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Intercultural repertories of women on HIV/AIDS conceptions in an interethnic scenario[a]

Repertórios interculturais de mulheres sobre concepções de HIV/AIDS em cenário interétnico

Repertorios interculturales de mujeres acerca de concepciones de VIH/SIDA en un escenario interétnico

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Abstract

Objective: to analyze, from the perspective of interculturality, the meanings attributed to HIV/AIDS that make up the repertoires of women in interethnic situations. **Method:** a descriptive, retrospective study, developed based on the primary research database. The sample consisted of 642 records, from the application of the Word Association Test, with 386 non-indigenous women and 256 indigenous women from the municipality of Rio Tinto-PB. The responses learned from the AIDS-inducing stimulus were categorized according to group belonging, age and marital status. Data were processed by the IRaMuTeQ software, and analyzed using the Descending Hierarchical Classification, complementary specificities and factorial correspondence analysis techniques. The discussions were based on the three perspectives that encompass interculturality: relational, functional and critical. **Results:** Three classes were formed: Biomedical Repertoire, Socio-emotional Repertoire and Behavioral Repertoire. Biomedical Repertoire was the most significant for both groups, being led by non-indigenous women; the socio-emotional and behavioral constituents were mostly represented by indigenous women. **Final considerations and implications for practice:** in this interethnic setting, intercultural dialogue materializes in the exchange of a heterogeneous way of thinking-knowing-doing, which unfolds in the light of relational and functional interculturality, demonstrating embryonic movements towards critical interculturality.

Keywords: HIV; Women; Women's Health; Culturally Competent Care; Acquired Immunodeficiency Syndrome.

Resumo

Objetivo: analisar, sob a perspectiva da interculturalidade, os significados atribuídos ao HIV/AIDS que compõem os repertórios de mulheres em situação interétnica. **Método:** estudo descritivo, retrospectivo, desenvolvido com base no banco de dados de pesquisa primária. A amostra foi constituída por 642 registros, provenientes da aplicação do Teste de Associação Livre de Palavras, com 386 mulheres não indígenas e 256 mulheres indígenas procedentes do município de Rio Tinto-PB. As respostas apreendidas do estímulo indutor AIDS foram categorizadas segundo grupo de pertencimento, idade e conjugalidade. Os dados foram processados pelo *software* IraMuTeQ, e analisados pelas técnicas de Classificação Hierárquica Descendente, Especificidades Complementares e Análise Fatorial de Correspondência. As discussões apoiaram-se nas três perspectivas que abarcam a interculturalidade: relacional, funcional e crítica. **Resultados:** foram conformadas três classes denominadas: Repertório biomédico; Repertório socioemocional; e Repertório comportamental. O biomédico foi o mais significativo para ambos os grupos, sendo liderado pelas não indígenas, e os constituintes socioemocional e comportamental foram majoritariamente representados pelas indígenas. **Considerações Finais e implicações para a prática:** nesse cenário interétnico, o diálogo intercultural se materializa no intercâmbio de forma heterogênea de pensar-saber-fazer, que se desdobra sob a luz da interculturalidade relacional e funcional, demonstrando movimentos embrionários para a interculturalidade crítica.

Palavras-chave: HIV; Mulheres; Saúde da Mulher; Saúde Intercultural; Síndrome da imunodeficiência adquirida.

Resumen

Objetivo: analizar desde la perspectiva de la interculturalidad los significados atribuidos al VIH y SIDA que componen los repertorios de mujeres en situación interétnica. **Método:** estudio descriptivo, retrospectivo, desarrollado con base en la base de datos de investigación primaria. La muestra estuvo compuesta por 642 registros, provenientes de la aplicación del Test Libre de Asociación de Palabras, con 386 mujeres no indígenas y 256 mujeres indígenas del municipio de Rio Tinto-PB. Las respuestas aprendidas del estímulo inductor del SIDA se clasificaron según pertenencia al grupo, edad y estado civil. Los datos fueron procesados por el software IRaMuTeQ y analizados mediante las técnicas de Clasificación Jerárquica Descendente, Especificidades Complementarias y Análisis de Correspondencia Factorial. Las discusiones se basaron en las tres perspectivas que engloban la interculturalidad: relacional, funcional y crítica. **Resultados:** se formaron tres clases: Repertorio biomédico; Repertorio socioemocional; y Repertorio conductual. El biomédico fue el más significativo para ambos grupos, siendo liderado por mujeres no indígenas, y los constituyentes socioemocionales y conductuales estuvieron mayoritariamente representados por mujeres indias. **Consideraciones finales e implicaciones para la práctica:** en este escenario interétnico, el diálogo intercultural se materializa en el intercambio de una manera heterogénea de pensar-saber-hacer, que se despliega a la luz de la interculturalidad relacional y funcional, evidenciando movimientos embrionarios hacia una interculturalidad crítica.

Palabras clave: VIH; Mujeres; Salud de la Mujer; Salud Intercultural; Síndrome de Inmunodeficiencia Adquirida.

INTRODUCTION

The global experiences accumulated during the AIDS epidemic, or acquired immunodeficiency syndrome, have highlighted the disparities with which HIV infection affects different social groups, disproportionately affecting people in sociocultural contexts marked by inequalities, violence, stigma and discrimination.[1,2]

This setting unfolds in increasingly challenging circumstances for the health sector, especially when focusing on the female public, especially when involving culturally differentiated populations, such as those that make up the indigenous segment. The increase in migratory flows and mobility of women living between cultures has, on the one hand, promoted positive changes in family dynamics and economy, in parental, feminine and educational roles, on the other hand, it has favored tensions and identity conflicts, accentuating differences between majorities and minorities.[3]

Indigenous women in general are poor and, in most cases, exposed to intra- and extra-group discrimination due to the social condition of being women and in contact with external society, marginalized due to their ethnic condition.[3] Such disadvantages increase their vulnerability to various diseases, including HIV/AIDS.

According to estimates from the Joint United Nations Programme on HIV/AIDS, 38.4 million people in the world were living with HIV in 2021. Of these, 54% were women and girls.[4] In Brazil, in 2021, around 3,900 women were infected with HIV, and more than 3,700 of them were diagnosed with AIDS. Among women of indigenous ethnicity, 306 cases of HIV infection and 136 cases of AIDS were reported between 2015 and 2021.[5]

In the context of non-indigenous and indigenous women, it appears that the spheres of vulnerability to HIV have a polymorphic dynamism that needs to be known and understood so that the measures provided for in public policies and care actions are meaningful in different realities. Each group brings with it cultural essences that act in the health-disease process. It is believed that, particularly, the indigenous population has been demanding an attentive and sensitive look at their multiple peculiarities, with the desire to establish a dialogue capable of reconciling the health care demands with cultural preservation.

To achieve this, it is necessary, based on investigations conducted in this area, to recognize that, in a world crossed by the coexistence of different cultures, those who do not practice globally hegemonic values or knowledge should not be excluded.[6]

Therefore, colored by the polyphony of cultural diversity, this study reports on indigenous women of the *Potiguara* ethnic group and non-indigenous women, from the municipality of Rio Tinto, in Paraíba. Circumstantially, the geographic proximity and social dynamics between these women promotes interactions and cultural dialogue, sharing values, practices, customs that transcend their cultural realities/specificities.[3,7] That said, it is clear, *a priori*, that this group is not untouchable, exempt and alienated due to interethnic coexistence.

In this context, resulting from the territorial transit and social interactions of these women, the aim is to uncover, from the perspective of an intercultural approach, the unique and/or analogous aspects that permeate their repertoires regarding HIV/AIDS.

The intercultural approach poses new questions regarding cultural diversity management, in particular intercultural communication and health communication, taking on a practical dimension of inter-relationships and dialogic encounters. It represents a logic built from the plurality of voices that interact based on the particularity of difference, cooperation and continuous construction.[8,9] In this format, there is no room for cultural hegemony, inferiorization and subalternity.[10]

It is worth highlighting that the intercultural approach has been expanding in the Latin American context, being understood from three perspectives: relational, functional and critical. Relational interculturality refers to contact and exchange between cultures that can occur under conditions of equality or inequality so that the contexts of power and domination remain, although they are hidden or minimized in relationships. Functional interculturality seeks to promote dialogue, coexistence and tolerance, disregarding social conflicts arising from power relations, which subjugate those who do not adapt to hegemonic models. Critical interculturality, on the other hand, points to the construction of societies that accept differences as constitutive of democracy and that are capable of building new relationships marked by equality and strengthening the power of those who have been historically inferior.[8,10]

Thus, this study aimed to analyze, from the perspective of interculturality, the meanings attributed to HIV/AIDS that make up the repertoires of women in interethnic situations.

METHOD

This is a descriptive, retrospective study, which used a primary research database developed in the municipality of Rio Tinto, officially recognized as one of the areas occupied by the *Potiguara* indigenous population, providing a suitable space for establishment of interethnic contacts. The primary research population comprised 386 non-indigenous women and 256 indigenous women, from Rio Tinto, whose data collection was completed in 2017.

For this study, data referring to 642 records (indigenous and non-indigenous women) were extracted from the database, and the following information was selected: ethnic group, age, marital status. The responses were issued based on the "AIDS" inducing stimulus, generated by the application of the Word Association Test (WAT). The WAT responses were transcribed and coded according to the number of participants, group of belonging, age and marital status.

The *corpus* was subjected to refinement to exclude vocabulary repetitions, grouping of words by semantic approximation and composition of a dictionary. Sequentially, the data were imported for processing in textual analysis software, *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires version 0.7 alpha 2* (IRaMuTeQ®), which classified the segments according to their respective vocabularies, generating the Descending Hierarchical Classification (DHC).[11]

From empirical material processing, the *corpus* generated 642 elementary context units (ECUs), corresponding to text segments depending on the *corpus* size. DHC retained 584 ECUs, with a success rate of 91.10%, generating response classes about AIDS based on the vocabulary and variables that contributed to the formation of each class, selected according to chi-square values (X^2).

Given this *corpus*, the criterion for descriptive analysis of words (lexicographic criterion) was used, considering for the composition of the classes only the words that presented $X^2>10$. Thus, three classes were obtained, which were called: a) Biomedical repertoire; b) Socio-emotional repertoire; c) Behavioral repertoire.

From the DHC, correspondence factor analysis (CFA) was carried out, which represents in a Cartesian plane the different words associated with each of the DHC classes. This interface enabled a detailed examination of the relationships between the profiles of individual responses, graphically showing connections and oppositions between participant characteristics.[11] Furthermore, statistical reports generated in IRaMuTeQ® were used to explore the specificities among groups and identify the unique and/or analogous aspects that intersect in the space of ethnic interactions. The discussions were based on the three different perspectives that encompass interculturality: relational, functional and critical.

The primary project was approved by the Research Ethics Committee of the *Universidade Federal da Paraíba* Health Sciences Center, under Opinion 1,984,528, on March 27, 2017. The current study did not require new approval.

RESULTS

Descending Hierarchical Classification

In the dendrogram (Figure 1), the *corpus* called "Meanings attributed to HIV/AIDS" was divided into two *subcorpora*. The first originated Class 3 called "Behavioral repertoire", which portrays a set of behaviors and practices related to HIV/AIDS infection. The second *subcorpus* is formed by Class 1, entitled "Biomedical repertory", which describes aspects alluding to hegemonic biomedical knowledge, and Class 2, entitled "Socio-emotional repertory", centered on negative elements that trigger mutual repercussions, of a social and emotional nature, in people who live or coexist with the disease.

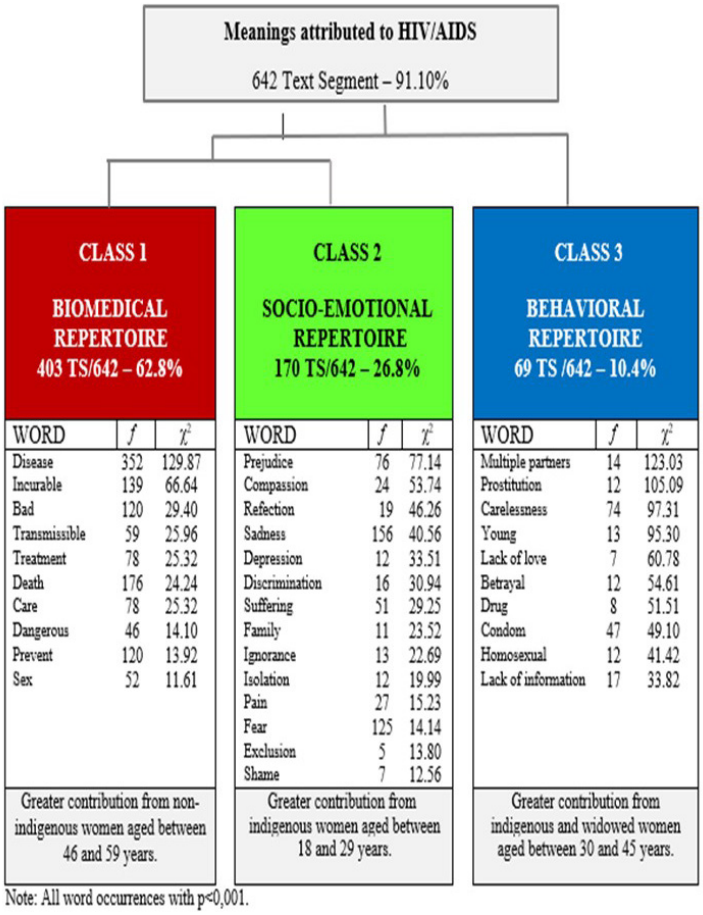

Figure 1. Dendrogram of vocabulary distribution of classes according to the Descending Hierarchical Classification related to the AIDS-inducing stimulus. Rio Tinto, Paraíba, Brazil, 2021.
Source: research data.

In Class 1, the biomedical repertoire retained 62.8% of ECUs, built predominantly by non-indigenous women aged between 46 and 59 years. In this class, aspects linked to knowledge produced by health sciences prevail, which denote the classic biomedical view regarding the aspects surrounding physical illness. From this perspective, AIDS is understood as an incurable and transmissible disease, with sex as the main route of contagion, but which has treatment. Therefore, they need to be careful and take precautions, as it can lead to death.

In Class 2, the socio-emotional repertoire comprised 26.8% of ECUs, corresponding to 159 ECUs, and had a greater contribution from indigenous women aged between 18 and 29 years old. In the class on screen, HIV infection and AIDS are portrayed from a psychosocial perspective, expressed by suffering and sadness arising from prejudice and discrimination. This facet of the epidemic divides society into two segments: one composed of those who praise the rejection of those affected by the virus/syndrome; and another composed of others who feel compassion and seek to act in welcoming and caring for these people. Among the fruits of this social dynamic are depression and isolation of those affected by the virus, supported by the lack of knowledge that plagues a high social group.

In Class 3, the behavioral repertoire concentrated 10.4% of ECUs, equivalent to 62 ECUs retained and classified. This class had the largest contribution from indigenous women, widows and those aged between 30 and 45 years. In this space of analysis, HIV infection and AIDS are linked to attitudes and actions present in women's daily lives, which are marked by carelessness in the use of condoms, misinformation and multiple sexual partners, whether as a practice of professional bias (prostitution) or as an option or relational habits (betrayal). Furthermore, it is observed that the aforementioned behaviors are associated with certain population groups, such as young people, homosexuals and drug users.

Analysis of complementary specificities

The graphs produced enabled comparisons between ethnic groups based on the frequency of words that made up each repertoire presented in DHC, allowing interpretation of similarities and singularities present in the indigenous (*gru_1) and non-indigenous universe (*gru_2).

In the biomedical repertoire (Figure 2), the most prominent words were mentioned by both groups, and this interethnic and intercultural (in)fluence contributed to the common biomedical understanding of HIV/AIDS infection, understanding them as potentially lethal (death), (incurable) and treatable (treatment) conditions of illness (disease). However, among the most prominent statements for non-indigenous women are care, prevention and transmissible.

In the socio-emotional repertoire (Figure 3), the highlighted words resonated with greater intensity among *Potiguara* women. It is believed that the mention of compassion, rejection, discrimination, isolation and depression is due to interethnic experiences marked by exclusion, accompanied by the high appreciation for collective actions, engagement and cultural functionality of this group. It is understood that the essence of this repertoire goes back to concerns about the weakening of community links due to an illness, the repercussions of which go against original peoples' sociocultural dynamics.

In the behavioral repertoire (Figure 4), there was greater participation of indigenous women, although some of its elements, such as the reference to carelessness in the use of condoms, had similar relevance for non-indigenous women. The mention of the juvenileization of the epidemic (young people) associated with misinformation and prostitution attracted greater attention from *Potiguara* women, unlike what was seen by non-indigenous women.

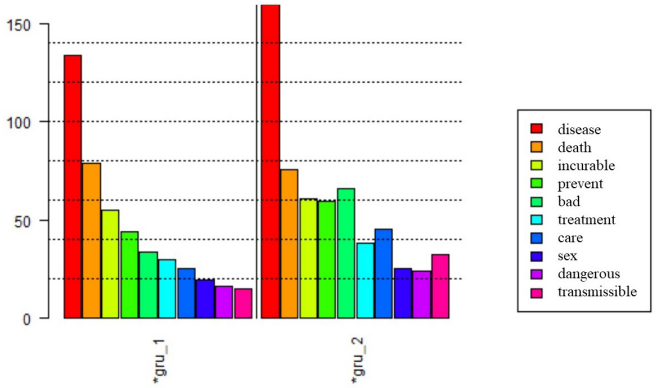

Figure 2. Relative frequency of content that made up the biomedical repertoire according to the groups of women investigated. Rio Tinto, Paraíba, Brazil, 2021
Source: research data.

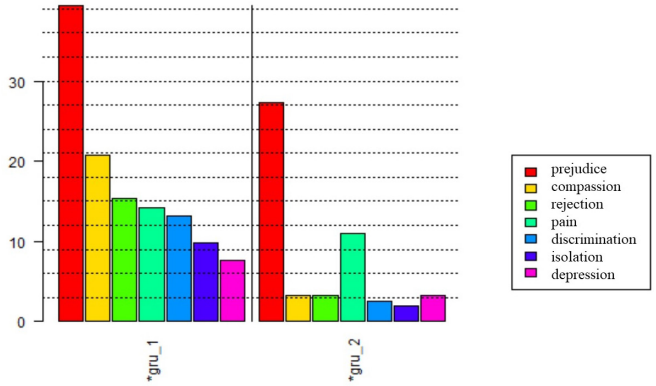

Figure 3. Relative frequency of content that made up the socio-emotional repertoire according to the groups of women investigated. Rio Tinto, Paraíba, Brazil, 2021.
Source: research data.

Correspondence Factor Analysis

In CFA (Figure 5), the positioning of the words that lead to the most enlightening interpretations of convergences and divergences, now sought in the course of interculturality study, is clearly visualized. In both factors, the total variance presented a value of 100%. Factor 1, which corresponds to the horizontal axis, explained 58.2% of the total response variance. Factor 2, which corresponds to the vertical axis, explained 41.8% of the total responses.

The classes occupied the Cartesian plane without overlapping words, with Classes 1 and 2 distributed in the right quadrants, expanding towards the vertical axis, while Class 3 spread towards the horizontal axis, partially extending into the left quadrants, with some words approaching Class 1.

In factor 1 (Axis 1), it is observed that, although the most prominent words, belonging to Class 3, are positioned in the central area of the Cartesian plane, they also occupy the neutrality zone, as seen in multiple partners, prostitution, carelessness, many affairs and homosexual. Given this presentation, it is inferred that such behaviors associated with HIV/AIDS infection are perceived by *Potiguara* women as general information about vulnerability to the virus, but do not match current practices in their contexts. Continuing in the horizontal direction, on the upper axis of this plane, from Class 3 to 1, it appears that the same behaviors make it possible to suffer from an incurable disease that requires biomedical care (Class 1). In the second factor (Axis 2), the aforementioned incurable disease is understood as promoting prejudice, sadness and compassion, present in the axis' negative extension.

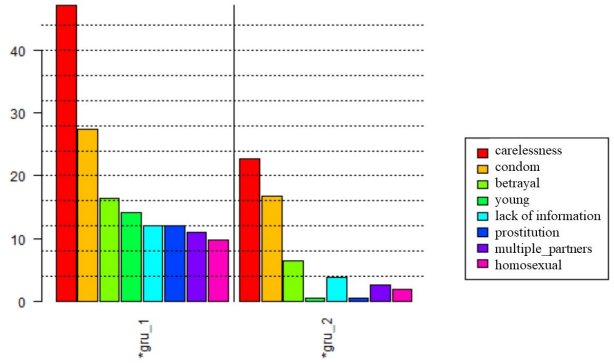

Figure 4. Relative frequency of content that made up the behavioral repertoire according to the groups of women investigated. Rio Tinto, Paraíba, Brazil, 2021.
Source: research data.

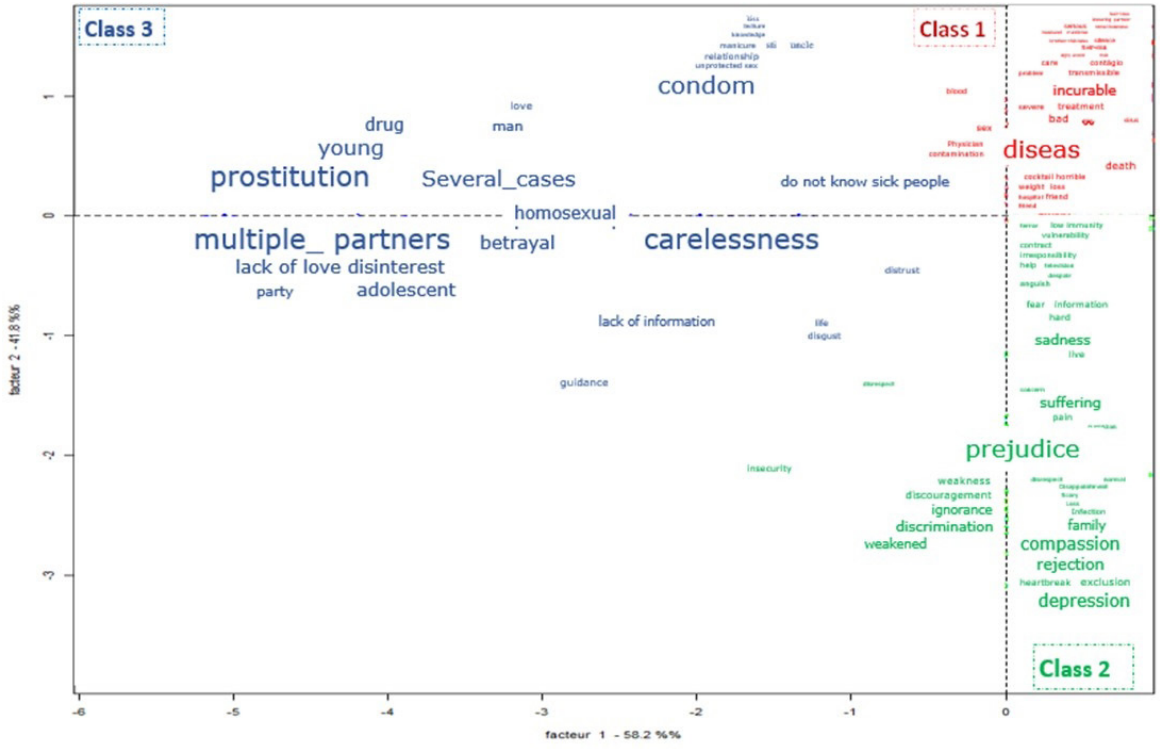

Figure 5. Correspondence factor analysis with the representation of coordinates highlighting three classes and words with higher factor loadings. Rio Tinto, Paraíba, Brazil, 2021.
Source: research data.

DISCUSSION

The meanings attributed to HIV/AIDS that emerged from DHC showed that individual behaviors are extremely valued, as attributes of vulnerability to HIV infection (Class 3). Although they demonstrate certain biomedical knowledge (Class 1), the socio-emotional implications of the infection and syndrome are negative (Class 2).

The study demonstrates, in the behavioral repertoire, how the AIDS phenomenon remains rooted in notions of a moral nature, and even though it has predominated among *Potiguara* women, they are not exclusive to this group. Research carried out with heterosexual men and women,[1-12] homosexuals and adolescents[13,14] also portrayed AIDS as a product of promiscuity, dangerous behaviors, drug use, carelessness and unprotected sex.

Negative perceptions, historically, have orbited the social and affective relationships of those living with HIV/AIDS, impacting the access and insertion of individuals in educational, work spaces, health services and broad spaces of life in society.[13,15]

The similarity visualized in Figure 3 denotes the occurrence of cultural itineraries, interactivity, conformity, possibly demarcated by interethnic encounter. Furthermore, it highlights how challenging HIV infection prevention actions are for women due to issues such as gender imbalances, socioeconomic and religious conditions, which, to a greater or lesser extent, compromise women's autonomy to make decisions regarding their sexual and reproductive demands, resulting, for instance, in the difficulty of negotiating the use of condoms in their relationships.[1,16]

From a prophylactic perspective, the Combined Prevention strategy is adopted in Brazil as a set of biomedical, behavioral and structural actions to be implemented simultaneously, in groups most vulnerable to HIV, such as sex workers, young people and indigenous people.[17] From this perspective, the study took nuances of the experiences of vulnerability to HIV mentioned by indigenous people, verifying that the adherence of young *Potiguara* women to the sexual market is associated with low and insecure socioeconomic conditions, linked to the gains arising from crafts, agriculture and fishing. In this situation, some women occasionally work in the sexual economy of the city of *Baía da Traição* (Betrayal Bay), where the tourist and fishing hub is located, and many young women move to larger municipalities, in order to hide their identity as a sex worker, considered inappropriate by their people.[18]

However, it is understood (Figure 2) that women living in the villages of Mont-Mór, Jaraguá and Silva de Belém consider themselves far from this reality. It is understood that prostitution is developed to a greater extent by indigenous people domiciled in the villages surrounding the *Baía da Traição*, pointing to a relationship between expressions of lack of care in relations with non-indigenous people, or tourists, and an increase in the number of cases of infection by the HIV/AIDS among *Potiguara* women.

Probably, the same understanding occurred among indigenous women when they mentioned homosexual relationships. In other words, it is believed that, in the villages where they live, this sexual orientation is hidden, or not very expressive, since, among the *Potiguara*, such relationships are crossed by social problems similar to those that occur among non-indigenous people so that ethnicity does not have a significant impact on affective and sexual experiences.[19]

Regarding the demand for information about HIV/AIDS, it is observed that, although this has been more significant among indigenous women, it corresponds to a common deficiency in the non-indigenous universe, as demonstrated among socioeconomically vulnerable women, gays, transvestites, men who have sex with men, sex workers and students,[20-22] even in the face of free access to information disseminated in the media. The importance of overcoming misinformation about sexually transmitted diseases and intimate self-care is highlighted through health education actions based on the peculiarities of each group. To this end, ideological precepts must be observed with a view to building an emancipatory dialogue capable of producing information multipliers in the social environment. In this process, it is possible to count on a partnership between educational and health institutions, envisioning the implementation of teaching strategies shaped by cooperation and the priorities of each clientele.[20,22] Health education actions must occur broadly, involving men and women in discussions about HIV infection, with the aim of developing paths for conscious empowerment and clarity of the emergence of self-care and care for others.[23]

In this perspective, the study invites us to reflect on the possibility of (re)emergence of partnerships between health and indigenous education professionals together with village leaders in favor of health education actions. From this perspective, they can propose moments of educational interaction in the schools themselves, or in the social settings of each village, especially those attended by young people, for instance, in *quadrilha junina* (a style of collective folk dance very popular in Brazil) rehearsals,[24] extending to preparations for traditional festivities, or other areas of daily coexistence, including in digital media.[25]

This repertoire produced, mostly, by indigenous people who go through adulthood and find themselves widows brings at least two aspects that illuminate the transition between relational and functional interculturality. In the first, they notice the increased vulnerability of their people to illnesses common in the non-indigenous universe, mobilized by interethnic coexistence. Despite this, they seem to understand that this social movement is inevitable in villages and has been occurring for centuries. The second aspect is the replication of conceptions about HIV/AIDS infection, made up of a collection of components, of a behavioral nature, originating in the non-indigenous universe, signaling approval for the content brought by the hegemonic culture. Furthermore, they seem to signal paths towards critical interculturality.

In the biomedical repertoire, the study points to the supremacy of scientifically disseminated knowledge, common in other investigations involving pregnant women and men who have sex with men.[26,27] It was shown how knowledge about the HIV epidemic is a guide for self-care, decision-making, ordering the work process of health professionals and the development of public policies.

For the *Potiguara* people, HIV infection and AIDS are included in the list of illnesses arising from contact with non-indigenous and which produce fear of death among their peers. They also understand that access to multidisciplinary assistance is important to help them care for various health problems, whether they can be resolved in the village itself or outside it. In this way, biomedical knowledge is accepted and valued by this indigenous community.[28]

However, it is believed that the repertoire on screen was less widespread among indigenous women, because culturally distinct groups tend to use traditional medicine in the health care of their people, which includes using medicinal herbs and religious practices. These treatments based on ethnomedicinal knowledge are provided in several indigenous communities distributed throughout Brazil, such as the *Kantaruré*, in Bahia, and the *Tenetehar-Tembé*, in Pará, in addition to the *Potiguara*, in Paraíba.[29-31]

The health practices developed by the *Potiguara* go beyond access to biomedical care, and occur in a heterogeneous way, through the association of traditional medicine and allopathic medicine. In the village of São Francisco, for instance, medicinal herbs are commonly used in the production of tea, natural products and juice, applied to headaches, inflammations and flu. Many *Potiguara* families adopt Western biomedicine models as a second choice, either due to their preference for traditional care or the difficulties in accessing health services.[31]

The study also shows that the expression of care among non-indigenous women (Figure 2) may be placed in the sense of paying greater attention to possible exposure to HIV, mobilizing the idea of protection - through adherence to condom use, for instance - it can also announce acceptance and adherence to drug and non-drug therapies in the face of the infection or syndrome. Whatever the meaning pointed out by the women, there is a correlation between the most prominent words, as care, prevention and communicable, placing health care aimed at prevention measures and possible therapies adopted in the face of this communicable illness at the center of the discussion.

Both groups of women made more reference to HIV infection prevention than to AIDS treatment, which may signal greater dissemination of preventive information in the social environment, possibly resulting from the work carried out in Primary Care services as well as the media in general. Despite this, it is observed that, for non-indigenous women, the expression of prevention proved to be equivalent to the understanding that AIDS is incurable, different from what occurred among *Potiguara* women, who, in turn, referred to prevention with lower intensity. This fact invites us to understand how health care for the *Potiguara* has been developed in the Indigenous Basic Health Unit and at the Base Pole, which make up the local Primary Care services, in which prevention actions must be promoted.

For the Brazilian National Health Care Policy for Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas*), professionals working in Indigenous Primary Care must carry out care actions similar to those developed for non-indigenous people, with the addition of dedicating attention to differentiated local demands, conferred by historical, geographic, cultural, political and social diversity contexts. Therefore, it seems opportune to reflect on possible operational bottlenecks that are making it difficult to strengthen preventive actions in this Primary Care, such as the turnover and irregularity of health professionals in the indigenous subsystem, poor conditions in Indigenous Basic Health Units' physical structures, in addition to the insufficient availability of medicines and supplies.[32,33]

However, it is not possible to state that such weaknesses are present in the *Potiguara* Special Indigenous Health District, as no studies were found that provided such information. However, it is understood that something is obstructing the expression of prevention coming from indigenous people.

On this occasion, we can only reaffirm that, in Primary Care, actions aimed at controlling HIV infection and AIDS are supported by ministerial recommendations, which prioritize the care of people exposed and affected by the virus, based on a definition of care flow composed of lines of care drawn up in accordance with the local reality. In this context, Primary Care is inserted as a space for welcoming and inserting users into care processes, under the support of Specialized Assistance Service.[34,35]

Given the biomedical repertoire, it is believed that the predominant representation of non-indigenous and older women is related to the fixation of their memories in the first decades of fighting AIDS in Brazil as well as greater approximation of this group to health science content in relation to *Potiguara* women. Thus, it is understood that this repertoire brings with it the precepts of relational interculturality. In the interaction between women from different cultures, there is permission for cultural encounter and recognition of their differences, but hegemonic knowledge is peacefully maintained.

Furthermore, the similarities of this repertoire also invite us to reflect on the presence of functional interculturality, as, in addition to showing the strength of hegemonic knowledge, it also allowed us to discuss probable supports for the permanence of cultural domination. This domination is observed in the provision of specific health services for the *Potiguara*, which reveals the institution of health care for a certain population fraction, justified by the recognition of their cultural specificities, keeping them under domination while minimizing tensions between groups.

In the socio-emotional repertoire, it is clear how social experiences of exclusion, justified by the condition of HIV seropositivity or manifestations of AIDS, orbit the lives of those affected by the virus. In this process, demonstrations of lack of interest in life and depression are common, especially in the diagnostic elucidation phase which, for many women, takes place during prenatal care. Negative emotional responses, when diagnosed with HIV, are one of the main obstacles to adherence to treatment and connection with health services. Possibilities for overcoming and redefining life include the provision of support networks, maintenance of a work routine as well as the possibility of making decisions about love, sexual and reproductive life.[36,37]

Appropriately, it is emphasized that the *Potiguara* socialization experience is based on kinship relationships or genealogical links, seeking articulation between families, with an emphasis on defending the territory and political organization of villages. They share the idea of reciprocal cooperation, common in the division of physical spaces for housing and cultivation. They demonstrate continuous concern with interethnic relations, especially regarding marriages with non-indigenous, their insertion in villages and the weakening of the possibilities of cultural perpetuation.[18]

This format of social relations extends to urban spaces, being shaped by the exercise of solidarity, kindness and mutual support when meeting relatives in cities. This atmosphere of hospitality facilitates the transit or settlement of these indigenous people outside their villages, helping them to establish new social networks, whether to continue university courses[38-40] or to support themselves while they seek paid activities in other cities.[18] This form of mobility among the *Potiguara* is permanently activated as a movement of resistance to the adversities that surround them, especially when they are outside their territory, "such as racial discrimination, indignation at the lack of social justice, anguish and fear".[40:11]

Considering the process of losses and gains arising from intercultural relationships, the study shows that *Potiguara* women's experiences are characterized by negative feelings latent in their memories, and instigate questions about access to the professional and community support network to deal with these socio-emotional losses as well as about the perception of this demand by indigenous leaders. Does the force of relational interculturality, acceptance of racial domination, immobilize the *Potiguara* to the point of nullifying any prospect of overcoming these problems?

The expression of compassion seems to give light to indigenous values, guided by group spirit, trying to mitigate the exclusionary manifestations now revealed. Regarding this precept, anthropological studies have shown that solidarity among the *Potiguara* is a common characteristic in everyday social relations within the villages, and has been experienced in extramural spaces.[39,40] In this regard, the expression of compassion proved to be an extension of the solidarity that prevails in the social interactions of these indigenous people.

The socio-emotional repertoire seen in Figure 1 and Figure 3 shows the strength of the expressions produced mainly by the *Potiguara*, understood as a product of the unequal exchange between cultures, characteristic of relational interculturality. Furthermore, the emphasis on compassion, as a form of sociocultural manifestation of this group, seems to herald a movement that calls for critical interculturality, given the intention of demarcating the difference between cultures, creating a social environment susceptible or not to appreciation of this cultural trait of the *Potiguara*.

FINAL CONSIDERATIONS AND IMPLICATIONS FOR PRACTICE

It is understood that, in the context of combating HIV/AIDS infection, especially when focused on the nuances surrounding women's health, the clarity of the vulnerabilities that follow them associated with the construction of interculturality signals paths towards controlling this challenging pandemic. In interethnic settings, intercultural dialogue materializes in the exchange of heterogeneous forms of thinking-knowing-doing, which unfolds in the light of relational and functional interculturality, demonstrating embryonic movements for the development of critical interculturality and allowing the recognition and socialization of interpretations and meanings attributed to HIV/AIDS.

The repertoire presented here leads us to recommend other studies and reflections on the interculturality that surrounds us, whether in recognizing cultural singularities present in specific groups or certifying the cultural diversity that ends in a continental country, such as Brazil. It is understood that the theoretical contribution of interculturality, with a focus on intercultural health, demands dissemination and deepening in settings of human resources for health training, and can be introduced in the discipline of collective health and similar. It is believed that the products of this training will be reflected in scientific studies and in the care practices of multidisciplinary and nursing teams. There is also potential for strengthening and implementing public policies that address society's structuring aspects, as these underpin access to a dignified life, portrayed in the interaction between sectors such as health, education, environment, economy and justice, and human rights.

Among the limitations for the development of this study, we highlighted the limited access to recent scientific productions aimed at the *Potiguara* population's health.

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