The Importance of Intercultural Dialogue in the Humanization of Indigenous Health Care

A Importância do Diálogo Intercultural na Humanização da Assistência à Saúde Indígena

La Importancia del Diálogo Intercultural en la Humanización de la Salud Indígena

RESUMO

Introdução: dada a necessidade de se efetivar a humanização nos contextos multiculturais de cuidado, sobretudo em relação à saúde indígena, que ainda encontra heranças etnocêntricas e coloniais em suas práticas. **Objetivo:** refletir sobre o cuidado intercultural à saúde indígena, enfatizando-se a importância do diálogo para a humanização dessa prática assistencial. **Método:** trata-se de um ensaio teórico reflexivo, conduzido a partir de uma fundamentação socioantropológica indígena e das ciências da saúde, onde buscou-se articular conceitos em torno do diálogo intercultural e da humanização da saúde. **Resultados e discussão:** o ensaio resultou em quatro eixos temáticos onde se discutiu a permanência do etnocentrismo nas práticas assistenciais, as subjetividades e necessidades subjetivas dos povos indígenas e as possibilidade de humanização da assistência a partir de um processo de diálogo intercultural. **Considerações finais:** identificou-se no diálogo intercultural uma possibilidade de promoção da transversalidade de saberes nos contextos de cuidado multicultural indígena.

PALAVRAS-CHAVE: Povos Indígenas; Humanização da Assistência; Assistência à Saúde Culturalmente Competente; Saúde das Minorias Étnicas; Etnicidade.

ABSTRACT

Introduction: given the need to achieve humanization in multicultural care contexts, especially in relation to indigenous health, which still finds ethnocentric and colonial legacies in its practices. **Objective:** to reflect on intercultural indigenous health care, emphasizing the importance of dialogue for the humanization of this care practice. **Method:** this is a reflective theoretical essay, conducted from an indigenous socio-anthropological foundation and health sciences, where we sought to articulate concepts around intercultural dialogue and the humanization of health. **Results and discussion:** the essay resulted in four thematic axes where the permanence of ethnocentrism in care practices, the subjectivities and subjective needs of indigenous peoples and the possibilities of humanizing care through a process of intercultural dialogue were discussed. **Final considerations:** a possibility was identified in intercultural dialogue to promote the transversality of knowledge in the contexts of indigenous multicultural care.

KEYWORDS: Indigenous Peoples; Humanization of Assistance; Culturally Competent Care; Health of Ethnic Minorities; Ethnicity.

RESUMEN

Introducción: ante la necesidad de lograr la humanización en contextos de atención multiculturales, especialmente en lo relacionado con la salud indígena, que aún encuentra legados etnocéntricos y coloniales en sus prácticas. Objetivo: reflexionar sobre el cuidado intercultural de la salud indígena, enfatizando la importancia del diálogo para la humanización de esta práctica de cuidado. Método: se trata de un ensayo teórico reflexivo, realizado desde una fundamentación socioantropológica indígena y de las ciencias de la salud, donde buscamos articular conceptos en torno al diálogo intercultural y la humanización de la salud. Resultados y discusión: el ensayo resultó en cuatro ejes temáticos donde se discutieron la permanencia del etnocentrismo en las prácticas de cuidado, las subjetividades y necesidades subjetivas de los pueblos indígenas y las posibilidades de humanizar el cuidado a través de un proceso de diálogo intercultural. Consideraciones finales: se identificó una posibilidad en el diálogo intercultural para promover la transversalidad de los saberes en los contextos de atención multicultural indígena.

PALABRAS CLAVE: Pueblos Indígenas; Humanización de la Atención; Asistencia Sanitaria Culturalmente Competente; Salud de las Minorías Étnicas; Etnicidad.

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INTRODUCTION

Since colonization, indigenous peoples have undergone an institutionalized process of extermination, invasion of their territories and marginalization of their being and existence in the world, so that this devastating process has generated not only innumerable damages to their ways of life, due to the destructuring of the relationships of these individuals with the territory, the community and nature [1], as well as a profound disidentification and epistemological erasure, caused by the cultural assimilation that was imposed on these people. [2]

Currently, despite this entire process, around 1.6 million indigenous people still resist in Brazil, totaling more than 300 ethnic groups [3], that despite being included in the scope of the prerogatives of the Unified Health System (SUS) [1], still face challenges in accessing and implementing comprehensive health care, especially due to neocolonialism and ethnocentrism that still afflict the system. [4, 5]

It is above all about maintaining a character of cultural imposition, which still renders the knowledge that makes up indigenous epistemology ineffective, to the detriment of biomedical scientific knowledge and Western worldviews[6], generating an assistance obstacle that produces effects on the multiple organizational levels of the SUS, dehumanizing and affecting the effectiveness and the resolution-assistance capacity of this system. [7, 8]

A problem that is often exemplified by the disregard for health needs and the effectiveness of their own healing methods that these people have accumulated throughout their existence, in addition to the impacts generated by the cultural contrast in the care process and by the nosological and interpretative differences regarding the concepts of care, health and illness. [9, 10]

Thus, given the ethical and legal imperative of the right to health that assists this population [1], This study questioned the importance of intercultural skills in the healthcare field, as well as the dialogical contributions to this process, especially for the implementation of an effective communicative and relational field, capable of promoting health in its entirety and providing responses aligned with the unique health needs of these individuals.

In this sense, the aim was to reflect on intercultural care for indigenous health, emphasizing the importance of dialogue for the humanization of this healthcare practice.

METHOD

This is a reflective theoretical essay, conducted based on the theoretical assumptions of Meneghetti (2021) [11] and Adorno (2003) [12] where the aim was, instead of proving a hypothesis or exhausting scientific evidence on a topic, to promote critical reflection in order to articulate concepts and promote conceptual and theoretical advancement based on questions arising from a reflective process.

This analysis was supported by a broad anthropological, social and legal bib-

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liographical foundation, aligned with studies of indigenous health and health sciences, so that this essay resulted in four thematic axes, namely: 1. Ethnocentrism and its impacts on the ways of life of indigenous peoples, 2. Subjectivities and worldviews of health in multicultural care, 3. The need for intercultural care and 4. Instrumentalizing culturally appropriate care through dialogue.

RESULTS AND DISCUSSION

Axis 1 - An anthropological look at ethnocentrism and cultural imposition:

From the first contacts between indigenous peoples and Europeans, in the colonization process, Western thought began to occupy a space of domination by force, so that, motivated by an ethnocentric point of view, Western society began to impose its cultural norms, to the detriment of the worldviews of traditional peoples, promoting a forced assimilation of these groups into the dominant culture. [2, 6]

Thus, this process was marked by a broad subrogation of indigenous knowledge to inefficiency and oblivion, given its reading, under a Western and ethnocentric interpretative bias, as being misaligned with rationality, therefore susceptible to assimilation into Western culture, so that they could reach the most recent state in the "linearity of social evolution". [9, 13, 1, 8]

However, from a wider dissemination of anthropological reflections, especially from the theoretical contributions of Mauss (2023) [14], Malinowski (1976) [15] and Lévi-Strauss (2011) [16], modern scientific thought begins to observe the need to adopt a counter-hegemonic stance, defending the importance of basing multicultural relations on ethical and anthropological principles such as otherness and cultural relativization.

It is therefore a matter of recognizing that Western thought, rationality and ways of life, despite being more widespread and dominant, are also cultural, so that they do not have an intrinsic epistemological superiority, nor can they be compared or hierarchized with those of other societies. [1]

In this line of thought, Lévi-Strauss (1952, 1990) [17, 18], defends the need to view cultures from a process of relativization, moving away from the notions that there is a linear cultural evolution, but rather that each way of being and existing in the world reflects the result of a set of historical, social and environmental factors specific to a people, which must be considered in the ethnographic reading, which Geertz (1978) [19] also conceptualized it as a "thick description", that is, one that delves into the realities and ways of life of the culture that one wishes to observe.

Thus, despite the theoretical innovations promoted by anthropology, especially for horizontality and humanization, it is still observed that colonial thought resists in numerous representations and social manifestations, including in health care, mainly due to the deep-rooted predominance of the biomedical paradigm, which begins to determine itself as the only legitimate way of thinking about health, under the scrutiny of Western scientific rationalism and conceptions reduced to the biogenetic aspects and causes of illness. [20, 21, 22]

Thus, as Sartori and Leivas point out (2017) 1, while biomedical understandings are capable of implying a mutilated reading of health for Western peoples, objectifying the body and disregarding the psychosocial impacts in the health-disease process [22], for indigenous people, this imposition can cause even greater problems, given the nosological, conceptual and paradigmatic discrepancy of these interpretative systems.

Axis II - Subjectivities and health worldviews in multicultural care:

From the observation of the exhaustion of the biomedical model, parallel to the paradigmatic overcoming of Western epistemological superiority, a process of opening up to an expanded conception of health begins in modern sciences, which begins to return the focus of care to the patient figure, and no longer to the disease, so that the phenomenon of illness begins to be seen as a highly subjective aspect and conditioned by numerous biopsychosocial factors, which feeds the increasingly emphatic discussion of the importance of guaranteeing humanization and patient-centered care. [21, 20]

Thus, it is clear that simply intervening in the physiological causes of illness, in a pathologizing and medicalizing action, is not enough, so that effective and humanized health care can only be provided through an intervention adapted to the needs and singularities of the patient. [21, 22] However, while in the context of a single-ethnic society this sensitivity is a necessity, when dealing with a multicultural context, such as indigenous health care, this requirement is completely expanded.

In view of this, indigenous representations reveal a divergent understanding of the health-disease process from the Western one, so that, based on the observation of the biopsychosocial aspects of this phenomenon, it is not possible for the health system to offer comprehensive care without being sensitive to different worldviews, adapting to multicultural concepts of health. [4]

Analyzing the challenges that involve the practice of humanized care requires understanding the timely context in which the intercultural therapeutic encounter can appear, because the very vision of the body and the health-disease process between cultures is discrepant, so that for Western society, while the body is seen as a material and individualized anatomical-physiological system, in the indigenous worldview it comes to be understood as a multifaceted and culturally constituted element, capable of suffering implications and imbalances arising from social, spiritual and environmental coexistence. [23]

An example of this is the notion of body adopted by the Kaiowá people, which as described by Cadogan (1962) [24], It is considered to be based on a construc-

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tion of two types of soul, one corporal and the other spiritual, which are accompanied by the tupichúa, an animal spirit that sits on the individual's shoulder and which, together with the other elements, conditions bodily aspects such as food cravings and sexual desire. [25]

Indigenous representations of the "body" and concepts of "health" and "well-being" demonstrate holistic considerations, based on an interconnection of different domains of nature, which align physiological processes, such as food, with sociocultural, environmental, physical and spiritual aspects, constituting something like systemic vitality, similar to a Western conception of biopsychosocial health. [23, 26]

A panorama that resembles the understanding of the Wajãpi, where the "disease" originates from a process of previous spiritual aggression 9 or the Wari', who interpret threats to *hwara oρά* (the Western equivalent of "health") as spiritual or extra-corporeal phenomena. [26]

Thus, given the apprehension of the differences in the Western and indigenous conception regarding the health-disease phenomenon, it is also observed that the understandings of the meaning of care are also dissonant, so that the notions of "cure" take on different forms, in indigenous societies, which do not present an alignment with intervention in individual or physical health conditions, but rather in the promotion of a spiritual, social, environmental and cosmic balance, to be achieved through a multifactorial action, involving aspects such as diet, social relations and spiritual interventions. [25]

Axis III - The need for intercultural care:

As observed by Pontes, Garnelo and Rego (2014) [27], in the Brazilian reality of a single-ethnic state that governs a multiethnic and multicultural society, there is a need to overcome the colonizer-colonized relationship. Thus, the articulation between practices, based on conditions of symmetry and equality, promoting a process of therapeutic negotiation, is highlighted as an essential element in the process of clinical dialogue, established in intercultural care.

This vision is necessary especially due to the cultural hybridism adopted by indigenous groups, who, when experiencing interculturality, adopt a non-conflictive complementary use of Western biomedical care, which is added to traditional [7, 9], constituting a practice of coexistence that is not to be confused with acculturation.

An example of this are the Siona and Wajãpi peoples, who recognize, in the words of Silveira (2022) [9], the pragmatic effectiveness of the biomedical approach in treating the symptoms and effects of certain diseases, especially the so-called "white people's diseases", reported by Gallois (1991) [28], so that in the midst of this cultural hybridism, the meanings and therapeutic choices go through a process driven by subjectivity and dialogue.

Therefore, culturally sensitive care must be aligned with intercultural negotiation, which, unlike an acculturation process, is open, based on respect, to a mutual understanding of the values, beliefs and visions of the actors involved, in a horizontal process that must be guided above all by an alignment with the needs and representations of patients [29], considering that "the changes that we consider necessary and essential to improve the living conditions of our clients do not always coincide with the desires and worldview of these people" (Sabóia, 2003, p. 120). [30]

A demand that in turn is pointed out by Leininger (2006) [31], which identifies in the Theory of Transcultural Nursing the possibility of providing, in its modes of action, a cultural accommodation of care, based on respect for the different expectations assumed by patients in multi-ethnic contexts, so that the care plan is adapted to the cultural demands of these individuals, reducing negative health outcomes, adverse events and problems in therapeutic adherence. [29]

Eixo IV - Instrumentalizando um cuidado culturalmente adequado através do diálogo:

As conceptualized by Brooks, Manias and Bloomer (2019) [29], The cultural adequacy of care has communication as its founding element. To this end, the authors outline the need for the professional to facilitate linguistic rapprochement, develop a relationship of trust, prioritize cultural considerations in care, and promote the participation of patients and families in therapeutic planning and decision-making as fundamental attributes of this process.

In a multicultural context, clinical barriers, strengthened by the professional's lack of "acceptance, appreciation, exploration, or understanding" of sociocultural differences, are elements capable of preventing culturally adequate care. [32] Thus, Pontes, Garnelo and Rego (2014) [27], in a study conducted with members of the Baniwa ethnic group, they exemplify elements that translate such clinical barriers in the context of indigenous health, generated mainly due to a lack of understanding [32] the cultural particularities, generating negative impacts, as described by the authors:

> "the mixing of people of different ethnicities, understood as a health risk situation; the disregard for traditional diets and dietary restrictions of sick families; and the prohibition of specialists, plant experts, shamans and healers from carrying out their treatments in public service spaces, in addition to the non-recognition of traditional diseases" (Pontes, Garnelo and Rego, 2014, p. 341). [27]

Thus, in line with Leininger (2006) [31], the importance of an effective communication process is defended as the primary means of implementing culturally appropriate and humanized care for indigenous health. [5] In this way, just like the human act of exchange, which assumes a prominent place in anthropological studies due to its symbolic function [33], the negotiation of knowledge in an intercultural relationship movement in care is of fundamental importance. [34]

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Therefore, only through a process that breaks the verticalization and imposition of knowledge in the clinical environment is it possible to implement multicultural care that is humanizing, horizontal and consequently allowing contributions from different actors in the clinical context.

This highlights the importance of healthcare professionals having genuine intentionality in their care, based on active listening and understanding the views and knowledge of indigenous patients [35, 36, 37], so that, based on a reading of the world of these individuals' representations, it is possible to implement a process of clinical negotiation, always with a view to promoting health, based on a hybridism between professional and patient considerations, in a dialogical movement.

And thus, as Lopes and Sathler (2022) point out 7, to implement a process of transversality between knowledge, so that they intersect and interpenetrate in a democratic process of intercultural care, where the health professional is able to understand subjectivities and promote adaptation in care, observing aspects of individual needs that condition the integrality of care.

CONCLUSION

As part of the colonial legacy, indigenous health care through the SUS still faces challenges in its effectiveness and humanization, especially due to the persistence of ethnocentric representations of the biomedical model and Western epistemological subrogation, which renders the indigenous worldview in health ineffective and irrational. Thus, in addition to the impacts that constituted the colonial trauma, this phenomenon impacts the recognition and consideration of the knowledge and ways of life of indigenous societies in care.

In view of this, intercultural dialogue is identified as a possibility of promoting the transversality of knowledge in multicultural care contexts, especially indigenous care, allowing the professional to recognize and understand cultural health needs, promoting, through a process of listening and negotiation, a culturally appropriate and consequently humanized care practice.

Therefore, there is a need to break with the colonial hegemony of ethnocentrism and subrogation in care practices, in order to guarantee integral, effective and, above all, human access to the SUS for indigenous societies.

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