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The meanings of differential health care given by health professionals of the Alto Rio Negro DSEI-AM, Brazil

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Abstract *This article discusses the meanings of differentiated health care guideline given by health professionals from the Indigenous Health Multidisciplinary Team (EMSI) who work at the Alto Rio Negro Special Indigenous Health District (DSEI-ARN). This exploratory, descriptive, analytical, and qualitative study conducted 15 semi-structured interviews with professionals from the Indigenous Health Multidisciplinary Teams of the DSEI-ARN, which were submitted to content analysis. The four meaning cores identified from the analyses were: Differentiated care as a way of providing primary care in the territory; Actions conducted under the population's cultural differences; Self-care, traditional medicine, and the construction of therapeutic itineraries; and Professionals' challenges and difficulties in addressing traditional indigenous health care. In the professionals' perspective, differentiated health care is linked to the conditions for working in this primary care type. For their performance, they refer to the need to respect the cultural differences of the Indigenous population. Professionals recognize the use and effectiveness of Indigenous practices, knowledge, and regional specificities.*

Key words *Indigenous health service, Health of Indigenous populations, Amazonian ecosystem, Health personnel, Qualitative research*

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Introduction

The Indigenous Health policy results from an achievement that started in the 1980s to guarantee Indigenous peoples comprehensive and differentiated health care based on the constitutional recognition of their territorial and sociocultural rights[1]. The National Healthcare Policy for Indigenous People (PNASPI), established by Ordinance No. 254 of January 31, 2002, determines the implementation of a model of "differentiated and complementary health care in the organization of services for the protection, promotion, and recovery of health, ensuring Indigenous peoples' exercise of their citizenship"[2] (p.6). This policy also guarantees access to comprehensive care, aligned with SUS principles and guidelines, considering social, cultural, geographic, historical, and political diversity, always favoring overcoming factors that make this population more vulnerable to health problems[3]. Thus, access to the Unified Health System (SUS) services was recommended to occur articulated with Indigenous health systems, adopting a complementary and differentiated model of organization of services targeting the protection, promotion, and recovery of health[2].

This health care organization model is implemented through 34 Special Indigenous Health Districts (DSEI) that underpin the Indigenous Health Care Subsystem (SASI). Each DSEI should have a service focused on "a dynamic ethnocultural space"[4] (p.30), seeking "efficiency and speed per each people's specificity"[4] (p.30) toward differentiated health care. Districts should guarantee PHC actions based on the differentiated care guideline through the work of Multidisciplinary Indigenous Health Teams (EMSI) composed of Indigenous Community Health Workers, Indigenous Health Sanitation Workers, nursing technicians, nurses, doctors, dentists, and oral health technicians.

However, Pontes *et al.*[5] observed that differentiated health care still has several limitations. Indigenous knowledge and practices are denied or disregarded by the hegemonic biomedical model, which is strengthened by the bureaucratic procedures of the Special Indigenous Health District (DSEI). Thus, the devaluation of other care that the Indigenous population provides is frequently observed.

São Gabriel da Cachoeira, in the state of Amazonas, has several ecosystems and geographic settings in which 23 Indigenous peoples coexist; that is, it has enormous sociocultural and linguistic diversity. The Indigenous territory of this municipality is part of the Alto Rio Negro Special Indigenous Health District (DSEI-ARN), and is a fascinating place to develop research to understand and implement public policies in the Indigenous context[6].

Besides aspects related to the sociodiversity of this Brazilian region, we observed several challenges for the implementation of health actions, such as the inequalities in the health conditions of the Indigenous population that lives in remote places, the logistical difficulties due to the territory's vast extension and its geographic characteristics and seasonality, the lack of adequate structures, and the unfavorable health indicators. In this context, this article aimed to discuss the meanings given to the guideline of differentiated health care by health professionals from the Indigenous Health Multidisciplinary Team (EMSI) who work at DSEI-ARN and address these diversities in their daily work. The lack of a concept of differentiated health care in the Indigenous Health policy documents hinders professionals from providing guidance and work in SASI[5]. Therefore, we should understand the meanings attributed by health professionals to this guideline.

Methods

This is an excerpt from the results of the Master's dissertation entitled "The Experiences of Health Professionals in Intercultural Contexts: Reflections from the Special Indigenous Health District of Alto Rio Negro/Amazonas", presented in the Postgraduate Program in Living Conditions and Health Situations in the Amazon (PPGVIDA).

A qualitative study was conducted based on the perspective of hermeneutics-dialectics to deepen the meanings attributed by the subjects in their relationship with the social environment and their interpretations of their experienced reality[7]. This study was held at the headquarters of the Alto Rio Negro Special Indigenous Health District (DSEI-ARN), which is located in São Gabriel da Cachoeira, in the state of Amazonas. Some 852 km from Manaus, the capital of the state of Amazonas, it is located on the banks of the Rio Negro basin, in the extreme northwest of the state of Amazonas, bordering Venezuela and Colombia[6].

Its coverage area is comprised of three municipalities: São Gabriel da Cachoeira, Santa Isabel do Rio Negro, and Barcelos. Although the

DSEI-ARN encompasses three municipalities, this study was limited to the territory of São Gabriel da Cachoeira since this is where the District headquarters are located and where most EMSI professionals live. We also considered that this municipality is highly ethnically diverse, with 19 of the district's 25 bases located and distributed along the riverbeds.

Data were collected through semi-structured interviews[7] administered individually and recorded by the researcher. The "Interview Guide" was structured into three thematic blocks: a) respondent profile; b) training experiences to work in the intercultural context; and c) differentiated health care guideline meanings. The semi-structured interviews adopted open-ended questions that allowed respondents to comment freely on the topic. In this article, we focused on the results regarding respondents' differentiated care guideline meanings based on their life and work experiences at DSEI-ARN.

Fifteen professionals working at the EMSI of the DSEI-ARN were interviewed, with the following profile: six nursing technicians, five nurses, two doctors and two dentists, who agreed to participate voluntarily and with consent after the disclosure. In the statements presented in the results, we identified the professional category (without gender attribution) and whether or not they were Indigenous.

The decision to interview more nursing professionals is justified because they are the largest professional category, with the longest staffing seniority and accumulating the most significant responsibilities for implementing the EMSI work. We aimed to reach saturation in the response levels without intending to include the entire universe of DSEI-ARN workers. This research was submitted for analysis and approved by the Research Ethics Committee (CAAE 26483319.4.000.5240). It was presented and approved by the president of the Alto Rio Negro District Council for Indigenous Health (CONDISI).

The interviews were conducted with the respondents at a time previously scheduled, in a location of their convenience, and with privacy guaranteed. The researcher then transcribed the interviews, and their contents were categorized based on the dimensions that emerged from the subjects' responses[8,9]. Only the researcher and her advisor had access to the audio recordings and transcripts.

The content analysis method was used from the perspective of hermeneutics-dialectics to analyze the interviews, searching for meanings the social stakeholders gave in their actions[7-9]. The readings of the transcripts aimed to identify at a deeper level the main sets of meanings attributed to the topic by the professionals. The material was organized in an Excel spreadsheet and then articulated with the concepts for the analysis. This article focused on the results of the core meanings attributed to the differentiated health care guideline.

Results and discussion

We highlight some characteristics of the health professionals interviewed who work at DSEI-ARN. Most were Indigenous, with six participants belonging to the Baré people, three to the Tukano people, and one each to the Piratapuia and Tariano peoples. Four of the fifteen respondents were non-Indigenous.

We identified four core meanings for the differentiated care guideline by analyzing the data, as follows: a) Differentiated health care as a way of providing primary care in the territory; b) Actions conducted under the population's cultural differences; c) Self-care, traditional medicine, and the construction of therapeutic itineraries; and d) Professionals' challenges and difficulties in addressing traditional health care.

Differentiated care as a way of providing primary care in the territory

The first meaning given by professionals for differentiated health care was regarding the characteristics of the work process that involves the deployment of teams to the communities and the service provided by active search in the territory, and not only by the spontaneous demand.

In my understanding, differentiated health care is when we take care of people in their homes (Yáwi Indigenous nursing technician).

Differentiated health care is when you are close to them, in their homes, providing care and attention to them in their territory in the communities, not in a hospital setting (Non-Indigenous Mawarí nurse).

Differentiated health care is what I said: here in the city, it is the population that seeks care; in Indigenous health, the team seeks out the patients (Kuphe Indigenous nurse).

This meaning relates to structuring health care based on the territory and programmed actions with active search and the frameworks of primary health care (PHC)[10]. PHC is the basis for

structuring Special Indigenous Health Districts, breaking with previous strategies of focusing on the walk-in spontaneous demand of users seeking the service[11]. However, we believe that there is a lack of in-depth understanding among professionals about PHC.

In other reports, professionals point out that differentiated care is linked to the conditions under which work is performed in this primary care modality, as it occurs in collective spaces.

Because the care provided at the health center in the city is different from that provided in the Indigenous area. There, health care is provided collectively. At the health center, it's not the same; the care is provided individually in a specific room (Icída Indigenous nurse).

The visits are different; we have to provide health care at the community center, where everyone can see us. We have to go after them (Icída Indigenous nurse).

In the statements above, we point out that the professionals highlight the differences in the workspaces since care is provided in the communities and is more precarious per the reports. Professionals have to adapt to their operating context. Thus, the respondents compare the work in the Indigenous territory with the urban context; in this process, according to the statements above, the professionals highlighted the dimensions of organization and service flows, but they emphasized the precariousness and the need for improvisation in the municipality's rural areas.

Another characteristic of the organization of primary care highlighted as different is the 24-hour service nature, which often involves more complex cases and emergencies:

It's different because it is a walk-in spontaneous demand. We don't have a set time to provide care or a set number of patients to attend to. Although it's primary care, we attend to other situations. So, I see this as a difference. If they come to the city, it's that hardship. There's no care at the health center on weekends. In the communities, we're on a 24/7 call (Pisana Indigenous doctor).

The fact that they have to perform the activities of other professionals was also attributed as a characteristic of differentiated care. This may be related to several issues that we were unable to delve into, such as improvisation, precariousness, team irregularity, turnover, function diversion, or even a more complementary team approach.

It's what I can do beyond what I should do, beyond my competence. When I hear this word, "differentiated health care", I immediately think of Indigenous health, because I, as a doctor, often have to do some nurse's tasks since she is often busy (Pisana Indigenous doctor).

Everything is different. Sometimes, we have to play the doctor's role because there is no doctor, so the need leads us to act as doctors. This is different from what happens in the municipality (Icída Indigenous nurse).

In this differentiated health care meaning core, we include work's organizational characteristics, precarious conditions, and other aspects of PHC. We also observe the need for professionals to perform different functions to meet the assisted population's demands.

Actions conducted under the population's cultural differences

The second differentiated health care meaning core refers to professionals recognizing the sociocultural differences and diversities of the region's 23 Indigenous peoples, particularly noticeable for those from other regions. Thus, differentiated health care is related to understanding the sociocultural specificities of the population assisted. Some respondents reported that providing differentiated health care means respecting the cultural differences of the population assisted, and the respondents highlighted the diversities per each riverbed.

The professionals recognize the ethnic differences between Rio Negro's several channels and the need to adapt the service to the ethnic reality. Thus, they indicate that the professional work's dynamics depend on the characteristics of the assisted population.

I've worked in another area; in Rio Negro, Cucuí, most are Baré and have other customs. In the Waupé, it's different. Then, I began to understand the difference between one ethnic group and another (Éinu Indigenous nursing technician).

The cultural issue. All of this, from my viewpoint, means differentiated care. Even among them! Caring for a Hüpda is not the same as caring for a Baré. It's different! I can't expect the same weight from a Hüpda as a Baré. They have different profiles, which counts in the care (Tháro non-Indigenous doctor).

Health professionals mentioned the need to have previous knowledge about the people and communities served to provide differentiated health care that respects cultural differences. Professionals affirm that the information provided about the population, whether by management or professionals who already work with this population, contributes to successful activities developed by health professionals.

I believe that to provide differentiated health care where I work with people, I need to know a little about them so I can know how far I can go (Pisana Indigenous doctor).

At night, I talk to my technicians about how we are going to work, the issues we will address because care in communities varies greatly from place to place; it depends on the served population (Icída Indigenous nurse).

Professionals also recognize that Indigenous peoples' relationships with biomedicine vary between groups and regions depending on each community's history of contact and characteristics. However, conflicts and refusals regarding biomedical care are perceived as "resistance" by health professionals.

There is a big difference in São Joaquim: everyone wants to be treated, even those who are not sick. Not so in Papuri. Only those who need treatment and want to be treated seek treatment. Those without any problems do not go. So, we have to go after them (Kuphe Indigenous nurse).

The different types of care will depend on each culture. The way of approaching a certain subject depends a lot on the ethnic group we are serving. Some ethnic groups are more flexible and accepting; others are more resistant. So, this influences the care provided (Tháro Non-Indigenous doctor).

Also, some aspects of the differences between gender relationships and social roles in care were highlighted in this meaning core. For example, it is pretty standard for Indigenous women not to feel comfortable with care provided by a male professional.

When an Indigenous woman has a health problem, she will not discuss the situation with a male professional, even if he is a family member. She does not talk about everything and feels embarrassed. So, the work is completely interrupted (Yáwi Indigenous nursing technician).

In their reports, health professionals highlight the relevance of knowing the specificities of the health knowledge and practices of each ethnic group in each region, as this contributes to understanding their behaviors and way of thinking about health.

Yes, it influenced me. I started to understand why they seek care from the health team when the disease is already in an advanced stage. In my interactions with them, I observed that their culture first seeks other means of treatment. So, I became more sensitive to that situation and understood that the care differs from that in the city (Tháro non-Indigenous doctor).

Differentiated health care means accepting that they bless the patient – they can do it because it is part of their culture. At first, the doctor did not accept the procedure. Later, I talked to him and said that this is part of their cure, so we must allow it (Phirípoma Kiwarí, non-Indigenous nurse).

Given the relevance of this dimension, we present a meaning core below, deepening this dimension.

Self-care, traditional medicine, and the construction of therapeutic itineraries

"Differentiated health care is best understood not as incorporating traditional practices into PHC services, but as promoting the articulation between these services and the self-care practices in the private community"[13] (p.42). Thus, Esther Jean Langdon[13] articulates the concept of differentiated health care with that of self-care, proposed by Eduardo Menendez[14]. Thus, the health care practiced by the Indigenous population of the Upper Rio Negro can be understood as self-care[14]. This care process involves different behaviors, interactions, negotiations, and conflicts, besides knowledge about the construction of the body, identity, and personality related to the cosmopolitical dimensions that involve the biological and social production of each group[14]. The forms of knowledge about the health of Indigenous peoples are related to cosmologies, coexistence with nature, eating habits, and other reproductive processes of daily routine[13,15].

In this meaning core on differentiated health care, we will seek to understand how health professionals understand the healthcare practiced by DSEI-ARN Indigenous communities.

I think the word 'differentiated' has to do with their customs, how they take care of their health, blessings, and care for their children, who do the whole ritual (Yaka non-Indigenous dentist).

Thus, professionals emphasize the autonomy of Indigenous users in choosing the health resources that will be adopted for each problem and the need to negotiate therapeutic projects.

Sometimes we have to take a step back, because the choice of health care is theirs, especially because they have free will to choose their treatment (Pisana Indigenous doctor).

Therefore, the respondents highlighted that differentiated care is related to constructing the therapeutic itinerary, which involves self-care and articulation with traditional indigenous healing systems. In these itineraries, self-care practices are the first care form to be activated

in the community, with the community elders as the primary references:

In my opinion, I see that they first seek their medicine, their tradition, doing all that ritual. If it doesn't work, then they inform us (Eínu Indigenous nursing technician).

What did he do? He went and took his son to the healer. I had no contact with this healer; I stayed at the center. He took the boy to pray and only then brought him to the center. However, I just stood at the door, giving him directions. The people who provided care were others because of their cultural issues (Tháro non-Indigenous doctor).

In this meaning core, we observed that a central issue for health professionals is the need to reflect on the legitimacy and effectiveness of Indigenous medicines for treating illnesses and protecting the population. Thus, the respondents highlighted experiences with positive results:

I was seeing a patient in Pari Cachoeira, and he said: "Doctor, I'm no longer hypertensive!". I said, "Really?". "Yeah... You can see my blood pressure; it's normal!" Moreover, it was indeed! "What did you take?" He said, "I took the bark of a tree". He got better! I had to remove the patient from the hypertensive registry because medication was being given to him for nothing when it could have been used on another patient (Tháro non-Indigenous doctor).

Sometimes we give our medicine, and we notice it's not working. However, when we call the shaman or healer, it's wonderful because, out of nowhere, that child, that adult patient starts to improve (Kuhéni Indigenous nursing technician).

I gave her dipyrone, and it didn't improve anything. The healer came and said that a snake was holding her. So, he blessed her, and she was better the next day, which is to say, dipyrone didn't solve the problem; the blessing did (Icída Indigenous nurse).

We should underscore that health professionals from the Alto Rio Negro region also highlighted the use of indigenous knowledge for their protection – particularly, precautions related to visits to "sacred places" and to "poison".

So that nothing happens to me when I'm menstruating, I close my body so that I don't fall under the spell because some places are dangerous and enchanted. So, I always use these protections so that nothing happens to me (Mápa Indigenous nursing technician).

So, I also look for healers to protect us so that nothing bad happens during the trip. Every time, before entering the area, I close my body so that nothing happens because they are unknown places (Nêwi Indigenous nurse).

We noticed that the professionals interviewed recognize the importance of Indigenous experts in the communities, especially in the absence of the team, as alluded to in the following responses:

I think that the fact that they are there in the community is crucial because when there is no team, they ensure the health of the population in the community (Kuhení Indigenous nursing technician).

The fact that these caregivers exist is essential in the communities, especially because we only make one or two visits. A month or two months goes by without anyone in the community. So, they are the only ones who remain in the community. These caregivers have the knowledge to work with the community, provide care and medications to this population to improve their health (Kuphe Indigenous nurse).

Some respondents highlighted the role of Indigenous experts in constructing the therapeutic itinerary for families, including referring them to the professionals on the teams. However, there is a gap:

You have to know how to put things together. Otherwise, it ends up hurting us because what the shaman says counts. So, when the shaman prays, and it doesn't work, he says: "See a doctor because now there's no way to do it with prayer. You have to see a doctor!" That's it! He comes already knowing that we'll find a way. Then, yes, they follow the doctor's advice! It depends a lot on what the shaman says! They obey the shaman (Tháro non-Indigenous doctor).

The professionals know that these caregivers exist, but they have never worked together, calling the shaman to work with him (Kuhení Indigenous nursing technician).

We see them providing care in their homes; however, never together with us, providing care at the health center or community center (Nêwi Indigenous nurse).

In general, we observed the complementarity and negotiation between the different care forms in the territory in the respondents' statements. Most Indigenous population uses several medical systems simultaneously, both for different problems and for the same health problem, which Eduardo Menendez calls medical pluralism[14].

We usually gather the two parties: the professional and the traditional experts. One day, I saw the nurse. She was there by our side. This is how we can bring their reality to ours; this way, they feel more at ease, as this treatment has been around for

centuries and passed down from father to son and generations (Kéhuri Indigenous dentist).

A child had fever and diarrhea, and we were taking care of it with our medicines. The shaman blessed him, placing the leaves on the child's body and speaking the languages. We continued giving him medicine, respecting their side (Kuhéni Indigenous nursing technician).

I had the opportunity to work with the shaman from the upper Tiquié, caring for a child who had suffered burns. It is vital to respect their treatment, to work in partnership (Mawarí non-Indigenous nurse).

Because, in my last entry, I saw the doctor asking whether I had already taken him to the healer, because he always works with the white treatment, and along with it is the healer's treatment (Mápa Indigenous nursing technician).

Therefore, we consider it essential that professionals actively participate in initiatives to strengthen Indigenous medical systems among the population in healthcare:

If we start talking, they will remember how they used home remedies; they know but don't practice them anymore. So, we need to encourage them to use them as an alternative, with the lack of medication (Kuhení Indigenous nursing technician).

Whenever I go to work, I listen to what they are saying. Nursing gives great importance to this context; even doctors are working more on this now. They are using medication together – not just one, but both (Yaka non-Indigenous dentist).

Finally, respondents highlighted strategies for discussing traditional care with healthcare professionals in this meaning core.

Because training at DSEI is related to this traditional knowledge, which we have to respect, and we always talk about it (Nêwi Indigenous nurse).

We talk here at DSEI. They hold meetings with us – what we can do, how to work with shamans and midwives (Icída Indigenous nurse).

Our team talks. So much so that we asked them for support in building vegetable gardens so we can plant the plants they use when they are vomiting or have diarrhea in the communities. The management helped us (Kuhení Indigenous nursing technician).

Professionals' challenges and difficulties in addressing traditional care

In the fourth differentiated care meaning core, we will encompass the conflicts and difficulties reported by the respondents when addressing self-care practices and Indigenous experts in Indigenous territories. We can point out that ethnocentrism is present in the vision of some professionals:

However, the negative side of new professionals is that they want to impose their way and knowledge, without respecting the traditional knowledge of those people (Yáwi Indigenous nursing technician).

The shamanic practices, these things, interfere with our treatment. However, we also have to understand that it is part of their culture (Tháro non-Indigenous doctor).

I have heard of traditions that keep sick patients with healers for a certain amount of time before releasing them for medical care using "white people's medicine". So, I see this as a negative point because if the disease becomes lethal, the patients will arrive at the center already in a complicated state (Pisana Indigenous doctor).

Several authors[5,13,15,16] warn that national health systems and biomedicine tend to deny, ignore or marginalize other care forms. The hegemonic biomedical model that overemphasizes the biological dimension of the health-disease process is also expressed in the use of technologies in diagnosing and medicalizing various health and life problems in general. In some circumstances, biomedicine scientifically legitimizes other health systems and incorporates them into its repertoire of health services with acupuncture. However, Menendez[14] emphasizes that, despite recognizing other medical systems, only the biological dimensions involving healing procedures are legitimized. In the interviews, we observed that professionals perceive a process of increasing medicalization in communities:

Not now. I see that the difference is that we have a lot of Western medicines from white people, and our patients have become very comfortable and no longer want to look for medicine in the forest. When their children have a cold, mothers no longer make that tea. They go to the health center for ibuprofen, amoxicillin, and other medication (Eínu Indigenous nursing technician).

They are already very used to medicine, which works faster. They no longer want to go to the forest to get the medicine because it is far away because it takes a long time to get the treatment (Yáwi Indigenous nursing technician).

Some diseases, especially chronic ones, that we must emphasize and tell them they must take our medicine! Can they pray? Yes, they can! However, they also take our medicine. Make them aware, but it is difficult! It is not an easy task, no! (Tháro non-Indigenous doctor).

Two decades after the implementation of SASI, respondents reported a lack of debate on differentiated care. Therefore, we point out that professionals must be qualified to work in an intercultural context at the beginning of their work with Indigenous communities.

Look, with all this experience I have, it's tough. We don't talk about it. It's challenging to bring up this subject. Sometimes very little happens (Kuhéni Indigenous nursing technician).

I've never participated in any team meeting to talk about this, about the care people have (Kúmada Indigenous nursing technician).

When referring to differentiated health care, Langdon[13] suggests that it means producing care articulated with self-care forms. The author emphasizes that the interaction and complementarity between care forms, biomedics, and traditional medicine occur from the users and do not generate contradictions. However, given the tremendous sociocultural diversity of Indigenous users and the lack of preparation of health services, differentiated care is still a challenge for health professionals.

Final considerations

In SASI's more than twenty years, we have made little progress in implementing the differentiated health care guideline as a link between the official system and Indigenous medical systems, as recommended in the National Healthcare Policy for Indigenous People (PNASPI). We believe that understanding the meanings attributed by health professionals to this guideline is essential for devising strategies to strengthen it.

We observed that the differentiated care meanings are linked to the characteristics and conditions of primary health care work in Indigenous territories, such as the emphasis on active search, work in collective spaces, and precarious infrastructure. On the other hand, the respondents showed that primary care in Indigenous territories involves emergency care in severe cases and emergencies. The accumulation or diversion of other professionals' functions to meet the communities' demands was also reported as a characteristic. However, we observed in the interviews a greater recognition of medical pluralism by health professionals.

Professionals also express another set of meanings about differentiated care related to recognizing the diversity of the population assisted so that their care has to adapt to each place of activity, whether due to linguistic or geographical characteristics or contact methods. The meaning of medical pluralism in Indigenous communities stands out among these aspects, so another differentiated care core meaning is constructing therapeutic itineraries and valuing self-care and articulation with traditional healing systems, particularly those of Indigenous experts. Thus, the work of professionals involves negotiation and complementarity with other care forms.

Although we have identified an essential recognition by health professionals of medical pluralism in Indigenous communities, strategies for training professionals and valuing Indigenous medical systems are necessary, as the hegemonic biomedicine and ethnocentrism are still very present in health training and Brazilian society.

Collaborations

Both authors participated in the article's conception, methodological design, and data analysis and wrote the text they reviewed and approved.

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