowed us to reflect on the way in which interculturality is conceived and operates in daily life, in addition to the formulations prescribed in government policy. It is through constant articulations and negotiations in the sociality of indigenous and health professionals, that intercultural processes are constructed and materialized, without being devoid of conflicts, ambiguities and contradictions.

An evident issue in the results of this research was the difference in the way in which interculturality is conceptualized and how it develops in praxis. For health professionals, the understanding of interculturality comprises an effort to reach the "ideal" perspective in a harmonious scenario of will, reciprocity and horizontality, the issues arising from the encounter with *difference*, however, highlight the dynamics established by the hegemonic structure and the asymmetries present in the relationships.

The constant tension experienced by non-indigenous professionals in the interaction with the knowledge and health practices of indigenous users reflects the impotence and discomfort when perceiving biomedical knowledge, situated in a hegemonic position, as insufficient. However, this situation allows us to consider the role of "other" knowledge to challenge and question the established limits, in a counter-hegemonic way.

An example of this is the way in which indigenous participants define the limits and scope of treatments and make different transactions with the therapeutic resources available to treat their ailments. In this process, heterogeneous ways of thinking-knowing are negotiated and articulated to create new interpretations and reinventions of knowledge[15], manifesting the ways in which interculturality materializes in the care trajectory of indigenous users and in local practices.

Likewise, the realization of interculturality, in addition to the prescribed, is manifested in the daily provision of PHC services in the different strategies for *thinking-knowledge* that both users and health professionals develop within the scope of the care units. Many of these strategies are creative constructions that start from empirical knowledge, from *common sense* placed in the *underground centrality*[11] of everyday life that goes beyond rationalizing logics.

It is considered relevant, therefore, to pay attention to these issues in order to consolidate the intercultural approach in PHC proposed by the new model of care in Guainía, starting from the constructions emerging from the daily lives of users and health professionals, which allow for a real dialogue of knowledge[7] within the scope of attention.

Collaborations

SE Arias-Murcia worked on research, analysis, data interpretation and final writing. CMM Penna participated in the critical review and approval of the version for submission for publication.

References

1. Colombia. Ministerio de Salud y Protección social (MSPS). *Política de Atención Integral en Salud.* Bogotá: MSPS; 2016.
2. Vega R, Acosta N. *Mapeo y análisis de los modelos de atención primaria en salud en los países de América del Sur: Mapeo de la APS en Colombia*. Rio de Janeiro: Instituto Sul-Americano de Governo em Saúde; 2014.
3. Colombia. Congreso de la República. *Ley 1438 de 2011, por medio de la cual se reforma el Sistema General de Seguridad Social en Salud y se dictan otras disposiciones.* Bogotá: Congreso de la República; 2011.
4. Colombia. Ministerio de Salud y Protección social (MSPS). *Modelo Integral de Atención en Salud (MIAS). Piloto de implementación en los departamentos con poblaciones dispersas.* Departamento de Guainía: MSPS; 2015.
5. Colombia. Ministerio de Salud y Protección social (MSPS). *Decreto No. 2561, por el cual se definen los mecanismos que permitan mejorar el acceso a los servicios de salud a la población afiliada al Sistema General de Seguridad Social en Salud -SGSSS y fortalecer el aseguramiento*. Bogotá: MSPS; 2014.
6. Giovanella L, Almeida PF, Oliveira S, Silva T. Panorama de la Atención Primaria de Salud en Suramérica: concepciones, componentes y desafíos. *Saude Debate* 2015; 39(105):300-322.
7. Langdon EJ, Garnelo L. Articulación entre servicios de salud y "medicina indígena": reflexiones antropológicas sobre política y realidad en Brasil. *Salud Colect* 2017; 13(3):457-470.
8. Colombia. Congreso de la República. *Ley 691 de 2001, mediante la cual se reglamenta la participación de los Grupos Étnicos en el Sistema General de Seguridad Social en Colombia.* Bogotá: Congreso de la República; 2001.
9. Colombia. Consejo Nacional de Seguridad Social en salud (CNSSS). *Acuerdo 326 de 2005. Por medio del cual se adoptan algunos lineamientos para la organización y funcionamiento del Régimen Subsidiado de los pueblos indígenas*. Bogotá: CNSSS; 2005.
10. Colombia. Congreso de la República. *Ley Estatutaria No. 1751, por medio de la cual se regula el derecho fundamental a la salud y se dictan otras disposiciones.* Bogotá: Congreso de la República; 2015.
11. Maffesoli M. *O conhecimento comum: Introdução a la sociologia compreensiva*. Porto Alegre: Sulina; 2010.
12. Yin RK. *Estudo de caso: planejamento e métodos*. 5ª ed. Porto Alegre: Bookman; 2015.
13. Bardin L. *Análise de conteúdo*. São Paulo: Edições 70; 2011.
14. Colombia. Ministerio de Salud y Protección Social (MSPS). *Resolución 008430. Por la cual se establecen las normas científicas, técnicas y administrativas para la investigación en salud*. Bogotá: MSPS; 1993.
15. Walsh C. *Interculturalidad crítica y (de)colonialidad: Ensayos desde Abya Yala*. Quito: Ediciones Abya-Yala; 2012.
16. Martins J. *O trabalho do enfermeiro na Saúde Indígena: desenvolvendo competências para a atuação no contexto intercultural* [dissertação]. São Paulo: Universidade de São Paulo; 2017.
17. Dias-Scopel R. *A cosmopolítica da gestação, parto e pós-parto: práticas de autoatenção e processo de medicalização entre os índios Munduruku* [tese]. Florianópolis: Universidade de Federal de Santa Catarina; 2014.
18. Campinha-Bacote J. The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care. *J Transcult Nurs* 2002; 13(3):181-184.
19. Pereira P. Limites, traduções e afetos: profissionais de saúde em contextos indígenas. *Mana* 2012; 18(3):511-538.
20. Langdon EJ. Os diálogos da antropologia com a saúde: contribuições para as políticas públicas. *Cien Saude Colet* 2014; 19(4):1019-1030.
21. Menéndez EL. Autoatención de los padecimientos y algunos imaginarios antropológicos. *Desacatos* 2018; 58:104-113.
22. Garnelo L, Wright R. Doença, cura e serviços de saúde. Representações, práticas e demandas Baníwa. *Cad Saude Publica* 2001; 17(2):273-284.
23. Ghiggi Jr A. *Uma Abordagem Relacional da Atenção à Saúde a partir da Terra Indígena Xapecó* [tese]. Florianópolis: Universidade de Federal de Santa Catarina; 2015.
24. Ferreira LO. *Medicinas indígenas e as políticas da tradição: entre discursos oficiais e vozes indígenas*. Rio de Janeiro: Editora Fiocruz; 2013. [Saúde dos povos Indígenas collection].
25. Diehl E, Langdon EJ, Dias-Scopel RP. Contribuição dos agentes indígenas de saúde na atenção diferenciada à saúde dos povos indígenas brasileiros. *Cad Saude Publica* 2012; 28(5):819-831.
26. Silva CD. *Cotidiano, saúde e política. Uma etnografia dos profissionais da saúde indígena* [tese]. Brasília: Universidade de Brasilia; 2010.

Article submitted 31/07/2019
Approved 07/02/2020
Final version submitted 09/02/2020

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva

This is an Open Access article distributed under the terms of the Creative Commons Attribution License