Nurses' performance on indigenous and African-Brazilian health care practices

Atuação de enfermeiros sobre práticas de cuidados afrodescendentes e indígenas

Actuación de los enfermeros en prácticas de cuidados afro descendientes e indígenas

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ABSTRACT

Objective: to analyze the performance of nurses from the *Estratégia Saúde da Família* (Family Health Strategy) on health care practices rooted in African and Indigenous cultures. **Methods:** Thematic Oral History was used and interviews were conducted with seven participants, who worked with Primary Health Care in Northeastern Brazil. The analysis was based on Leininger's Theory of Cultural Care and the intercultural concept of human rights, among others. **Results**: nurses are unaware of the religious and historical context of the ethnic groups cared for and do not appreciate their self-care practices in areas with a predominance of African and indigenous cultures. These practices coexist with the hegemonic biomedical model. **Conclusion:** the debate on cultural competence in the context of professional qualification and exercise is required, aiming to promote the nursing work in the perspective of diversity and comprehensiveness of health care.
Descriptors: Nursing; Community Health; Cultural Diversity; Ethnic Groups; Care.

RESUMO

Objetivo: analisar a atuação de enfermeiros da Estratégia Saúde da Família em relação às práticas de cuidados, cujas raízes têm origem nas culturas africana e indígena. **Método:** utilizou-se o método da História Oral Temática, em que se entrevistaram sete colaboradores atuantes na Atenção Básica de uma região do nordeste brasileiro. A análise foi fundamentada pela Teoria do Cuidado Cultural, de Leininger, concepção intercultural dos direitos humanos e outras. **Resultados:** os enfermeiros desconhecem o contexto histórico religioso dos grupos étnicos assistidos e desvalorizam suas práticas de autocuidado em territórios com predominância de culturas afro-indígenas. Essas práticas coexistem com o modelo biomédico, ainda hegemônico. **Conclusão:** faz-se necessário ampliar a discussão sobre competência cultural no âmbito da formação e exercício profissional, de modo a promover o trabalho de enfermagem na perspectiva da diversidade e da integralidade do cuidado em saúde.
Descritores: Enfermagem; Saúde Comunitária; Diversidade Cultural; Grupos Étnicos; Cuidado.

RESUMEN

Objetivo: Analizar la actuación de enfermeros de la Estrategia Salud de la Familia con relación a las prácticas de cuidados cuyas raíces se originan en las culturas africana e indígena. **Método:** Se utilizó el método de la Historia Oral Temática y se entrevistaron siete colaboradores actuantes en la Atención Básica de una región del noreste brasilero. El análisis se fundamentó en la Teoría de los Cuidados Culturales de Leininger, concepción intercultural de los derechos humanos, y otras. **Resultado:** Los enfermeros desconocen el contexto histórico religioso de los grupos étnicos atendidos y desvalorizan sus prácticas de auto cuidado en territorios con predominancia de culturas afro-indígenas. Dichas prácticas coexisten con el modelo biomédico, aunque de manera hegemónica. **Consideraciones Finales:** Es necesario ampliar la discusión sobre la competencia cultural en el ámbito de la formación y el ejercicio profesional para promover el trabajo de enfermería según la perspectiva de la diversidad y de la integridad en el cuidado de la salud.
Descriptores: Enfermería; Salud Comunitaria; Diversidad Cultural; Grupos Étnicos; Cuidado.

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INTRODUCTION

In the city of Conde, in the Northeastern region of the state of Paraíba, in Northeastern Brazil, there are native groups which are predominantly indigenous and of African descent. Currently, there are 14,766 African descendants, distributed in the following rural areas: Mituaçu, Ipiranga and Gurugi[1]. These communities originated from the 250 black families that either escaped from or were emancipated in the slave quarters of the states of Pernambuco, Sergipe and Alagoas, during the time of the Brazilian Monarchy. Only in 2005 and 2006 were these communities recognized as *quilombola* (communities of former slaves) areas, receiving the *Certificado de Comunidade Quilombola* (Quilombola Community Certificate) from the *Fundação Cultural Palmares* (Palmares Cultural Foundation), which is associated with the Brazilian Ministry of Culture[2].

With regard to the indigenous group in this city, since the 16th century, history shows that there have been fights among indigenous people and white Portuguese, French and Dutch, who battled to conquer the coast of Northeastern Brazil. From 1585 onwards, the Tabajara and Potiguara tribes lived in the territories of Conde, Alhandra, Caaporã and Pitimbu, located between the state of Pernambuco (PE) and the city of João Pessoa, the capital of the state of Paraíba (PB), an area geographically known as the Southern Coast[3]. After a disagreement and division, the Potiguara migrated to the Northern Coast and settled in the cities of Bahia da Traição and Marcação. However, the Tabajara remained in Conde, PB.

In the health care network of the city of Conde, place of study, there are 6,356 registered families followed by nine family health teams, 100% covered by the Primary Health Care system[4]. These families live off fishing in the ocean, hunting, subsistence agriculture, and fruit picking and selling. Moreover, as sources of income, they sell handicrafts, foods and beverages in shacks on the local beaches and receive *Bolsa Família* (Family Allowance) program benefits and Social Security pensions.

With regard to religion, according to the 2010 Demographic Census, there were Catholics (68%), Evangelicals (22%), Spiritists (2%) and 8% without a religion[1]. Data show a religious diversity, although there is intolerance, which threatens the right to freedom of awareness and belief, guaranteed by Brazilian law. In the universe of wide expression of beliefs in this region, the sect of Evangelicals known as Neo-Charismatic believers stands out with their sessions aimed at healing the sick by placing hands over their heads to either bless them or cast out evil spirits, who shout, cry, dance, jump and spin in ecstasy[3].

It should be emphasized that similar expressions are also viewed in healing rituals in the African-Brazilian religious system, suggesting that ancient traditions blend together and are revealed in the diverse modern religious context. There is a close connection between the ritual healing practices of Catholic folk healers, Catholic and Evangelical authorities (priests and pastors), Spiritists and Jurema cult followers. These are partly similar to complementary integrative therapies in health developed by science professionals.

Religious practices promote community health and have a positive effect on social inclusion and the recognition of religious expressions in the affirmation of life. January 21st was the date defined as the National Day of Fight Against Religious Intolerance, in accordance with Federal Law 11.635/2007[5]. However, associated with normative resources, it is necessary to break away from secular customs that reveal religious and racial prejudice, as they demonize certain forms of representation of beliefs, especially those that involve care through the use of religious symbols and rituals, such as *banho de descarrego* (baths with herbs aimed at removing evil spirits and bad energy), hand healing to remove evil spirits, prayers, faith healing with herbs and prayers, sermons, *passes* (hand healing), homemade teas, *garrafadas* (plant root-based beverages) and poultices.

Currently, health care practices must consider cultural diversity as a key aspect, as they incorporate different senses and meanings. However, intolerance and discrimination arise when unorthodox practices are performed in a world of scientific knowledge.

Religiously speaking, African descendants have been discriminated because of their skin color and excluded socially, especially black women. These women, in terms of gender and class intersection, are more vulnerable to endanger their personal identity, body image, self-concept and their health in general. The discrimination of native practices is clear and they are disqualified when compared to official practices. African descendants, apart from other distinct groups in Brazil, require care that also includes the subjective spiritual dimension.

In 2002, spirituality became a key concept for the World Health Organization (WHO), where the domains of physical, psychosocial and spiritual well-being began to guide the technical-scientific production of areas of knowledge comprising sciences and of health in particular. Nurse and philosopher Wanda de Aguiar Horta (1926-1981) recognized spirituality as a basic human need in the 1960s, something essential to achieve quality of life, which is to be cared for by nurses in the health plan of patients[6].

Thus, cultivating the roots of historical formation evident in the ethnic diversity of individuals is believed to be the safest way to guarantee affirmation of identity, autonomy of individuals and the overcoming of cultural conflicts. Cultural values must be respected, especially religious ones, in view of the variety of expressions of beliefs in a country as large as Brazil.

Home self-care practices from the traditions of ethnic groups are indissoluble aspects of ways of life, cosmovisions and systems of values and meanings from local cultures[7]. These aspects are in agreement with the National Policy on Primary Health Care, as it adopts the view of human beings contextualized with their demographic, epidemiological, social, economic, political and cultural conditions, with increasingly guided and efficient health actions[8].

Apart from technical competence, health professionals are required to appreciate cultures, as they consider the differences in ways of being and action of the user populations to understand their values, beliefs and customs related to health. Thus, there is the possibility of health care practices, regarded as scientific, to be integrated with those guided by cosmovisions comprising the complex human existence.

Acknowledging that tradition supports healing and care practices founded on secular African-indigenous beliefs in the

city of Conde-PB; considering the display of discrimination against native care practices; considering the implementation of Family Health services for nearly two decades as an expression of official medicine; and recognizing the paradigm change in health care that presupposes acknowledging the singularity of others in the perspective of diversity as something that integrates people's cultures and promotes peace; the following question is raised: How do nurses deal with the context of cultural diversity of ethnic groups and their spiritual roots when providing care in the primary health care system? Thus, the present study aimed to analyze the performance of nurses from the Family Health Strategy on care practices rooted in African and indigenous cultures.

The relevance of this study lies in recognizing and learning about the universe of health care practices based on knowledge from indigenous and African cultures in a more consistent way, as these groups are considered to have the knowledge required to increase the debate about comprehensive care and the deconstruction of discriminations against traditional self-care practices revealed by professionals who work in primary health care services.

METHODS

Ethical aspects

The present study was approved by the Research Ethics Committee of the Health Sciences Center – CEP/CCS of the Federal University of Paraíba (UFPB) under Protocol number 0010/12, aimed at guaranteeing the ethical aspects.

Theoretical-methodological framework

Thematic Oral History, one of the types of oral History, proposed by José Carlos Sebe Bom Meihy, was used to provide theoretical-methodological support. Thematic oral history begins with a specific topic and the objectivity is direct. The peculiarities of the personal history of those who narrate it are only of interest in the sense that aspects which may be useful for the central thematic information are identified[9]. This path favors interviews with criteria to approach the theme.

Type of study

A descriptive exploratory study was performed using a qualitative approach.

Methodological procedures

Interviews with study participants were recorded after the present study was authorized by the Research Ethics Committee and the Informed Consent Form was signed in the respective workplaces. Interviews were previously scheduled by both parties after discussions about the research project. These discussions followed a guiding question as cut-off point: *Talk about situations with your users when you valued health care practices rooted in indigenous and African spiritual traditions.*

The place of study was the city of Conde-PB, in Northeastern Brazil, given the historical-cultural peculiarity of its African-indigenous ethnicity, the ideal location to investigate health care and its relationship with traditional types of knowledge. It is situated in the northeast region of the state of Paraíba and in the southern coast, 22 kilometers far from the capital city of João Pessoa. The 2010 Demographic Census recorded 21,400 inhabitants, of which 56% are mixed (black and white); 29%, white; 13%, black; and 2%, indigenous and Asian descendants.[1] Including the mixed and Black indices, there is a total of 69% of African descendants, who stand out due to their mystical self-care practices connected to nature and their customs, which remain in their language, clothing, beliefs, songs and dances mainly.

Data originated from the participation of seven individuals (sample) from the –sample comprised of 12 nurses, selected according to the following inclusion criteria: to be a nurse, to work for the Family Health Strategy in the city of Conde-PB, and to accept to participate in this research project. These professionals were selected because of their bond with users. A key informer was established and the others were selected according to her recommendations.

Data collection was conducted between August and October 2012, maintaining participants' anonymity, as all of them were females. Participants were identified by names of flowers. During data organization, the following stages were considered: interview, transcription, textualization and transcreation, which comprise the Thematic Oral History method.

Analysis of the empirical material – comprised of narratives – followed the study objective and methods to identify the main themes discussed in the light of the Theory of Cultural Care Diversity and Universality (TCCDU) developed by Madeleine Leininger (1925-2012). It recognizes that cultural factors influence the health-disease process and, as a tool, it strengthens the planning of actions and decisions in nursing care. Additionally, Boaventura de Sousa Santos' intercultural concept of human rights was used as it includes the diversities and differences between cultures. It does not seek equality among groups, but it recognizes inequalities among cultures to understand and preserve them. Moreover, this study was also founded on other Primary Health Care theories.

The analysis showed participants' approach towards health practices of an ethnic nature and the values attributed to users' knowledge. Thus, the main themes were developed: 1) (Lack of) knowledge about cultural practices of indigenous and African-descent origins; and 2) (Lack of) knowledge about health care practices of indigenous and African-descent origins, described as follows.

RESULTS

(Lack of) knowledge about cultural practices of indigenous and African-Brazilian origins

This theme reveals excerpts of narratives from *Daisy, Tulip, Dahlia, Jasmine* and *Orchid*, which show that, among participants, affirmations are divided into being aware/unaware of the use of traditional health care practices by users from that region.

I don't know any religious practices of indigenous or African-Brazilian origins used by families searching for health care. Indians here are very weird [...]. I visited one of their

homes, there was a young pregnant woman and I was welcomed [...]. Here in this area, according to the Health Agent, there are some faith healers who are sought by the community to pray for children and a lay midwife, who is already very old. (Daisy)

It is known that some elderly people use herbal teas, hand healing and prayers with herbs. During consultations, they keep quiet. (Dahlia)

In the group cared for by the CAPS [Psychosocial Care Center], *I don't know anybody who believes and/or uses spiritual practices of indigenous and African-Brazilian origins.* (Tulip)

I know that some people use teas, "garrafadas", healing baths, "passes", holy water, prayers and other rituals to be healthy. However, I can see that some refuse medication, especially those of continuous use, when they follow these practices. This becomes a problem. Some believe that they'll be healed by spirits or shamans. (Jasmine)

In this region, there are some faith healers and witch doctors. [...] I have a client who goes to the Alhandra Spiritist Center, which is nearby. There, the medium receives the spirit of Father Inácio, a slave from Bahia, and even prescribes medication. [...] Here, close to Jacumã, there's a Spiritist Center called Chico Xavier, many go there too. (Orchid)

Participants informed about the existence of individuals who work in the traditional world of healing and care. There are faith healers, midwives, spiritists who use hand healing, mediums and *umbandistas* (followers of a Brazilian religion that blends African traditions with Catholicism, Spiritism and indigenous beliefs). Moreover, they emphasized the use of medicinal plants by elderly individuals, prayers with herbs and healing baths. However, the majority of participants, not having a connection with African and indigenous cultures, affirm that they are unaware of health care and healing practices derived from the ethnic groups previously mentioned. The expression "*I'm not aware*" stood out in the reports.

(Lack of) appreciation of care practices of indigenous and African-Brazilian origins

The second theme shows the narratives of Magnolia, Jasmine, Orchid and Rose disqualifying health care practices originated from indigenous and African traditions.

About spiritual or religious practices of indigenous and African-Brazilian origins, I understand and respect them, but I don't value those from the "Quilombola" groups found in this town. Although there are no experiences with such practices in my area. (Magnolia)

I don't value these beliefs or their practices. (Jasmine)

There, [Alhandra Spiritist Center], *the medium receives the spirit of Father Inácio, a slave from Bahia, and even prescribes medication. Sometimes, she* [the medium] *shows the prescription and I keep quiet. What can I do? Personally, I don't agree. She finds a car and when the car is full of*

people, they go to have a consultation with this Mr. Inácio. I've heard he died recently, but has been replaced. (Orchid)

I don't value African-Brazilian practices. (Rose)

However, I'm aware that we should respect and value all types of beliefs, such as Camdomblé, Spiritism and others. (Tulip)

I don't value them because I'm not aware of the use of indigenous and African-Brazilian practices by these families. But some elderly individuals are known to use herbs, hand healing and prayers with herbs. During consultations, they keep quiet. (Dahlia)

The majority of nurses prefer not to value traditional healing practices rooted in indigenous and African knowledge. The following expressions stand out: "*I don't value*" and "*I disagree*".

DISCUSSION

The results in the main themes previously described will be discussed in the light of Leininger's Theory; Boaventura de Sousa Santos' intercultural concept of human rights; and other theories, aiming to qualify the work of nurses.

The positions that revealed lack of knowledge about and no appreciation for ethnic culture expressions hinder certain ways to provide health care in the perspective of comprehensiveness, in view of nurses' detachment from complementary health resources, assumptions from the Statute of Racial Equality and the recommendations from the National Policy on Integrative and Complementary Practices, in accordance with Decrees number 971/2006 and number 1.600/2006.

Health care management in the family context is the responsibility of Primary Care professionals, whose privileged participants are family members, friends and neighbors. This management seeks to meet the unique needs of each individual in different moments of their life, aimed at their well-being, safety and autonomy to live a productive and happy life[10]. In this particular region, relationships are intertwined, so that different types of self-care and manifestations of support are founded on knowledge from local traditions, even before seeking the nearest health services.

By reviewing Canguilhem's (1904-1995) "The Normal and the Pathological", "the ways to live life" are emphasized, an expression that became well known as it deals with the singularities of individuals[11]. Therefore, it corroborates the need to consider individuals and their cultural expressions that characterize their way of life. In practice, it requires the indispensable appreciation of the subjective processes of those cared for.

Participants' lack of knowledge about practices rooted in African and indigenous traditions practiced by Unified Health System (SUS) users goes against the preservation of native knowledge and loss of ethnic characterization of native groups. Traditional practices are recognized and protected by the State as a historical-cultural heritage, in accordance with Articles 215 and 216 from the Federal Constitution of 1988[12]. It should be emphasized that Tabajaras descendants use natural products and interact with nature in a relevant and

meaningful way, as well as the population of African descent who inherited the use of medicinal plants[3,13].

Moreover, this lack of knowledge reveals the predominance of the biomedical model, founded on scientific knowledge to the detriment of cultural competence, so that health production associated with questions of ethnic diversity is recognized. Thus, to be unaware of users' own knowledge implies the creation of an obstacle to the dialogue between health professionals and users, resulting in therapeutic failure.

It should be emphasized that nurses work in the area of traditions of ethnic origins, but demonstrate lack of knowledge about the TCCDU. This considers the view of the world of individuals and social and cultural structures to influence one's health condition, well-being or disease[14]. This theory was found to be relevant with the culture of ethnic groups. Nursing should work according to their principles and consider the regional diversity of social and cultural contexts in Brazil, a fact that generates different responses to the health care needs, meanings and expectations of users. It can be assumed that participants' qualification did not involve this concept.

Health care practices rooted in African and indigenous traditions are neither accepted nor valued by participants. Expressions such as "I don't appreciate it", "I disagree" and "I keep quiet" point out that there is no space for dialogue between health professionals and users during therapeutic meetings. *Dahlia* informed that elderly individuals used teas as self-care practice and that "they keep quiet" during consultations, thus affecting the universe of values of those seeking care and rendering it ineffective.

Authors showed that the use of ethnic therapeutic resources cannot be ignored as part of the micro-space of family, friends and neighbors, where the family dimension of health care management takes place[8,10,13-14].

It could be noted that there are two systems aimed at health that are not in agreement. *Orchid* pointed to health care actions performed by male and female priests from African traditions, mediums, faith healers and others that coexist with the hegemonic technical-scientific/biomedical model. These (re)produced positions show that participants received their qualification supported by the dominant class, legitimized by the standard scientific knowledge and in view of their lack of awareness of users' culture.

Throughout history, this secularly dominating qualification recreates and transmits truths that disqualify indigenous and African rituals, demonized since the time of discovery of Brazil, as described in the work of historian Laura de Mello e Souza entitled "The Devil and the Land of Santa Cruz: Popular Religiosity and Witchcraft in Brazil during Colonial Times"[15]. The reports given by *Orchid* and *Rose* increase the fear that breeds intolerance and hinder health care, contrary to the perspective of comprehensiveness and cultural diversity.

It is worth mentioning Portuguese thinker Boaventura de Sousa Santos with his intercultural concept of human rights and dialogue about exchange of knowledge. In a globalized world, against cultural universality, intercultural discussions should be proposed, the reason being: "Not all equalities are identical and not all differences are unequal"[16]. This corroborates Spanish thinker Raimon Panikkar's (1918–2010) view on the intercultural dialogical nature of diatopic hermeneutics, which seeks to raise the awareness of mutual incompleteness through dialogue. Moreover, this is associated with Segato's thoughts on aspects of tension between culture and human rights[17].

With regard to health and diversity, it is impossible to think about humanity without beliefs and religions, as it is to consider medicine and therapies from diverse societies without a fetishist and magical-religious background[7-13]. Every therapeutic system is an indissoluble part of society's cultural repertoire, as integral parts of culture, being influenced by it and vice-versa. Following the biomedical model, folk knowledge about health remains alive in the routine of the population. This is because homemade preventive and therapeutic measures aim to seek or maintain a level of well-being close to that regarded as ideal. These practices are, in general, performed in the family context and almost always passed on from generation to generation.

Differences in cultural diversities of a religious, educational, ethnic, gender, age, social class, standard of beauty, somatic and regional nature, among others, allocate modern health systems in view of the pluralistic multi-faceted universe that requires distinct attentions and perspectives. For this reason, local health interventions, projects and programs must also be diversified[13]. However, in practice, differences, inequalities and social inequities found in society must not be ignored.

The WHO acknowledges traditional health care practices that seek health as an indigenous and native heritage from diverse cultures. The term "traditional medicine" is used by the WHO to refer to health practices, approaches, knowledge and beliefs that incorporate mineral, animal and plant-based medications, spiritual therapies, and techniques performed by hand, used for both the diagnosis and cure of several illnesses[18]. Thus, prayers and healing rituals that involve dance and plant use derive from the cultural flow between African descendants (*Candomble/Umbanda*), indigenous people (traditional healing rituals) and Europeans (Catholicism).

These practices, present since the colonial period in Brazil, have a symbolic efficacy, are a part of the cultural traditions and collective memory, go beyond the provision of health services, and are regarded as immaterial heritage. However, with the development of biological, human and social sciences – for nearly 100 years in Brazil –old shamans, faith healers, fortune tellers and others were certainly forced to give way to systematized knowledge that allowed the appearance of nurses, physicians, psychologists, sociologists, educators and other professionals.

It should be emphasized that the intention is not to deny either scientific knowledge or its importance in human development, but rather to warn that science is not the only truth that regulates human life in society. Additionally, purity of knowledge cannot be praised to the point of making them exclusive among therapeutic processes. In other words, health cannot be reduced to the field of knowledge. Instead, it should be promoted through the interrelationship between scientific and folk knowledge, which involve human beings in their historical context and culture. Thus, the relevance of nurses understanding the confluence of different types of scientific knowledge, among other processes.

The Statute of Racial Equality (Law 12.288/2010), Article 8, defined the foundation of the Policy on Comprehensive

Health for the Black Population: to promote comprehensive health for the black population, prioritizing the reduction in ethnic inequalities and fight against discrimination in SUS institutions and services; to improve the quality of information systems during data collection, processing and analysis by color, ethnicity and gender; to support studies on racism and health; to include this theme in the qualification and continuing education in health; to include this in the political formation of leaderships of social movements for the exercise of social control and participation in the SUS[19].

These foundations pose challenges for health care management; however, trans-religious spirituality can be viewed as a therapeutic resource to promote community health, as it reverberates in social relations and the improvement of health and life conditions of individuals. This possibility stands out on behalf of beings capable of rising to fulfill their human potential with dignity, promoting the deconstruction of discrimination which is still found in health services and, as described here, in regions included in the Primary Care System.

The social role of nurses in the context of primary care is to deal with victims of discrimination, including ethnic discrimination; situations of hopelessness; chemical dependency; aging; fear resulting from domestic violence; abandonment; loneliness; depression; death and even existential and diffuse suffering, which leads to frequent somatic complaints in health services. These situations require individuals to be better received and cared for, including spiritually, aiming to strengthen the flow of vital energy.

Viktor Frankl (1905-1997) states that the well-being conditions of individuals are associated with interpersonal relations, traditions, artistic productions and fair work. It reveals the possibilities of bringing meaning to life, preventing lack of meaning in life, with the care provided by the spiritual dimension as one of human needs[6-20]. Spirituality represents a dimension of human beings that is neither necessarily the monopoly of religions nor predefined spiritual paths. It is revealed through an individual's capacity of self-determination, ethics and truth; the relationship between me-you (nurse/client); and the establishment of dialogue with oneself and All/Oneness/Nature[20]. It is translated through love, sensibility or cultural competence, compassion, listening to others in a transcending way, responsibility and care as an essential attitude.

In these terms, the production of health requires planned actions, execution and continuous assessment aimed at promoting the potentialities of individuals and their professional capacity for this theme. It is in agreement with WHO recommendations when defining principles that guide health promotion: holistic concept, intersectorality, empowerment, social participation, equality, multi-strategic and sustainable actions. The provision of health practices in the SUS network can promote spiritual education and ethnic equality.

Integrative and complementary health practices (massage, sports, yoga, meditation and integrative community therapy, among others) are in agreement with the view of spiritual education and multicultural aspects of human rights. Such care arouses positive emotions that can reduce anxiety, fear, loneliness, aggressiveness and feelings of inferiority, caused by any form of discrimination or not.

These resources increase the universe of health care practices in Primary Care. This is a perspective that acknowledges differences, reduces universalisms created by globalizations and enables the promotion of spiritual education and ethnic equality as humanized care, in agreement with social inclusion and the culture of peace among distinct ethnic groups.

Study limitations

There were limitations to this study in terms of grasping another's thoughts about the historical-cultural context, as this is always partial and vulnerable to the reductionist risk of understanding reality, apart from the representativeness of individual speech compared to the greater collective. It is believed that such reality depends on the meaning attributed to health by the local culture, the qualification of participants and researchers, and the scarce research production on this theme.

Study contributions

The present study contributes to debates on health care that include knowledge in agreement with the cultural diversity of ethnic groups, aiming to support nurses' performance on health practices that go beyond biomedical knowledge. It values nurses' performance, founded on Leininger's Theory, a theoretical construct inherent in Nursing. This study is expected to contribute to the debate on the deconstruction of discrimination in SUS institutions and services; and to the appreciation of the therapeutic dialogue between professionals and users in the perspective of care, in agreement with the logic of social inclusion, comprehensiveness, humanization and the culture of peace.

FINAL CONSIDERATIONS

In this perspective, the position of nurses who participated in the present study shows the ways they are unaware of and not appreciative of traditional cultural practices, thus hindering health care and the logic of comprehensiveness, in addition to causing the historical and religious contexts of practices of ethnic groups in this city, where there is a predominance of African descendants, to become vulnerable. This way of producing health care conflicts with the precepts of Leininger's Theory; Boaventura Santos' intercultural concept of human rights; the Primary Care Policy; the Policy on Comprehensive Care for the Black Population; and the preservation of local culture as an immaterial heritage of priceless value and meaning for locals.

On the other hand, the care provided by nurses and other health professionals is always an action that includes beliefs, values, myths, (pre)conceptions and even discriminations, alienations, unfamiliarity and silences. To discuss this not always friendly relationship is a significant assumption for rights not to be violated, as discrimination prevents the process of receiving and caring for patients in the perspective of comprehensiveness of beings.

Discussions on the following should be developed: transculturality; spirituality; indigenous health; and Policy on Health for the Black Population due to their particularities; among others. Thus, nurses and other health professionals can understand the cultural differences of ethnic groups,

meanings, implications and subjectivity included in the process of caring for human beings, regardless of the group to which it belongs, religion followed and choice for not having a formal religion. It is believed that health care in the perspective of ethnic diversity preserves the local culture, apart from being an essential condition for comprehensive care for individuals-users, as spirituality rather than religion comprises

the alternative of a new civilized paradigm in modern times.

In conclusion, the research objective of this study was met, with the two axes of analysis. We hope that what has been described here can bring new possibilities to provide care; contribute to the interdisciplinary dialogue which is essential for all sciences in modern times, considering the comprehensiveness of being; and enable new studies on this theme to be performed.

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