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ORIGINAL PAPERS

Religiosity and Indigenous Cosmology in a Brazilian Hospital Setting: The Challenges Faced by Health Professionals

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Abstract

This article focuses on the description, discussion, and problematization of the ways indigenous spirituality is presented in a Brazil's hospital, in the context of the treatment of chronic illnesses in children under medical supervision. It describes a short extract from a more wide-ranging study, focusing on the analysis of excerpts of the verbal responses of health professionals, and of two specific cases. Adopting a phenomenological approach, the vicissitudes of the hospitalization of indigenous children are described from the perspectives of the professionals, with an emphasis on the outcomes of the reported cases, which are riddled with impasses and challenges, with important implications for the country's health policy and for the training of health professionals. Grounded on the cosmological explications for the illness, the indigenous child's family members tend to resort to *pajelança*, (indigenous traditional healing rituals), even within the hospital environment, with or without the consent of the medical team. This process does not always end harmoniously or in an integrated fashion, evidencing the rifts in the interaction between indigenous curing practices, underpinned by thousands of years of tradition, and medical practices grounded on formal, rational, and scientific understanding. We conclude by indicating perspectives for professional training and the respective ethical considerations.

Keywords Religiosity · Humanization of care · Health of indigenous populations · Professional training · Religious support in hospitals

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Introduction

Rituals, pyres, cheroots, dancing, chanting, shouting and prayers are ways to experience health—and also to deal with its maladies, including chronic illness—among the indigenous peoples of northern Brazil. It so happens that these significant forms of cosmological expression are not integrated into the medical and hospital models. After all, these models originated and have developed within the context of a "white, civilized" culture (Vukic et al. 2011), in which illness is conceived from a biological perspective. On the other hand, among the indigenous population, in the beginning, it was not their practice to resort to scientific medicine. It was contact with white people and civilised society that changed the epidemiological picture for indigenous Brazilians, with the introduction of new illnesses, often impossible to cure using native therapy (Andrade and Sousa 2016; King and Trimble 2013; Kopenawa and Albert 2015; Melatti 1987). This is the backdrop to encounters between health professionals and indigenous communities with complex narratives emerging and a certain tension between the two perspectives, that is, biomedicine and indigenous medicine, in the way they perceive health and illness.

In Brazil, despite the best efforts made in recent decades to expand public health policy and make it more compatible with the ethnic, social, and cultural diversity in the country (Brasil 1991, 2002, 2016), the hospital system is still verticalized; in other words, it is founded on concepts of health and illness tied to biomedical and organicist models (Cardoso 2014; Wayhs et al. 2019). This situation can create disagreement and conflict when indigenous people need to be admitted to hospital or receive services provided by the state's formal health system, particularly in hospitals (Rodrigues 2017; Silva 2013). In cases of chronic illness, which generally require extended periods of hospital treatment, the presence of an indigenous individual in the hospital can generate even bigger challenges. Needing more care and supervision, this also results in greater contact, interaction, and/or possible friction between the two paradigms: the cosmology of indigenous peoples and biomedical science. This leads to big challenges for the various professionals working in the hospital setting: doctors, psychologists, nurses, social welfare assistants, and also for those voluntarily providing pastoral care. Likewise, for the indigenous peoples, the challenges are clearly no less complex, whether it be due to language limitations, restrictions in the environment or the ways the illness are perceived and treated by the health professionals, so very different from those which characterise their own traditions.

Hence, the need to develop more studies into religiosity, indigenous cosmology, and their relationship with health is to produce supporting data that underpin specific guidance for the training and work of professionals in this field. This study aims to make a contribution to this effort. However, the main aim is to describe and analyse the perceptions and ways that health professionals (doctors, nurses, social welfare assistants, and psychologists) in hospitals have dealt with manifestations of indigenous spirituality and religiosity in the context of treatment of chronic illness in children admitted to hospital and under medical supervision. The

article begins with a theoretical introduction in which the initial topic addresses the relationship between indigenous cosmology and the medical model and their conceptions of health, illness, and chronicity. It will then put into context the contemporary reality in Brazil, presenting demographic data, indigenous health policy, and its operationalisation, especially in hospitals, and in the care of children with chronic illnesses. Thirdly, it will discuss the concept of spirituality and its relationship with religiosity, religion, and, primarily, indigenous cosmology, with a clear explanation of the phenomenological option adopted in this study.

The methodology employed in this study will then be described, followed by a presentation of five vignettes and two cases. The vignettes illustrate perceptions and experiences of health professionals treating hospitalized, indigenous children suffering from chronic illnesses, situated in the northern region of Brazil, with regard to the relationship between spirituality and indigenous health. As far as the two cases are concerned, these illustrate real-life situations which these professionals deal with on a daily basis in this context. Lastly, the discussion addresses the implications for the modes of caring for indigenous individuals within hospitals, for the country's policy on indigenous health, and the training of health professionals. Concrete perspectives and guidelines are suggested for its improvement, particularly with regard to the role of psychology, spiritual guidance, and the respective involvement of *pajés*[1] or shamans.

Health, Illness, and Chronicity for Indigenous and Non-indigenous People: The Anthropological, Practical, and Ethical Implications

In contemporary Western culture, medicine, religion, and magic are conceived as completely separate, mutually exclusive, and epistemological worlds. This tripartite conception tends to assume that it falls to the first medicine, the primacy of healthcare, underpinned by scientific understanding in the areas of biology, pharmacology, and other areas comprising medical knowledge. Given this perspective, religion would be the object of theology and magic of anthropology. From a phenomenological point of view, however, these three classifications are historical, cultural constructions revealing specific ways to organize experiences in the life-world.[2] In the early decades of the last century, Rivers (1864–1922), an English anthropologist, neurologist, ethnologist, psychiatrist, and pioneer in the anthropological approach to health, maintained that a more profound, extensive understanding of the subject leads us to conclude that the supposed separation and radical distinction between medicine, religion, and magic are misleading (Rivers 1927, p. 1). After all, for many peoples, these "three sets of social processes are so closely interrelated that the

[1] Term arising from Amerindian tribal societies, from the *Tupi-Guarani* family of languages, used to designate the individual responsible for conducting magical ritualism, and to whom the tribe attributes shamanistic authority to invoke and control spirits, to make wise use of elements extracted from nature, investing in him the power of mystic, incantatory, prophetic, soothsaying, and curative acts.

[2] Derived from the German word *Lebenswelt.*

disentanglement of each from the rest is difficult or impossible". For many others, "the social processes to which we give the name of Medicine can hardly be said to exist, so closely is man's attitude towards disease identical with that which he adopts towards other classes of natural phenomena" (p. 1). This would appear to be true in the case of the indigenous peoples cared for by the health professionals taking part in this study.

Later on, another medical anthropologist, the American Ackerknecht (1971), regarded as the father of medical anthropology, made a significant contribution to the understanding of health practices as being profoundly related to cultural contexts, and not being confined to that which was conventionally referred to as "medicine" nor its etiological notions being limited to biological and biochemical processes. Along similar lines, Lévy-Strauss (1829–1902) and Evans-Pritchard (1902–1973), the two pioneers, suggested that not just medical culture but also certain indigenous cultures, with their cosmologies rooted in a mystic, spiritualized view of the world, take the etiological notions as the starting point for organizing their interpretation of the processes of health and illness and, as a consequence, the procedures of diagnosis and treatment. As summarized by Langdon (2014, p. 1021), the contribution of both these scholars showed that healthcare among indigenous peoples also follows the logic of causes. Thus, "illnesses originating from magical causes" are "treated with magical therapies", while those deriving from natural causes are "treated with natural therapies". This was corroborated in subsequent studies, although it was also discovered that the therapeutic itinerary among these peoples and the relationship between the causes and treatment of diseases may be more complex, determined by a variety of other factors, beyond the etiological ones.

Along similar lines, Cunha (2007) stresses that what sets apart traditional knowledge, which includes that of the indigenous cultures, from scientific knowledge, whose domain includes medical knowledge, are not exactly the logical operations that underpin them, but rather their different premisses about what exists in the world. So, while medical knowledge is rooted in conceptual units, the knowledge at the heart of the indigenous cosmologies operates with sentient characteristics. In fact, it may be asserted that the conception of health and illness among indigenous peoples in Brazil's northern region, although it takes natural causes into consideration, is not restricted to biological processes verifiable by way of concrete observation, as is the case with biomedicine. To put it another way, "illness is not envisaged as a set of universal physical symptoms that manifest themselves in any context" (Langdon 2005, p. 122). Rather, it is an existential experience full of meaning, demanding a far more complex and comprehensive understanding, capable of moving from the merely conceptual plane to other planes that involve the dimensions of sensitivity, symbolism, and spirituality. In the view of an indigenous person, "the health versus illness process is part of the cosmological order that embraces invisible forces, forces of nature and human forces" and the very "understanding of the illness emerges through therapeutic rituals that attempt to discover the true causes of the suffering" (Langdon 2005, p. 124).

On the other hand, the very conception of body—susceptible to illness—and the conception of the individual—susceptible to suffering as a result of the illness—is, in indigenous people, completely different from non-indigenous individuals in the

Western world. As Langdon points out (2005, p. 125), "for indigenous cultures, the body is socially and spiritually constructed through special diets, rites of passage and other practices that construct the social individual". Thus, it is understandable that, in these cultures, the signs of illness and the causes should also be looked for outside the body itself, and it may be, for example, that the pathology is triggered by the breaking of a taboo, by a social conflict, and so on. Accordingly, the curing process, in harmony with its cosmology, should not only be directed towards the treatment of physical suffering but also, and even more so, towards the care and overcoming of moral and spiritual suffering (Langdon 1988; Andrade and Sousa 2016). In other words, indigenous cosmology is also a factor that is a fundamental part of its own diagnosis and treatment itineraries (Langdon 2014), and this needs to be taken into consideration in the health policies and practices directed towards this population.

Specifically with regard to the notion of the chronicity of a disease (*doença*), Canesqui (2007) suggests it be employed through the biomedical model, to refer to a permanent morbid state, with residual incapacity and causality based on irreversible pathological changes, usually associated with the presence of other comorbidities. This state of chronicity, therefore, imposes limits of an organic nature on patients and of a technical nature on health professionals. However, from a phenomenological standpoint, it is also worth recalling here, as does the author herself, the distinction between illness, as it is defined biomedically (disease) and the experience of falling sick as experienced by the individual himself (illness). In this way, even in the case of chronic sickness (disease), as it is referred to by health professionals, it should be remembered that, for the individual and the indigenous culture, what will continue to be relevant is the subjective, social, and spiritual meaning of suffering experienced by the sick individual and his/her family members. This meaning, as Langdon points out (2014, p. 1027), is "simultaneously: an experience in the life of an individual and his group; a threat to order and good health; a set of references to the environment; and, sometimes, an opportunity to gain access to spiritual realities".

Chronic illnesses in children, from the perspective of scientific medicine, are those which persist for over 3 months, or manifest themselves three or more times within the last year, compromising the characteristics of sociability unique to infancy and limiting their day-to-day activities. Thus, many of them end up needing special support for interaction, communication, and expression, depending on technological life support. This may be accompanied by changes in physical, emotional, developmental, and behavioural states that require the provision of differentiated healthcare (Moreira et al. 2014). The condition of chronicity in a disease, considered by medicine as a manageable condition, but without a cure, is accompanied by continuous, periodic symptoms, interfering enormously, not only in the lives of the sick children but also their families. In this regard, Vukic et al. (2009) and Moreira et al. (2014) warn of the dangers of treating the illness by decontextualizing it from the sick individual. Particularly when it comes to children and growing individuals, it is essential for their monitoring and treatment to consider the broader dimensions of life, with an emphasis on care that includes playing games and assistance from multidisciplinary professionals, family members, and spiritual leaders. In the

case of indigenous children, spiritual care can mean involving the *pajé*. In fact, as in indigenous logic mystic and natural forces may act upon the child and his/her chronic illness, this may require of the hospital unit a receptiveness to a combination of biomedical procedures and shamanic interventions. This would be in line with the understanding that the etiological factors conceived by indigenous cosmology also include mystic causes, and, in this case, only the *pajé* would be capable of acting upon them and curing the illness, which anthropologists generally call symbolic efficacy (Langdon 1988; Lévi-Strauss 1949).

The receptiveness to a possible integration of scientific medical knowledge and the traditional knowledge of indigenous culture results in a recognition that it is from actual people—and their identities and historical, cultural connections—that healthcare conceptions and practices are built (Vukic et al. 2011). To put it another way, the scientific, medical model is also a socio-cultural construction and should not claim supremacy over others in the name of a universal, incontrovertible truth. Recognised as being from this place of sociocultural construction, it will be necessary to accept that "illness is not just a set of universal, physical symptoms observed in an empirical reality, but rather a subjective process in which bodily experience is mediated by culture" (Langdon 2005). In this regard, effective treatment must involve reciprocity that combines elements from different spheres, including biomedicine and pharmacology, but also others deriving from plural knowledge present in specific situations and cultures, like, in this case, the indigenous people (American Psychiatric Association 2000).

Demographics, Epidemiology, Policies, and Indigenous Healthcare in Brazil

In the last census, conducted in 2010 by the IBGE (Brazilian National Institute of Geography and Statistics), the country's indigenous population which was self-declared or considered itself "Indian" was 896,000. In 2020, more up-to-date data should have been available, but, as a result of the COVID-19 pandemic, these data have still not been updated, with the new census forecast to take place in 2022. However, a concern has been reported by the Socio-Environmental Institute (ISA) with regard to the 96% reduction in the IBGE's census funding, which may have a serious impact on public policy related to indigenous peoples, *quilombolas*[3] and traditional tribes in Brazil (ISA 2021). Of the total population announced at the time of the last census in 2010, it was determined that the population was distributed across 305 ethnic groups, speakers of at least 274 languages. The data make Brazil one of the most socio-culturally diverse countries in the world. The population that has self-declared or considers itself indigenous is, for the most part, located in the northern geopolitical region of Brazil (Brasil 2012). Table 1 shows that 572 (63.8%) of indigenous Brazilians live in rural areas, which is very different from the national population as a whole, where the percentage living in urban centres is 84.4%. On the one

[3] Afro-Brazilian residents of *quilombo* settlements first established by escaped slaves in Brazil. They are the descendants of Afro-Brazilian slaves who escaped from slave plantations that existed in Brazil until abolition in 1888.

Table 1 Distribution of the indigenous population in Brazil* (2010 demographic census)

Location of domicile	Indigenous population per domicile situation		
	Total	Urban	Rural
Total	896,917	324,834	572,083
Indigenous lands	517,383	25,963	491,420
Non-indigenous lands	379,534	298,871	80,663

*Reproduced from the Brazilian Institute of Statistic and Gheoghrapy, IBGE (Brasil, 2020)

hand, this reveals the indigenous population's strong attachment to the land. However, it also means that when indigenous people are afflicted with chronic illnesses and require more specific medical supervision, they need to move to urban centres where the hospitals and specialized health services are usually located.

Despite the lack of knowledge about the epidemiological profile of the indigenous peoples in Brazil (Basta et al. 2012), it is known to be particularly unfavourable when compared to the non-indigenous population (Santos et al. 2020) and that the main causes of morbidity and death are non-transmissible chronic diseases (Brasil 2016; Carvalho et al. 2014). Specifically, with regard to chronic illness among children, the narrative is no different (Souza et al. 2018), as indeed is the case in other countries across the world (Chang et al. 2014; Harfield et al. 2018; Torzillo and Chang 2014; Valeggia and Snodgrass 2015). This huge disparity may be related to the precariousness of the basic socioeconomic and nutritional conditions of these people, accompanied by high rates of parasitic infection and obstacles posed by ethnocentric cultures to the continuity of their traditional subsistence models (Gracey and King 2009; Harfield et al. 2018; King et al. 2009; Souza et al. 2018). Similarly, the impasses and challenges identified in the health systems show that this precariousness is not only associated with a lack of implementation of public policies directed towards indigenous peoples in Brazil, but also to the contradictions inherent to them. For example, the indigenous peoples in Brazil enjoy the rights established in the organic law which advocates the universality of healthcare within the national health system (SUS). However, universality does not sustain the principle of equity which establishes special care for people in vulnerable situations as a result of the historical processes of colonialization, violence, and racism. Almeida (2019) describes reflections on racism as being of a structural order in Brazil, intrinsically related to the precarious conditions in which the indigenous peoples live.

As Coimbra Jr et al. (2005) indicated, expounding on the epidemiology and health of indigenous peoples in Brazil, significant changes in the country's health system have taken place since 1999, with the aim of meeting the specific needs of these peoples. Throughout this restructuring process, enormous challenges have been faced in the consolidation of a model that involves hundreds of thousands of users and both government and non-government agencies faced with huge indigenous social diversity and the respective epidemiological profiles. Initially linked to the then National Health Foundation (FUNASA), in 1999, a total of 34 Special

Indigenous Health Districts were created accompanied by the implementation of health centres and basic medical centres[4] in indigenous communities and territories (Cardoso 2014). Three years later, the founding document of the National Healthcare Policy for Indigenous Peoples made clear its legal commitment with the recognition of and respect for the traditional systems typical of these people, as well as the promotion of liaisons between these systems and scientific medicine, at all levels of healthcare provided by the State:

> "With the aim of guaranteeing access to medium-to-high complexity healthcare, procedures should be defined with regard to referrals, counter-referrals and incentives for health units through the provision of differentiated services with influence over the process of recuperation and cure of indigenous patients (such as those relating to food restrictions/prescriptions, monitoring by relatives and/or interpreters, visits by traditional therapists, implementation of networks, among others) when deemed necessary by the users themselves and negotiated with a service provider" (Brasil 2002, p. 15)

From 2010, the country's indigenous peoples started to be cared for under the Unified Health System (SUS), connected to the Ministry of Health, with the creation of a Special Indigenous Health Department (SESAI). SESAI was designed to protect, promote, restore the health of the indigenous peoples, to administer indigenous health, provide guidance on the development of integrated healthcare actions for indigenous peoples and on health education, and to manage the epidemiological profile and health status of each Special Indigenous Health District (DSEI) in accordance with the policies and programs of the SUS. Despite said initiatives, the concept of a differentiated healthcare, according to which the health actions taken in conjunction with the indigenous people should be socio-culturally adapted and take into consideration cosmological, epidemiological, and logistical peculiarities (Cardoso 2014; CONASS 2014; Mota and Nunes 2018), continues to be problematical. The controversy revolves mainly around the process of transculturation accompanied by conflict between the official medical system and the indigenous system of beliefs and healing practices (CONASS 2014), as well as conflicts between the viewpoints of health administrators and the indigenous users themselves (Cardoso 2014).

Specifically, with regard to the care of indigenous children suffering from chronic illness, when admission to hospital is not required, this takes place in their villages using teams of flying doctors from the respective health district. If more complex interventions are deemed necessary, the child will be admitted to a hospital, which could be basic medical centres close to the village or hospitals that are able to provide medium-to-high complexity treatment and which offer more specialized services. These are located in urban centres, most commonly in state capitals, as is the

[4] The basic medical centres (*Pólos-Base*) represent the initial point of contact for the indigenous health agents (AIS) that operate in the villages. They may be located inside an indigenous community or in a referral municipality, in the latter case, corresponding to an existing basic health unit in the town's service network. They are equivalent to the Basic Health Units in the Family Health Strategy and count on the involvement of the Multidisciplinary Indigenous Health Team (EMSI), primarily composed of a doctor, nurse, dentist, and nursing auxiliary.

case to be analysed below. Also in this case, the biggest challenge for professionals lies in the implementation of the integrated care program, a principle enshrined in law and in documents of the country, and supported by the recommendations of the World Health Organization (WHO) (1978, 2002, 2013), which require liaison between the conventional health system and the traditional indigenous system. In a document compiled by the Pan American Health Organization (PAHO) (2018), within the four fronts for achieving universal health within the SUS, the following requirements are recommended: fully accessible and quality health services; effective governance of the health system; adequate and consistent public funding of health amounting to at least 6% of gross domestic product (GDP); and action involving socioenvironmental health determinants. The PAHO identifies the experience of the UK and Italy as pioneers in creating avenues to universal health systems. In neither country have the strategies of sustainability affected the principle of universality. However, it also acknowledges that maintaining integrality, despite it being a central pillar for sustainability, is a very complex issue since, even with the intensive use of regulatory mechanisms, in some cases, there are delays with or restrictions on certain modes of service. In this regard, the abovementioned document recommends the strengthening of regulatory mechanisms based on scientific understanding and on situations of scarce resources and the production of evidence that legitimises actions within the system, drawing attention to the fact that such measures are not just a question of technical choice but that they are a truly ethical imperative.

Spirituality, Religiosity, Religion, and Indigenous Cosmology

Curiously, in the selfsame Western society that demarcated aseptic distinctions between medicine, religion, and magic, the notion of spirituality has resurfaced in recent decades. This has happened as one of the alternatives that may account for what Steil and Toniol (2013, p. 7) labelled a veritable "detachment between empirical reality, as described in the ethnography of practices, institutions, groups and religious experiences, and the concepts of religion, secularization, public and political space, created and defined on the basis of a different social and historical context". It is interesting to observe that, according to their etymological origins, the meanings of the words health and spirituality were very akin to one another (Freitas 2016, p. 4). Thus, as an example, if we take the two words in the Portuguese language, we will see that spirituality (*espiritualidade*) and health (*saúde*) are, respectively, derived from the Latin noun *spiritus*—"breath of life" or "breath" (Teixeira 1999) and the Latin adjective *salus*—"entire", "intact", "full"—or the medieval Latin word *sanus*—"pure, immaculate" or "correct and true" (Rey 1993). There exists a quasi-direct relationship between the two words which may be interpreted as follows: the integrity and condition of being in perfect operation (and hence, correct), linked to the notion of health, would be maintained precisely thanks to an uplifting, vital principle linked to the notion of spirituality. This recalls a number of aphorisms attributed to Hippocrates (460–377 BC), considered as the father of Western medicine, e.g. "There is a common circulation, a common breath. All things are related."; "The natural force within

each of us is the greatest healer of all". Paradoxically, however, at the same time that these aphorisms seem to a large extent to imitate indigenous cosmology, it is known that it was Hippocrates himself that founded the separation between medicine and theurgy, a set of ritualistic, religious practices which sought connections with divinity.

In fact, the reemergence in recent decades of the term spirituality is the result of a crisis that is, at one and the same time, epistemological, ideological, political, cultural, and existential, involving the conception of the term religion and its uses/implications in the life-world, including in the process of colonisation and indigenous acculturation. From an epistemological point of view, since the controversial work of Durkheim (1912/1995) entitled "The Elementary Forms of the Religious Life", a veritable debate has been waged concerning the legitimacy and recognition of the very concept of religion. At the same time that this French sociologist stated that "all religions are true" and not mere phantasmagoria—thereby debunking both the radical discourse in favour of secularism and also the defenders of hegemonic religions—he also reduced religion to a social phenomenon, divesting it of the intrinsic nature of religious experience. In other words, his reference to a divinity transcends humanity. This also aroused fierce criticism from certain pioneers in the psychology of religion, as with Leuba (1913), for instance. In the long run, these and other sociological and anthropological forms of compressing religion, when applied to indigenous cosmologies, at the same time that they ennoble them, in terms of recognition and respect for their cultural identity, they also delegitimise them, framing the spiritual experiences of the indigenous individual in a scientistic discussion, in which the object of his beliefs is reduced to the power of group effervescence (Gray 2005; Groover 2008; Fontão and Pereira 2017). From an ideological, political, and cultural point of view, the fact that no religion is neutral must be taken into consideration, and the more it aspires to the condition of universality, as occurred and is still occurring with the imposition of Christianity on indigenous peoples in Brazil, the more it runs the risk of being unsuited to analysing other cultural accounts (Assis 2019). This happens because, by claiming for itself the conception of oneness, certainty, and irrefutability, a religion assumes an ethnocentric posture that leads to the disqualification of other forms of spiritual expression, which end up being assigned with other names, e.g. mysticism, syncretism, esoterism, animism, *pajelança*, shamanism, and so on and so forth—frequently charged with pejorative, disqualifying connotations that serve to justify the imposition of that which is considered genuine and redeeming (Wolff 2012). The vicissitudes of this process, within a contemporary context, culminate in a veritable dichotomy between religion and spirituality in which the latter is regarded as a cultural, subjective alternative to the former, with the aim of opening oneself up to diverse lifestyles and enabling a connection with different discursive and existentialist traditions. Many scholars, however, prefer to continue using the term religion to refer to indigenous cosmologies—and their spiritual expressions—emphasizing the category of "indigenous religions" as a tradition that is distinct from the hegemonic category of "world religions" (Cox 2016; Harvey 2000).

Reducing indigenous traditions and cosmologies of the precolonial era to hegemonic, scientific, or religious, scientistic or religious discussions, severely affects the ethnic identity of these peoples, preventing it from being passed down to future generations as a basis for their continuous existence as a people, in accordance with their cultural norms, institutions, and legal system. This has serious consequences for the health of the indigenous individual, being associated with depression, alcoholism, and even suicide (Gracey and King 2009; Oliveira and Neto 2003; Santos et al. 2020), even in children (Souza 2019). Now, it is known that the religious manifestations of these peoples have even been forbidden in many countries during the process of colonisation, even in Brazil (Costa and Carvalho 2019; Santos 2014) and the USA (Garroutte et al. 2009). So, since the last century, they have become objects of protection for human rights movements, accompanied by legal justifications, recognition, and formalization in international law (Niezen 2017; Odello 2012). In 2007, the United Nations took a decisive step in this regard when it published its declaration on the rights of indigenous peoples, aiming at protecting the cultural and religious integrity of these peoples and guaranteeing them the right to express, practice, promote, and teach their spiritual and religious traditions and their customs and ceremonies (UN 2007).

In the current work, an effort has been made to avoid any of the reductionism indicated above, thereby adopting a conception of spirituality, religiosity, and religion inspired by phenomenology (Freitas and Vilela 2017; Freitas et al. 2022), by promoting, at one and the same time, a differentiated, integrating, and qualifying interpretation of these three phenomena and their manifestations in human experience, be they that of the health professionals or that of indigenous patients, their family members, or leaders representative of their cosmology. From this standpoint, spirituality is understood in the Husserlian sense, referring to an existential demand for meaning and being directed "exclusively to human beings as persons, to their personal life and activity, as also correlatively to the concrete results of this activity". And, as Husserl states (1936/1965, p. 150): "Here the word "live" is not to be taken in a physiological sense but rather as signifying purposeful living, manifesting spiritual creativity, in its broadest sense, creating culture within historical continuity". Thus, spirituality is situated at the primordial pole of the big questions about life and about existence, often formulated by the common man, but also by religionists, philosophers, and scientists: "where did we come from?", "where are we and what are we doing here?", and "where are we going to?".

It is the case that, to understand spirituality effectively, it will also be necessary to understand its affinity for figures that execute it. In this way, belief in a dimension that is transcendental, sacred, creating, infinite, final, or beyond human has been framed in a form of response that accompanies humanity, historically and geographically, in all known cultures. The term religiosity has been applied to this way of responding to the demand for meaning, which may or may not be collectively shared, as occurs with religion. Of course, answers to the big questions about meaning may be sought in a number of other ways, whether by contact with nature or through art or even through philosophical constructs or scientific activity. However, for the vast majority of the Brazilian population (Brasil 2012), they take the form of an affiliation to a religion. When these ways to find answers through religiosity are

shared collectively, in an institutionalized fashion or by forming a hierarchical social body, or even by characterising the cultural identity of a people, as is the case with the indigenous population, the concept of religion is applied. Thus, for religious people, religiosity and religion are made up of figures which expedite the search for connectivity to the response prompted by the demand for meaning, typical of spirituality.

Study Methodology

The empirical data presented in this article were collected within the scope of a more comprehensive study,[5] coordinated nationally by the first-named author and regionally by the second-named author,[6] having been previously submitted to and approved by the Research Ethics Committee at the Catholic University of Brasília and by the Departments of Health in the states where the study took place. Following the respective approvals, the hospital institutions were contacted with a view to obtaining authorization to conduct interviews with the health professionals: psychologists, doctors, nurses, and social welfare assistants. Participation in the study was voluntary. Each interviewee signed a free and informed consent form prior to taking part, with the researchers promising to maintain the confidentiality and privacy of the information provided. Accordingly, throughout the accounts presented below, any information, which could lead to the identification of the professionals or the institutions from which the data analysed in this article were collected, has been suppressed. Twenty-one professionals were interviewed in one hospital unit in the northern region of Brazil. Several extracts from the interviewees' verbal responses concerning the religiosity/spirituality of the indigenous patients have been reproduced in "Experiences, Perceptions, and Cases Reported by Professionals" section, including vignettes from a nurse, a doctor, a social welfare assistant, and a psychologist, followed by a report of two more detailed cases, accompanied by a psychologist from the aforementioned unit.

The scope of the study, as originally planned, included the relationship between religiosity, spirituality, and health in a more general fashion, while the interviews with the professionals sought to investigate if and how issues of a spiritual and/or religious nature are communicated by patients within the hospital setting, such as the following: their perceptions and experiences of the relationship between religiosity/spirituality (R/S) and health; what they believe to be good and bad professional practices in terms of managing this binary within the scope of hospital clinical care; what role does their own religiosity play in this process and the extent to which the topic was dealt with in their training, if at all. These topics were the core themes of

[5] Research coordinated by Freitas and Vilela (2017), funded by the National Council of Development in Science and Technology (CNPq) and the Ministry of Science, Technology, Innovation and Communications (MCTIC), through the Spontaneous Demand Announcement, 2013.

[6] Sub-project "*Religiosidade e espiritualidade no contexto hospitalar em Tocantins: percepções e experiências de equipes multiprofissionais em saúde*" (religiosity and spirituality in a hospital setting in Tocantins state: perceptions and experiences of multi-professional health teams) (Freitas and Vilela 2017).

the in-depth, semi-structured interviews conducted within the interviewees' working environment.

The interviews were conducted according to a phenomenological approach, aiming to create a climate of spontaneity and empathy with the interviewee, in order to capture their experiences in an authentic way (Amatuzzi 2012). They were all recorded, transcribed and revised, going on to become part of a database in the research laboratory with which the authors are affiliated. In some hospital units, particularly those located in the northern region of the country, it was the case that several professionals, when talking about their perceptions and experiences, spontaneously raised issues relating to indigenous religiosity, demonstrating how engaged they are in regard to this subject. Accordingly, based on a phenomenological interpretation of the interviews, extracts were collated of the professionals relating their experiences, perceptions, and concerns regarding the treatment of indigenous individuals, more specifically with regard to their cosmologies and to the way they are manifested in the setting of hospitalized children accompanied by their family and other members of the tribe and even their religious leaders. Responses were selected that were the most representative and paradigmatic for the purposes of this article. They are reproduced in full in "Vignettes Reproduced from the Spoken Words of the Health Professionals Interviewed" section, followed by a more detailed description of two cases, in "Report of two specific cases" section, gathered from one of the psychologists who participated in the study and who closely monitored them.

Experiences, Perceptions, and Cases Reported by Professionals

Vignettes Reproduced from the Spoken Words of the Health Professionals Interviewed

> [...]... on several occasions the indigenous culture has interfered with our culture, with our... with our treatment. There was one case that was particularly glaring. (...) was the case of a condition that required surgery, an illness in which, according to the literature, 100% of children who did not undergo the surgery and did not have a transplant ending up dying. There was no other solution available, the diagnosis was already confirmed, the child needed surgery and the family refused it, and we managed to persuade the family etc., you know? With the help of a psychologist, with the entire multidisciplinary team. To get the approval of the medicine man, you know? "Of the" tribe's religious leader, to see if he would help, for us to perform the necessary treatment, otherwise there was a 100% chance of death. The *pajé* was also against it and according to the special laws for the Indians and so on, as the family were against it, they had the right to decide, you know? We went to court and so on but they were granted the right to refuse the procedure. So, the child spent a few more months at home, they wanted to go home, they didn't want to do the surgery. They went home. Afterwards, the child came back to hospital and three days later he passed away (...) from liver failure. (Doctor)

We have problems with this indigenous issue you know, they've got their beliefs, they already built a pyre, they wanted to go to another hospital so they could prepare a pyre inside the emergency room (she laughs). Yes, to tell the truth, I wasn't on duty, it was the day after and there was this Indian, he was there in the emergency room, he was serious and here comes the *pajé* and he needed to prepare a pyre because he had to perform a ritual to save the child, all of that stuff, they told me that he gave them a lot of trouble until he was allowed to prepare the pyre outside the hospital building. And he did! (Nurse)

There was this case of an indigenous girl, because they worship their God, don't they? We had this case where the child died because the mother did not allow the doctor to perform surgery. (...) It was a surgery on the spleen, I think. (...) The child's abdomen was completely swollen. It was damaged. He spent a long period of time here with us. He was admitted to hospital but there was no way the family would approve the surgery. He underwent all the required treatment but without being operated on. The day the child died I was on duty. So, it was down to me to disentangle the whole situation. So, I remember very well what happened - she claimed that, that their God would cure him and we get a lot of indigenous people in here. We find that when the indigenous patient is already seriously ill, when the *pajé* can't cure him, their prayers don't work, so they come to the hospital. And sometimes they arrive in critical condition, you know, already in an acute state; that's the way it is. We find that in many cases the indigenous people prefer to perform spiritual treatment rather than accept treatment here. In this region, we have a lot of native Indians (...) so it's... they say their prayers, they use lucky charms... (Social Welfare Assistant)

[...]...this is a very thorny issue, isn't it, something like that... the more you investigate, the better it is, you know? These days I was watching… we had a meeting over there in the Regional Psychology Council. The people from here on the CRP, we have two members who are very involved in the indigenous area. So, they showed some videos about a *pajé* who was travelling around the world teaching their techniques, you see, and they showed a film of the techniques he uses inside hospitals. They were investigating if it is suggestion, if it isn't suggestion, if the person is cured from... because then the person abandons treatment and decides to get treatment from the *pajé*. And his practice is to pass his hands like this and he creates a powder, and it turns to stone. Have you seen that? And the individual is cured. (Psychologist)

So how am I going to tell this Indian woman to stop suckling if she believes that will cure the child, eh? (...) so you try and make the doctor more aware, for him to try and understand this as well, it's really difficult, isn't it? People want their treatment to be over and done with, don't they? I do understand this you know. So, you have to strike an enormous balance in the intervention, because you are dealing with two extremes, you know? One which demands a fast recovery and quick discharge, ready to go home as soon as possible, and the other which believes that if you don't do it, you will not get better. And often they really don't get better, and

the doctor doesn't know why. There's a lot at stake. So, you have to have a different sort of reading of the situation, you have to understand the whole process so you can try and help and even know how to say all this to an Indian who doesn't even understand your language, you know? So, I learned a skill that I use a lot with Indians. I learned a skill to be able to try and demystify this a little, and know how to mediate the situation between doctor and Indian, because you can get caught in the crossfire. Sometimes the doctor doesn't even want to go and see the patient and nor does the Indian want the doctor to come. So, you get stuck in the middle, you go and see where you can help out in this process, and try to understand this tug-of-war, because for them it's something which is also related to health. It's something very different, very different perspectives. There are some parents that have a history of inhaling smoke, which is very common in the villages. They believe that the smoke is what leads to the spirit of healing, so they go and blow the smoke in the child's nostrils, and so on. They arrive here, the doctor, the team finds out about all of this, the boy with pneumonia. My God! There's confusion because, well, it's not on, is it? The mother brings over the thingy wotsit and she goes and blows the smoke into the child's nose, and the doctor sees this. It's a big mess. Then the psychologist comes over and tries to calm the situation. So, you'll have to mediate between the sides, to try and reach an agreement to do the... It's very complicated because it is a question of the sacred versus the material. How do you explain this, it's hard isn't it? And what about the doctor who doesn't live there, he doesn't understand it, you know? It's all of that. (Psychologist)

Report of Two Specific Cases

Case A—The Krahô Neonate

A two-month old baby of Krahô ethnicity came into the infant unit with its 14-year-old mother, and its maternal grandfather. The neonate came in with a congenital malformation and presented with neurological symptoms, constantly crying and finding it difficult to swallow, it was necessary to use a nasogastric tube and to suspend breastfeeding. With the help of a speech therapist, the baby had had its mouth stimulated for a month, but the evolution of the condition indicated it was necessary to perform a gastrostomy. In this period, the baby's grandfather, on receiving information about the evolution of his grandson's clinical condition, rejected the possibility of surgery and demanded that a *pajé* from his village be called, in order to carry out spiritual treatment.

The team mobilized and the psychology professionals, together with the social welfare assistants, liaised with a team from the Special Indigenous Health District (DSEI), managing to get a *pajé* to come to the hospital. He then worked his *pajelança* outside the hospital building, with the ritual involving pyres and prayers. However, the *pajé* needed the baby to ingest a medication he had prepared, made with specific herbs, explaining that as the baby's father had eaten a monkey during the gestation of the child, this act must have led to the son's infirmity and that it was now necessary to purify him. He stated that the baby's

brother had had the same problem and that he had been cured using the same potion. The medical team who had initially accepted the work with fire and smoke refused to allow the baby to drink the potion as he was unable to swallow. With the appropriate instructions provided to the grandfather and to the *pajé*, the neonate continued to receive stimulation and was kept under observation by the team. However, as the evolution of the child's condition did not improve, and at the request of the family to go back to the village to carry out *pajelança* on the child, several meetings were arranged in which I was able to take part, along with professionals from the Hospital's multidisciplinary team, as well as FUNAI, DSEI and the Public Prosecutor's Office, in order to discuss the best solution, given the specific nature of the culture and the family's needs. As a result of these meetings, it was decided with the family that the *pajelança* could be performed back at the village, with assisted discharge supervised by the DSEI and a commitment given by the family to return to the outpatient department after 15 days. The family returned at the prearranged time but the baby's nasogastric tube was dirty and he had breathing difficulties, which resulted in him being admitted. However, there was resistance on the part of the family, who said they were not prepared to let him be admitted again as they only had the clothes they were standing up in, and that they were still treating the baby using *pajelança*, and visiting several other *pajés* in neighbouring villages.
During this new admission to hospital, it was interesting to note that the little baby was no longer crying persistently, as was observed during the initial admission. He spent around another month receiving treatment in the hospital and more meetings were arranged. There were times when I passed to the multiprofessional team information obtained from listening to the members of the family, who said they were fed up with the lengthy hospitalization and that they wanted... they wanted to have finished the *pajelança* with the baby. During this lengthy hospitalization, with the baby being fed via the nasogastric tube and with no forecast discharge date, the grandfather ended up agreeing to the surgery and the procedure was performed. (Psychologist)

Case B—The Little Krahô Boy

An ethnic Krahô baby arrived in the emergency room in the infant unit in a very grave condition, accompanied by mother, grandparents, uncles and aunts. There was a suspected diagnosis of H1N1, however, while waiting for the examinations, the baby suffered a cardiac arrest. At this point, the psychology professional was called to provide emotional support to the family which, at that point, did not know that the baby's heart had stopped and were apprehensive and crying outside the emergency room. Having listened to each of the family members, I found a peaceful area outside the hospital building so they could resort to their beliefs and intercede on behalf of the health of the child, in line with their practices and traditions. Having been directed to this space, the baby's grandfather held a moment of prayer, in their Krahô language, with all the family joining in, and accompanied by a lot of crying. In

that moment I was drawn very closely to that family and they seemed to leave there more comforted and prepared to deal with the news of the death of the child, which they received a few minutes later. Although I felt that my behaviour was human and ethical, I still felt uneasy, feeling a strange sensation for having permitted and encouraged the manifestation of spirituality. Even more so for having joined in this manifestation, holding hands, I felt I was part of the group. (Psychologist)

Discussion, Consequent Implications and Perspectives

The set of perceptions and experiences reported by the professionals treating the indigenous children and families in the context of hospitalization permit us to glimpse, on the one hand, their efforts with a view to realizing the policies for integrating the medical model and indigenous traditions was implemented in the country in recent years. However, conversely, they also reveal their insecurities, uncertainties and even their resistance to this process and its consequences.

It was in fact found that the chronic condition of an illness, in itself, defined as a disease and strictly within the biomedical model, already signifies a huge challenge for health professionals working in hospital environments. This is because it implies not only organic limits for the patients but also technical limits for those caring for them, requiring very specific skills, whether in the provision of palliative care or in rehabilitation. These challenges are elevated to the nth power when they involve the treatment of indigenous peoples, particularly children, inasmuch as the participation of family and *pajé* makes them very important figures during the process, as it is they who represent the native culture and offer psychological and existential relief by way of their rituals. This is clearly witnessed, for example, in the various reports and specifically in the two reported cases. In the case of the Krahô neonate, it is clear how much he was seen to be soothed after undergoing his tribe's rituals, even having to go back to the hospital due to the respiratory infection without the persistent crying that was present before. Similarly, in the second case, the child's family, after performing their typical recitations in accord with their traditions and beliefs, finds itself more prepared to deal with the loss of the little Krahô boy who died as a result of a cardiac arrest. But it is interesting to note that the psychologist's demeanour, even though it was experienced as something human and ethical, left her feeling very uneasy and with a sense of disorientation. Ultimately, as she herself subsequently stated that at no time in her training, it had been authorized or recommended to encourage prayers or religious practices and even less so to have actually taken part in this process. What she sought after, and what then generated this sense of disorientation, was to have acted as though she was part of the group, but in this case, as a way to appear empathetic and to embrace and legitimise the experience of that indigenous family and their religious traditions.

The two cases described above corroborate the assertion of Vukic et al. (2011, p. 70) that "the indigenous culture offers a rich tradition of curing rituals". They are also in agreement with the studies conducted by indigenous psychologists McCormick (2009) and Gone (2009) concerning the resources inherent to the cultural

practices of these peoples that could be incorporated into the healing process. In line with these studies, contemporary literature argues that there is no one, exclusive curing model but rather that there is a need for "shared care", that is to say, the need to articulate a mutually respectful and collaborative working relationship with the communities' traditional healers (Vukic et al. 2011, p. 79). Faced with this scenario, the practice of indigenous health attains a high level of complexity, particularly on account of the questions that arise from professionals in respect of their conceptions of what work needs to be done. Finding themselves under pressure due to the urgency of translating one working scenario to another, professionals may be led towards ethnocentric translations or to affectations that end up modifying the very significance of their involvement, but which could be a new way to act and think of indigenous health (Pereira et al. 2014). In fact, in the responses of the interviewees, a relative receptiveness to the idea of differentiated care for indigenous children was noted. However, this acceptance occurs more readily with regard to the psychological impacts of this care rather than with regard to its possible physiological effects on the state of health of the child being cared for.

The literature attests to the efficacy of interventions that take into account the cultural aspects of indigenous peoples and also regards interventions that ignore these aspects as unethical and immoral (Vukic et al. 2011). Moreover, Browne and Fiske (2001) warn of the risk of the indigenous patient feeling vulnerable and discriminated against when the nuances of interpersonal communication are misinterpreted or ignored by professionals in the process of evaluation and diagnosis. Therefore, it will be essential for health professionals to familiarize themselves with the cultural norms of emotional expression, verbal style, and mannerisms in the indigenous context in order to avoid errors of interpretation which could adversely affect treatment (Jackson et al. 2006; Whitbeck 2006). Aspects such as language, religion, and culture could be mutually interactive and influence the manifestation of the illness, its evolution, and the articulation of intervention. Therefore, some knowledge or counsel in this area could promote a more accurate diagnosis and result in a more appropriate and effective proposal for treatment (Kirmayer et al. 2014).

Especially from the medical standpoint—as can be understood from the various excerpts from the responses given by the doctor and the other interviewees, and also in the case of the Krahô neonate—the practice of *pajelança* employed by the families and the *pajé* is often interpreted as harmful and aggravating to the state of health of children in hospital care. A major paradox can be observed here. On the one hand, there is a recognition that the medical model is also a culture when one says, for example, "sometimes the indigenous culture interferes with ours". On the other hand, though, it is also very difficult to provide care when it is not based on positivist, ethnocentric models deemed to be 100% true, rooted in research and medical precedent. This difficulty has even given rise to lawsuits filed by health professionals against indigenous families who refuse to accept medical procedures such as surgery, for example (Vilela and Freitas 2022). This agrees with what Cardoso (2014) had already asserted: actions involving indigenous health in the country still stem from positivist criteria, regarding as universal various assumptions that are incompatible with indigenous conceptions. These include a complex system of conceptions concerning birth, death, health, illness, body, self-care, and methods

of treatment. Understanding this system seems to be the main challenge to public health policy as well as to the tangible care of indigenous populations.

This study has found that, with experiences that are challenging for doctors, who see their role as being to save lives, the refusal of an indigenous person to authorise hospital treatment, which may range from guidance or medical prescriptions to surgical procedures, is neither understood nor accepted. Such situations require some effort to establish a bioethical dialogue with the patient for the restoration of his/her health. However, as has been shown, this process is still full of holes, when, for example, there exist limitations in terms of the skills of professionals, including linguistic limitations, to communicate effectively with sick individuals and their families. Or when there are failures with the way in which the referral or counter-referral system is working. Or, additionally, when the hospital environment restricts the space made available for *pajelança* rituals. Or even when the professionals themselves identify a kind of subtle dereliction in the indigenous individual's desire for "better treatment". In this context, the reports of the perceptions and experiences of health professionals have drawn attention to the role attributed to and expected of social welfare assistants and, in particular, psychologists, in the mediation of the process of communicating with the families and the negotiation of a potential integration of the requirements of medicine and the cosmological policies of each tribe. The literature reveals that resistance, desistance, and sometimes the total refusal of the Indian to resort to traditional Western treatment are down to its fundaments in the Eurocentric, Western paradigm, ignoring traditional, spiritual methods that prevail in the communities and in the cultural, historical, social, and political contexts of the indigenous people (Cote and Schissel 2008; Duran 1990; Hill 2003; Poonwassie and Charter 2005; Smye 2004; Smylie et al. 2011; Stewart 2008; Vukic et al. 2009). This reality has demanded of the health professionals an effort to appropriate holistic and culturally sensitive approaches that mix indigenous curing practices with Western cure models (Cote and Schissel 2008; Hill 2003; Poonwassie and Charter 2005; Rojas and Stubley 2014), although this is also rife with ethical and bioethical implications.

Another aspect that is evident from the spoken words of the interviewees relates to the inflexions of a posture and a discourse that desire to integrate treatment provided by scientific medicine with the principles of indigenous cosmology, but which also have their cracks and crevices. In this way, at the same time that they are given with a certain understanding of and respect for the indigenous culture and their methods of cultivating spirituality, the verbal pronouncements of professionals are frequently marked out by characteristic signs of a certain distancing, awkwardness, and resistance to an acceptance of their cosmology, e.g., "a glaring case", "we have problems with this indigenous issue", "they prepared a pyre (…) all of that stuff", "it caused us a lot of work", "because they worship their God (…) that their God is going to cure them", "they say their own prayers", "they use lucky charms", "very thorny topic", and "they have a history of inhaling smoke". This was found in all the categories of professionals interviewed and may be understood as symptoms of the hegemony of the medical model, but it may also be symptomatic of the professionals' own religious values. Accordingly, even though the professionals may have access to courses or primers that provide guidance on health policies and actions

involving indigenous peoples (Brasil 2016), the process of the internalization of differentiated care is not simple and requires a subjective, intersubjective, and cultural approach that takes time to bed in. This consolidation will only happen when the cosmology of the indigenous peoples and their conceptions of life and death, their forms of symbolic construction of the body, and their understanding of the health/illness process and respective local curing practices cease to be seen as a threat to and disruption of the existing order.

In this sense, the role of the psychologist, though also encumbered by the need for a revision of his/her own paradigms, is seen as essential for mediating the prerogatives of a medical nature and those of a cosmological nature, positioning themselves in a terrain described as "difficult", situated "between two extremes", "confused", "complicated", and in short, a veritable "crossfire". This mediation requires of the psychologist a sensitivity and a relational wisdom to manage the communication between medical staff and patient and to enable a compromise to be reached in which the suffering of the child and its family can be minimized. But it also requires the prevailing positivist paradigms in their own training to be surmounted, particularly those that appeared to them to require, in the name of professional ethics, absolute suppression of issues related to spirituality and religiosity (Freitas 2007, 2020). In this way, initiatives to benefit an indigenous family, to have an outlet for their religious expression and to accompany them effectively in this process, leads to discomfort and a certain self-criticism, demonstrating that, internally, they are also experiencing a veritable "crossfire" between the psychological sciences and their own spirituality. The same set of issues was observed in the vignettes, in the questioning of the real or symbolic efficacy of shamanism, whether it be related to the debate on the subject in the Regional Council of Psychologists (CRP), or whether asking the interviewer if she might also have glimpsed the real power of the *pajés* to transform the powder into stone.

The narrative above begs an ethical question. It has become essential to have an understanding that, in certain indigenous cultures, the practices, instruction, and cures realized by the *pajés* are grounded on a firm conviction that they emanate from a divine realm. Usually in these cultures, in the moments of curing rituals, the *pajé* does not belong to humanity, and the people being treated do not see him as someone who is part of a kindred group, linked to some position of power in the village. Thus, the *pajé*, when carrying out his work, stays alongside the patient and family members during the entire process of diagnosis and cure, which can last days and days. His care is all-encompassing; guidance on diet and on behaviour to be followed by patient and family is part and parcel of the treatment, and he may also make concomitant use of medicinal plants and help from the spirits (Langdon 1988). On the other hand, in Western culture, and especially within the context of education in psychology and anthropology, there are various ways to interpret this indigenous tradition. Thus, for example, the anthropologist Lévi-Strauss (1949) developed the concept of symbolic efficacy and, in doing so, associates shamanic cures with a kind of psychological cure that only makes sense if we define the way in which particular psychological representations are invoked to combat physiological disorders. In his description of the Cuna Shaman, he understands that it is a question of purely psychological medication, seeing that the shaman does not touch the sick individual's

body and does not give him any medicine; rather, he calls into question the pathological condition and its origins. His chanting represents a psychological manipulation of the sick organ, expecting a cure to be possible through this manipulation. It is the transition to this verbal expression that provokes the unlocking of the physiological process. Meanwhile, from a phenomenological point of view, it seems to us to be inappropriate to reduce indigenous rituals and their curing efficacy to the power of suggestion or metaphor. In concert with the critique made by Renshaw (2006), we feel that it is more ethical not to interpret conceptually the ability to harness the power of the mythical world demonstrated by the indigenous cultures and for us to respect the experience as it is genuinely lived by its own representatives.

The position outlined above does not imply naivety or a rejection of science, but rather a greater openness to mystery and differences, rather than the imposition of one truth over another. According to Langdon (1988), in general, shamans do not reject the power of doctors to treat illness, but it is important that the professionals also do not reject the shaman's important task of curing. Receptiveness to indigenous medicine, already significantly disseminated in the health policies established by the SUS, proposes that both forms of treatment should operate side by side, with mutual respect. This joint operation needs to recognise and accept that scientific medicine must respect the principles of indigenous medicine. As Langdon (1988) points out, according to the principles of the latter, when lives are at risk, explanations about the illness are sought in the body of spiritual ideas that explain the world order, the destiny of man. Indigenous people want to know the reason for the suffering and their beliefs about mystical causation explain this. Mystical causes may include attacks by the spirits, sorcery, loss of the soul, and the breaking of a taboo. In fact, these elements are also incorporated into their curing rituals, and therefore, the families also do their utmost to be involved in the process of the treatment of chronic illnesses in their children, even when they are hospitalized for long periods of time.

Another aspect which can be grasped from the vignettes obtained from the words of the professionals interviewed, and also from the two cases described, relates to the role of ambience in embracing the indigenous children and their families. For example, the presence of an interpreter of the indigenous language was required to assist with the communication between the children and their families and members of the health team. It was clearly important to provide an adequate environment within the hospital grounds that permits the various manifestations of indigenous spirituality such as pyres, smoke inhalation, and among other rituals that are important mechanisms in terms of enabling the integration of their cosmologies with the medical services offered there. Another ambience to be considered with regard to the services offered relates to the possibility of the presence of the *pajé*, as the group's religious leader, promoting spiritual care for patients and their families. This matter is indeed already envisaged in a specific Ministry of Health Directive (Brasil 2017), in which article 275 establishes the following in subsections III and IV, respectively (III promotes the ambience in the establishment according to the ethnic specificities of the indigenous populations cared for; IV facilitates the care provided by traditional caregivers, when requested by the indigenous patient or by the family and, when necessary, adapts spaces to make such practices possible).

Despite this, it is known that, in Brazil, as in other Western countries, the openness to manifestations of spirituality in the services provided in the hospital setting, in the vast majority of cases, when it exists, takes place by means of pastoral care. These services have traditionally been provided by professionals representing one of the categories referred to as "world religions", especially all those of Christian tradition (Nwora and Freitas 2020). Esperandio and Leget (2020) put into context the debates on public theology and show that patients and their families feel more at ease discussing ethical decisions with someone who has received theology training than with other health professionals, confirming the importance of this speciality in the multidisciplinary team, but which still tends to go unrecognized in Brazil.

The presence of *pajés* is shown to be even more rudimentary in the context of health in Brazil, even with policies existing at the national and international level that advocate the necessary integration of the practices of traditional medicine with the practice of biomedicine, recognising their effectiveness in treating and curing illness (Brasil 2006; UN 2008). One project which has produced good results is the one being developed in the Xingu, through which the *pajés* take active part in the treatment of illnesses in the indigenous outpatient clinics. Other initiatives have been identified based on a meeting held to monitor the Vigisus Project (Ferreira and Osório 2007), in which one of the proposals is the integration of the area of indigenous traditional medicine, when indigenous health was still under the administration of FUNASA. However, many impasses were observed with this process, particularly due to the lack of clarity concerning what traditional medicine consists of (Langdon 2007), which does not allow itself to be reduced to universally applied protocols.

Vilela and Freitas (2022) consider that receptiveness to the integration of traditional and biomedical knowledge and practices is neither a simple nor comfortable process for health professionals, educating in accordance with a model in which illness is merely considered from an objective point of view, of the *soma* (Greek word for body), particularly for the medical classes. After all, there are aspects associated with the experiences of the patient which are not necessarily treated from an ontic perspective, but much more from the perspective of their meaning and significance. In this perspective, it can be seen that the recommendation to integrate healthcare requires the revival of a conception of health and illness that has been rejected and cast aside, and insofar as the positivist, rational discourse has become hegemonic. Medicine, as is well known, was born out of the practice of magic, investigating little understood phenomena, often considered as having spiritual origins. However, as a science, the perceptions that once upon a time they were modelled on the order of the sensitive have been consigned to the past, excluding from its discourse and its practices. Thus, the practices which today we call complementary, which are not limited to religious/spiritual rituals, but encompass options of traditional, spiritual care, emerge with this internalizing function, require a revision of the very ontology of conceptions of health and illness that has been consolidated in the health sciences.

The proposal for integration argued here, involving a partnership of traditional medicine and complementary indigenous medicine, has proved to be effective (Bodeker and Kronenberg 2002) in a number of countries, despite only 25 of the 191 member states of the WHO possessing national policies concerning traditional

medicine and alternative, complementary medicine, including Great Britain, New Zealand, China, India, South Korea, and the USA. Research conducted by Allen et al. (2012) highlights a successful experiment realized in Canada, where many indigenous communities have worked to strengthen the practice of cultural curing, with the recognition by the official system that the indigenous healthcare partnerships furnish innovative models of interprofessional collaboration, whether in the community, in remote clinics, or in urban hospitals. The same is true of other countries, such as in the south of the US state of Alaska, in Japan, China, South Korea, India, Vietnam, Nicaragua, and Australia. The authors agree that if the increased efforts of the elders, the holders of knowledge, and the healers could be endorsed by the medical community in general, and if the obstacles to full rights to health for indigenous peoples could be reduced or removed, systemic racism could be overcome, enabling the realization of equity in health.

Boon et al. (2004), for example, portray seven different health practice models that can be used by health teams: parallel, consultative, collaborative, coordinated, multidisciplinary, interdisciplinary, and unifying. These models are aimed at four main components of the integrative practice of healthcare: philosophy/values, structure, process, and results. As far as philosophy and values are concerned, the involvement of and emphasis on the person as a whole are the aim, as well as diversity of understanding in the area of health, and an increase in the number of health determinants considered. From this perspective, dependence on the biomedical, scientific model is diminished. In the structure, it can be seen that, according to the degree of complexity of the service, dependence on the hierarchy and the clearly defined roles either increases or decreases. In the process, communication, the number of participants involved, individualization, synergy, and the importance of greater consensus are all taken into consideration—diminishing the professional's autonomy. In the results, we see an increase in complexity and diversity of practices. The authors argue that a health system that incorporates different models for different types of treatment needs to be flexible, particularly if the patients are able to choose the type of care that they believe most suits their needs. They explain that the integrative model stems from multidisciplinary practice, where the professionals on the team begin to take decisions as a group (generally based on consensus) about the patient's treatment, facilitated by regular face-to-face meetings. And that it is based on a specific set of core values that include the objectives to treat the individual holistically, helping with the curing properties, innate to each individual, and promoting health and wellbeing, as well as the prevention of illness. So, it is a question of an interdisciplinary team approach driven by the building of consensus, mutual respect and a shared vision of healthcare, enabling both medical staff and patients to contribute to their understanding and particular skills within the context of a shared plan of care. The possibilities afforded by this integration may also materialize in Brazil, as long as the health professionals come to understand them and value them in their university training.

Despite successful efforts and experiences in a number of countries, which are members of the UN, in terms of the construction of formal health spaces integrating traditional health practices, there are still very few countries which have fully integrated traditional practices, such as the official practice of chaplaincy exercised

by aboriginals, though still not frequently practised across the world. However, in the Canadian setting, there is the Royal Canadian Chaplain Service (RCChS), which possesses representatives in the "indigenous religions" category, seeking to provide support and assistance to the different expressions of spirituality of these peoples, within the Armed Forces and in other situations where they are called upon to offer their services (Government of Canada 2019). However, this assistance, which is directed towards the spiritual needs of individuals, whether Christian, Muslim, Jew, Spiritist, or coming from African religions or indigenous cosmologies, is far more effective when provided by their own religious leaders, within the hospital domain, in a way that integrates with the medical services they also receive there, as the literature has demonstrated. Nwora (2020) and Nwora and Freitas (2021) also highlight the need for a more humanized chaplaincy, with an integrated approach to the multiple expressions of spirituality in the population being cared for. Given this potential convergence of healthcare efforts to treat illness, it is advantageous to both the hospital team and the indigenous communities. After all, this would likely help relativise the ethnocentric supremacy of scientific knowledge in healthcare, typical of today's Western countries, as well as prevent services offered in hospitals from reducing the sick individual to just an organic body. As long as this combined effort fails to materialise, it can be seen that not only are the prescriptions of the *pajé* seen to be responsible for aggravating illness and causing death, as in the case of the RN Krahô neonate, but also that treatment based solely on the medical model, neglecting the perceptive, symbolic and spiritual dimensions that are so fundamental to indigenous cosmology, may lead to the accentuation of the pathological condition instead of promoting the recovery of the sick individual. In Brazil, one counterpoint that has been the subject of discussion, based on the principle of the universality of the SUS, is the idea of differential healthcare (Cardoso 2015; Ferreira 2015; Garnelo 2012; Langdon 2016). It can be seen that this principle has not truly materialized, in the name of equality of rights for all citizens, and the processes of inequality, exclusion and racism remain masked. It is with this in mind that it is considered that, to guarantee the health of the indigenous populations, there exist not only epistemological, technical and bioethical impasses to overcome but also political ones (Vilela and Freitas 2022).

As far as the education of the health professional is concerned as well as the care he/she provides, here, we have a number of contributions from Brazilian authors which could also be made available during the health professionals' training and qualification. Lorenzo (2011) proposes that the training of health professionals should follow bioethical principles founded on elements of moral philosophy, seeking dialogic grounds for ethical relationships. In other words, in situations such as the case of the Krahô neonate where there is explicit resistance to treatment and a desire to resort to indigenous medicine, clinical bioethics must be sought that emerge from intercultural contact. Among the health professionals, it is necessary for the patients and their families to have reserved spaces for dialogue which enable free attitudes and choices, where the decisions and the consequences thereof can be evaluated and are acceptable to all. For such a model to work, it is important to recognise that the values derived from one culture alone will not necessarily be capable of guiding ethically acceptable actions in a different culture and that, to be

implemented, it is necessary to make dialogue the way to build or discover values common to the diverse visions of the world involved in the acts of assistance to be implemented. Along similar lines, Junqueira (2012) states that, by virtue of historical, cultural, and social influences, there is a risk of losing the parameters that should guide professional activity with ethical attitudes. The author presents several criteria that should guide health professionals in the decision-making processes when faced with paradigmatic situations and whose ethical grounding will always be respect for the human being, in all his singularity, totality, and dignity. Resulting from the Belmont Report (1978), several principles to be considered in professional practice are highlighted: recognition of the value of the individual; beneficence; respect for their choices; justice based on the recognition of the dignity of the human being, considered as a whole—the physical, psychological, social, and spiritual aspects.

Esperandio and Leget (2020) consider that the empirical evidence of the impact of religiosity/spirituality should be sufficient to change healthcare in at least two ways. The first relates to the discourse of professionals about the shortcomings in training or the lack of time available to incorporate spiritual care into their practice. The second refers to public policy. For the authors, the practice of spiritual care promotes individuals' dignity, improves the quality of life, increases the sensation of wellbeing, and affords greater clarity in terms of important decisions in the context of palliative care to the chronically sick and those close to death. The authors present bioethics as an interdisciplinary field that binds together the discussion about spiritual care as a public health issue, and they indicate concerns and approaches in common between the global, narrative, and protective field of bioethics and the field of public theology. This is all about actions of solidarity, compassion, and the ethics of care. So, for example, narrative ethics that have as its fundament the "life story" told by the infirm individual look for elements that explain and give meaning to the bioethical decision-making process. According to the authors, through its characteristic of active listening and appreciation of aspects related to the relationship between all those involved, both health professionals and patients, it promotes human dignity, valuing both the past and the present, considering the way the personal story expresses meaning and purpose, permitting a deeper reflection when deciding on treatment.

Final Reflections

The health professionals' experiences of listening, through the study reported here, allowed them to share significant, striking perceptions and experiences in their routine efforts to care for hospitalized indigenous children suffering from chronic illnesses. In this regard, in addition to having made it possible to address the aims of an investigation into the way they perceive and deal with the topic of spirituality and religiosity in the context of their work, the qualitative methodology, phenomenological in nature, also enabled the professionals to express themselves and be heard with regard to their impressions, their dilemmas, concerns, difficulties, limits and achievements. This listening to their experiences is seen to be fundamental, perhaps even the first stage of a process that could really lead to a profound revision of paradigms and promote a more human approach, rather than a merely technical one, to topics related to religiosity/spirituality, secularism, knowledge, and traditional indigenous practices.

We would stress here the importance that said revision of paradigms should take place in the health professional's initial training. Only in this way will it be possible to get coherence in the realization of that which the WHO and public healthcare policies advocate for the indigenous peoples in this country and across the world. Throughout the training, it is necessary to work on the sensitivity to their religious specificities, an understanding of the traditions, values and systems of beliefs in indigenous health, respect for their cosmologies, a professional ethical posture, and revision of their own beliefs and prejudices and also their ability to communicate effectively with indigenous people and help them to benefit from medical knowledge, though not at the cost of seeing them stripped of their identity.

In other words, a professional, ethical stance, in this case, should not be reduced to the glamorous jargon of "scientific neutrality", forged within an ethnocentric, medical model of healthcare management. At the end of the day, in the name of this model, a narrow professional training and an inflexible hospital structure have been sustained, both of which are unattached to the life-world and its existential flow. Glamour must be supplanted by a commitment to care for actual, diverse, and plural people with specific identities, deserving of a care that respects them as such.

Author Contributions All authors contributed to the study conception and design. Material preparation, data collection, and analysis were performed by Marta Helena de Freitas and Paula Rey Vilela. The first draft of the manuscript was written by Marta Helena de Freitas, and all authors commented and added information and specific contribution on previous versions of the manuscript in according to their specific competences and expertise. Emmanuel was the translator from Portuguese to English version. All authors read and approved the final manuscript.

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Data Availability The vignetes of the selected interviews were translated and reproduced in this paper. All the the interviews are in the data base of the Lab "Religion, Mental Healht Culture", linked to the Graduation Psychology Program at Catholic University of Brasília, coordinated by the first author. But it is not possible do be public available, cause we commited with the Ethical Committe in Brazil to maintain privacy of every participants of the original and umbrela research.

Declarations

Ethical Approval The research data collection involved human beings, and therefore, the project was duly approved by the research ethics committees of the institutions to which the authors were affiliated: Catholic University of Brasília, CAAE 319491 14.0.000.0029, and Tocantins State Department of Health (Secretaria do Estado da Saúde de Tocantins—SESAU). All participants signed an informed consent form.

Competing Interests The authors declare no competing interests.

References

Ackerknecht EH (1971) Medicine and ethnology. John Hopkins Press, Baltimore, Selected essays
Allen L, Hatala A, Ijaz S, Courchene ED, Bushie B (2012) Indigenous-led health care partnerships in Canada. The Canadian Geographer. Le Geographe Canadien 56(2):292–294
Almeida SL (2019) Racismo Estrutural. Jandaíra, São Paulo, Brazil. (Collection: Feminismos Plurais, coordinated by Djamila Ribeiro).
Amatuzzi MM (2012) Pesquisa fenomenológica em Psicologia. In Bruns MAT, Holanda AF (eds) Psicologia e fenomenologia: reflexões e perspectivas. Alínea, São Paulo, Brazil, pp 17–25
American Psychiatric Association (APA) (2000) Diagnostic and statistical manual of mental disorders, 4th edn. American Psychiatric Association, Washington
Andrade J, Sousa CKS (2016) Práticas indígenas de cura no nordeste brasileiro: discutindo políticas públicas e intermedicalidade. Anuário Antropológico 41(2):179–202. Available via anuário antropológico https://periodicos.unb.br/index.php/anuarioantropologico/article/view/6406/6156. Accessed 20 Jan 2022
Assis TS (2019) Between religious and secular: the spirituality in a non-religious world. Revista Eletrônica de Ciências Sociais 29. https://doi.org/10.34019/1981-2140.2019.17569
Basta PC, Orellana JDY, Arantes R (2012) Epidemiologic profile of indigenous people in Brazil: notes on selected diseases. In: Garnelo L, Pontes AL (eds) Saúde Indígena: Uma introdução ao tema. Edições MEC/Unesco, Brasília, Brazil, pp 60–106. (Serie Vias dos Saberes n 5. Collection Educação para todos.) Available on https://www.arca.fiocruz.br/bitstream/handle/icict/56803/Cap_02_Perfil_Epidemiologico_Povos_Indigenas_Brasil.pdf?sequence=2&isAllowed=y
Belmont Report (1978) Ethical principles and guidelines for the protection of human subjects of research, Report of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. DHEW Publication No. (OS) 78–0012. Available via digital library https://digital.library.unt.edu/ark:/67531/metadc1213679/m2/1/high_res_d/78-0012.pdf. Accessed 14 Apr 2020
Bodeker G, Kronenberg F (2002) A public health agenda for traditional, complementary, and alternative medicine. Amer J Public Health 92(10). https://doi.org/10.2105/ajph.92.10.1582
Boon H, Verhoef M, O'Hara D, Findlay B, (2004) From parallel practice to integrative health care: a conceptual framework Heather. BMC Health Serv Res 4–15. https://doi.org/10.1186/1472-6963-4-15
Brasil (1991) Decreto 23. Regulates conditions for offering healthcare to indigenous populations. Presidência da República, Brasília. Available via planalto.gov http://www.planalto.gov.br/ccivil_03/decreto/1990-1994/D0023.htm. Accessed 17 Apr 2020
Brasil (2002) National policy of indigenous healthcare. Ministério da Saúde, Brasília. Available via Ministério da Saúde http://bvsms.saude.gov.br/bvs/publicacoes/politica_saude_indigena.pdf. Accessed 4 Apr 2020
Brasil (2006) Política Nacional de práticas integrativas e complementares no SUS. Ministério da saúde, Brasília. Available via Ministério da Saúde http://bvsms.saude.gov.br/bvs/publicacoes/pnpic.pdf. Accessed 20 Feb 2018
Brasil (2012) Brazilian Institute of Geography and Statistics – IBGE. The indigenous People in the 2010 demographic census: first considerations based on the question of colour and race. Ministério da saúde e Ministério do Planejamento, Orçamento e Gestão, Rio de Janeiro. Available via IBGE https://indigenas.ibge.gov.br/images/indigenas/estudos/indigena_censo2010.pdf. Accessed 19 Apr 2020
Brasil (2016) Health, illness and healthcare in indigenous territories. Unidade II, Área Temática I. Promoção da Saúde no Território Indígena. Secretaria de Gestão do Trabalho e da Educação na Saúde Departamento de Gestão da Educação na Saúde. Programa de Qualificação de Agentes Indígenas e Saúde (AIS) e Agentes Indígenas de Saneamento (AISAN). Ministério da saúde, Brasília. Available via Ministério da Saúde https://bvsms.saude.gov.br/bvs/publicacoes/politicas_saude_primaria_brasil_saude_indigena.pdf. Accessed 19 Apr 2020
Brasil (2017) Joint Ordinance Nº 2.663, of 11 October 2017. Ministério da Saúde, Gabinete do Ministro, Brasília. Available via Ministério da Saúde https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2663_16_10_2017.html. Accessed 15 Apr 2020
Brasil (2020) "Indigenous Brazil" special studies: the indigenous people in the 2010. Demographic Census: Instituto Brasileiro de Geografia e Estatística (IBGE), Rio de Janeiro. Available via IBGE

https://indigenas.ibge.gov.br/pt/estudos-especiais-3/o-brasil-indigena/os-indigenas-no-censo-demografico-2010. Accessed 4 Apr 2020
Browne A, Fiske J (2001) First nations women's encounters with mainstream health care services. Western J Nurs Res 23(2):126–147. https://cewh.ca/wp-content/uploads/2012/05/2000_First-Nations-Women-Encounters-with-Mainstream-Health-Care-.pdf
Canesqui AM (2007) Olhares antropológicos obre os adoecidos crônicos. Hucitec/ Fapesp, São Paulo, Brazil, p 149
Cardoso MD (2014) Health and indigenous peoples in Brazil: notes on some current policy mistakes. Cad Saúde Pública 30(4):860–866. https://doi.org/10.1590/0102-311X00027814
Cardoso MD (2015) Políticas de Saúde Indígena no Brasil: do modelo assistencial à representação política. In: Langdon EJ, Cardoso MD (eds) Saúde Indígena: políticas comparadas na América Latina. UFSC, Florianópolis, Brazil, pp 83–106
Carvalho ALM, Oliveira ALBS, Guimarães SS (2014) Epidemiological characterization of indigenous peoples and subsystem indigenous health in Brazil: an integrative literature review. Boletim Informativo Geum 5(3):72–78
Chang AB et al (2014) Lung disease in indigenous children. Paediatr Respir Rev 5(4):325–32. https://doi.org/10.1016/j.prrv.2014.04.016
Coimbra Jr CEA; Santos RV, Escobar AL (Ed). (2005). Epidemiologia e saúde dos povos indígenas no Brasil [online]. FIOCRUZ, ABRASCO, Rio de Janeiro. Available via SciELO Books http://books.scielo.org. Accessed 29 Jul 2022
Conselho Nacional de Secretários da Saúde, CONASS (2014) Nota técnica. A integração da saúde indígena no SUS: Uma proposta da gestão estadual. Brasília, Brazil. https://www.conass.org.br/wp-content/uploads/2014/04/NT-04-2014-SAU%CC%81DE-INDIGENA.pdf
Costa AMD, Carvalho JS (2019) The Afro-indigenous legacy to healers of Pedreira: shamanism in criminal cases in Belém of Pará (1929–1933). J Brazilian Stud 8(1–2):229–249. https://doi.org/10.25160/bjbs.v8i1-2.114793
Cote H, Schissel W (2008) Damaged children and broken spirits: a residential school survivor story. In: Brooks C, Schissel B (eds) Marginality & Condemnation: an introduction to critical criminology. Fernwood Publishing, Black Point, NS, pp 220–237
Cox JL (ed) (2016) Critical reflections on indigenous religions. In: Book Series Vitality of indigenous religions. Routledge, New York, p 214
Cunha MC (2007) Relations and dissensions between traditional knowledge and scientific knowledge. Revista Usp (75):76–84. https://doi.org/10.11606/issn.2316-9036.v0i75p76-84
Duran E (1990) Transforming the soul wound. Arya offset Press, Delhi, India
Durkheim É (1995) The elementary forms of religious life. The Free Press, New York, Translated by Karen E. Fiels
Esperandio M, Leget C (2020) Espiritualidade nos cuidados paliativos: questão de saúde pública? Rev Bioét 28(3). https://doi.org/10.1590/1983-80422020283419
Ferreira LO (2015) Interculturalidade e saúde indígena no contexto das políticas púbicas brasileiras. In: Langdon EJ, Cardoso MD (eds) Saúde Indígena: políticas comparadas na América Latina. Editora da UFSC, Florianópolis, Brazil, pp 217–246
Ferreira LO, Osório PS (2007) Medicina Tradicional Indígena em Contextos. Anais da I Reunião de Monitoramento, Projeto Vigisus II/Funasa, Fundação Nacional de Saúde, Brasília (https://acervo.socioambiental.org/sites/default/files/documents/2007_prov_42.pdf)
Fontão MAB, Pereira ÉL (2017) Projeto Mais Médicos na saúde indígena: reflexões a partir de uma pesquisa de opinião. Interface 21, supl. 1. Available via Scielo https://www.scielo.br/pdf/icse/v21s1/1807-5762-icse-1807576220160387.pdf. Accessed 25 May 2020
Freitas MH (2007) Quando o silêncio transborda, calaboca já morreu - religiosidade, cientificidade e formação em psicologia. In: Marta HF, Ondina PP (eds) As vozes do silenciado: estudos nas fronteiras da Antropologia. Filosofia e Psicologia, Universa, Brasília, Brazil, pp 187–205 (Collection Margens e Confluências)
Freitas MH (2016) Spirituality and health: from the original connections to the efforts of its recovery in contemporaneity. Interações – Cultura e Comunidade 11(20):3–8
Freitas MH (2020) Religiosity, Spirituality and Wellbeing in the Perception of Brazilian Health and Mental Health Professionals. In: Bettina ES, Jeff L (eds) Spirituality and Wellbeing - Interdisciplinary Approaches to the Study of Religious Experience and Health, vol 1. Equinox, Sheffield, pp 199–224. https://doi.org/10.1558/equinox.35871

Freitas MH, Vilela PR (2017) Phenomenological approach of religiosity: implications for psychodiagnostic and psychological clinic Praxis. Revista da Abordagem Gestáltica 23(1):95–107 https://doi.org/10.18065/rag.2017v23n1.1

Freitas MH, Leal MM, Nwora EI (2022) Praying for a miracle part II: idiosyncrasies of spirituality and its relations with religious expressions in health. Front Psychol 13:893780. https://doi.org/10.3389/fpsyg.2022.893780

Garnelo L (2012) Política de Saúde Indígena no Brasil: notas sobre as tendências atuais do processo de implantação do subsistema de atenção à saúde. In: Garnelo L, Pontes AL (eds) Saúde indígena: uma introdução ao tema. MEC-SECADI, Brasília, Brazil, pp 18–59

Garroutte EM et al (2009) Religiosity and spiritual engagement in two American Indian populations. J Sci Study Relig 48(3):480–500. https://doi.org/10.1111/j.1468-5906.2009.01461.x

Gone J (2009) Encountering professional psychology: re-envisioning mental health services for Native North America. In: Kirmayer E, Valaskakis VG (eds) Healing Traditions: The Mental Health of Aboriginal Peoples in Canada. University of British Columbia Press, Vancouver, pp 419–439

Government of Canada (2019) Direction and Guidance on Indigenous Spiritual Practices. Available via Government of Canada https://www.canada.ca/en/department-national-defence/services/benefits-military/health-support/chaplain/direction-and-guidance-on-support-for-indigenous-spiritual-practices.html. Accessed 31 Mar 2020

Gracey M, King M (2009) Indigenous health part: determinants and disease patterns. The Lancet 374(9683):65–75. https://doi.org/10.1016/S0140-6736(09)60914-4

Gray M (2005) Geodiversity and geoconservation: what, why, and how? Geodiversity and Geoconservation 22(3)-pp. 4–12. Available via researchgate https://www.researchgate.net/publication/237586700_Geodiversity_and_Geoconservation_What_Why_and_How. Accessed 15 Jan 2022

Groover JG (2008) Challenges in applying indigenous evaluation practices in mainstream grant programs to indigenous communities. Canadian Journal of Program Evaluation 23(2)- pp. 33–50. Available via Canadian of Journal of Program Evaluation https://evaluationcanada.ca/system/files/cjpe-entries/23-2-033.pdf. Accessed 20 Feb 2022

Harfield SG et al (2018) Characteristics of Indigenous primary health care service delivery models: a systematic scoping review Global Health 14(12). https://doi.org/10.1186/s12992-018-0332-2.

Harvey G (2000) Indigenous religions: a companion. In: Paperback. Continuum, London

Hill DM (2003) Traditional medicine in contemporary contexts: protecting and respecting indigenous knowledge and medicine. National Aboriginal Health Organization, Ottawa

Husserl E (1965) Phenomenology and the crisis of philosophy. philosophy as rigorous science and philosophy and the crisis of European Man. Harper Torchbooks, New York (Original publication 1936)

Instituto Sócio ambiental (Isa) (2021) Notícia: Corte no censo 2021 ameaça políticas públicas para povos indígenas e tradicionais. Available via Isa https://site-antigo.socioambiental.org/pt-br/noticias-socioambientais/corte-no-censo-2021-ameaca-politicas-publicas-para-povos-indigenas-e-tradicionais Accessed 23 Apr 2021

Jackson L et al (2006) Applicability of cognitive behavior therapy with American Indian individuals. Psychother: Theory Res, Pract, Train 43:506–517

Junqueira SR (2012) Bioethics. Especialização em Saúde da família. UNIFESP, São Paulo. Available via Una Sus http://ares.unasus.gov.br/acervo/handle/ARES/231 Accessed 14 April 2020

King J, Trimble JE (2013) The spiritual and sacred among North American indians and Alaska natives: mystery, wholeness, and connectedness in a relational world. In: Pargament K (ed) APA handbook of psychology, religion, and spirituality: context, theory and research. American Psychological Association, Washington, DC, pp 565–580. https://doi.org/10.1037/14045-031

King M, King A, Gracey M (2009) Indigenous health part 2: the underlying causes of the health gap. The Lancet 374(9683):76–85. https://doi.org/10.1016/S0140-6736(09)60827-8

Kirmayer LJ, Jarvis GE, Guzder J (2014) The process of cultural consultation. In: Kirmayer LJ, Guzder J, Rousseau C (eds) Cultural Consultation: Encountering the Other in Mental Health Care. Springer, New York, pp 47–69

Kopenawa D, Albert B (2015) A queda do céu: palavras de um xamã yanomami. Companhia das Letras, São Paulo

Langdon EJ (1988) Saúde indígena: a lógica do processo de tratamento. Saúde em Debate (special issue) 12(5):12–15. Available on https://www.academia.edu/20233740/Sa%C3%BAde_ind%C3%ADgena_a_l%C3%B3gica_do_processo_de_tratamento

Langdon EJ (2005) A construção sociocultural da doença e seus desafios para a prática médica. In: Roberto Baruzzi R, Junqueira C (eds) Parque Indígena do Xingu: saúde, cultura e história. Terra Virgem, São Paulo, pp 115–133

Langdon EJ (2007) Problematizando os Projetos de Medicina Tradicional Indígena. In: Ferreira LO, Osório PS (eds) Medicina Tradicional Indígena em Contextos. Anais da I Reunião de Monitoramento. Projeto Vigisus II/Funasa, Fundação Nacional de Saúde, Brasília, pp 110–119. https://acervo.socioambiental.org/sites/default/files/documents/2007_prov_42.pdf

Langdon EJ (2014) The dialogues between anthropology and health: contributions to public policies. Ciência Saúde Coletiva 19(4):1019–1029. https://doi.org/10.1590/1413-81232014194.22302013

Langdon EJ (2016) Os diálogos da antropologia com a saúde: contribuições para as políticas públicas em saúde indígena. In: Langdon EJ, Grisotti M (ed) Políticas públicas: reflexões antropológicas. UFSC, Florianópolis, pp 17–41

Leuba JH (1913) Sociology and psychology: the conception of religion and magic and the place of psychology in sociological studies: a discussion of the views of Durkheim and of Hubert and Mauss. Amer J Sociol 19(3)-323–342. Available via Jstor https://www.jstor.org/stable/2763188?seq=1#metadata_info_tab_contents. Accessed 10 Apr 2020

Lévi-Strauss C (1949) L'efficacité symbolique. Revue de l'histoire des Religions, Tome 135(1):5–27. https://doi.org/10.3406/rhr.1949.5632

Lorenzo CFG (2011) Challenges to a clinical and inter-ethnic bioethics: reflections from the national policy of indigenous health. Rev Bioét (Impr.) 19(2)-329–42. Available via redalyc.org https://www.redalyc.org/articulo.oa?id=361533256003. Accessed 14 Apr 2020

McCormick R (2009) Aboriginal approaches to counseling. In: Kirmayer E, Valaskakis VG (eds) Healing Traditions: The Mental Health of Aboriginal Peoples in Canada. University of British Columbia Press, Vancouver, pp 337–354

Melatti JC (1987) Índios do Brasil. Hucitec, Brasilia, Brazil

Moreira MCN, Gomes R, Sá MRC (2014) Chronic diseases in children and adolescents: a review of the literature. Ciência Saúde Coletiva 19(7):2083–2094. https://doi.org/10.1590/1413-81232014197.20122013

Mota SEC, Nunes M (2018) For differentiated and less uneven health care practices: the case of the special indigenous sanitary district of bahia. Saúde Soc 27(1):11–25. https://doi.org/10.1590/S0104-12902018170890

Niezen R (2017) Indigenous religion and human rights. Univ Press Scholarship, Oxford, UK. https://doi.org/10.1093/acprof:osobl/9780199733453.003.0007

Nwora EI (2020) Religiosidade, espiritualidade e saúde mental na percepção de capelães brasileiros. 231 f. Tese (PhD Theses), Graduation Psychology Program, Catholic University of Brasília, Brazil. https://bdtd.ucb.br:8443/jspui/handle/tede/3069

Nwora EI, Freitas MH (2020) Religiosidade e saúde mental na percepção e na experiência de capelães brasileiros. In: Alminhama, LO, Freitas MF, Aquino TA (eds) Experiências religiosas, espirituais e anômalas: desafios para a saúde mental. UFPB, João Pessoa, Brazil, pp 141–176

Nwora EI, Freitas MH (2021) Intervenções em contextos indígenas: vicissitudes e perspectivas. Caminhos de Diálogo 8(12):126–140. https://doi.org/10.7213/cd.a8.n12.p126-140

Odello M (2012) Indigenous peoples rights and cultural identity in the inter-American context. Int J Human Rights 16(1). https://doi.org/10.1080/13642987.2011.597747

Oliveira C, Neto FL (2003) Suicide among indigenous people: a Brazilian statistical view. Rev Psiq Clín 30(1):4–10. https://doi.org/10.1590/S0101.60832003000100001

Organização das Nações Unidas, UN (2008) Declaração das Nações Unidas sobre os direitos dos povos indígenas. United Nations, Rio de Janeiro. Available on https://www.acnur.org/fileadmin/Documentos/portugues/BDL/Declaracao_das_Nacoes_Unidas_sobre_os_Direitos_dos_Povos_Indigenas.pdf

Organização Pan-Americana da Saúde, OPAS (2018) Relatório 30 anos de SUS, que SUS para 2030? OPAS, Brasilia Available on https://iris.paho.org/handle/10665.2/49663

Pereira ÉR et al (2014) The experience of a specialized health service for the care of Indian patients. Saúde Soc 23(3):1077–1090. https://doi.org/10.1590/S0104-12902014000300027

Poonwassie A, Charter A (2005) Aboriginal worldview of healing: inclusion, blending, and bridging. In: Moodley R, West W (eds) Integrating traditional healing practices into counseling and psychotherapy. Sage, Thousand Oaks, CA, pp 15–25

Renshaw J (2006) A eficácia simbólica revisitada. Cantos de cura ayoreo. Revista de Antropologia 49(1). https://doi.org/10.1590/S0034-77012006000100012
Rey A (1993) Dictionnaire Historique de la langue Française. Dictionnaires Le Robert, Paris
Rivers WH (1927) Medicine, magic and religion. Kegan Paul, Trench, Trübner and Co, Ltd, London, p 144
Rodrigues MG (2017) The confluence between anthropological thought and the public health policies of Brazil Mal-Estar e Sociedade 2(2):3–21. Available via revista uemg http://revista.uemg.br/index.php/gtic-malestar/article/view/701/2149 Accessed 15 April 2020.
Rojas M, Stubley T (2014) Integrating mainstream mental health approaches and traditional healing practices. A literature review. Adv Soc Sci Res 1:22–43
Santos T (2014) Shamanism: religion and society in the 19th and 20th centuries. In: Trabalho apresentado na 29ª Reunião Brasileira de Antropologia, realizada entre os dias 03 a 06 de Agosto de 2014, Natal, RN. Available on http://www.29rba.abant.org.br/resources/anais/1/1401808338_ARQUIVO_TextoCompletoThiagoLimadosSantos.pdf. Accessed 15 Apr 2020
Santos RV et al (2020) Indigenous children and adolescent mortality inequity in Brazil: what can we learn from the 2010 National Demographic Census? SSM - Population Health 10:100537. https://doi.org/10.1016/j.ssmph.2020.100537
Silva CB (2013) Health professionals in indigenous context: the challenges to an intercultural and dialogic practice. Antropos - Revista de Antropologia, Ano 5:6-3-36. Available on https://revista.antropos.com.br/downloads/dez2013/Artigo-1-Profissionais-de-saude-em-contexto-indigena-Cleonice-Barbosa-da-Silva.pdf. Accessed 5 Apr 2020
Smye VL (2004) The nature of the tensions and Disjunctures between aboriginal understandings of and responses to mental health and illness and the current mental health system. Unpublished Doctoral Dissertation, University of British Columbia, Victoria. Available on https://www.collectionscanada.gc.ca/obj/thesescanada/vol2/001/nq90270.pdf?oclc_number=58454261
Smylie J et al (2011) Our health counts: urban aboriginal health database research project community report: first nations adults and children, Toronto, ON. Available on https://www.researchgate.net/publication/259184358_Our_Health_Counts_Community_Report_First_Nations_Adults_and_Children#fullTextFileContent
Souza MLP (2019) Mortality from suicide in indigenous children in Brazil. Cad Saúde Pública 35(supl. 3):e00019219. https://doi.org/10.1590/0102-311X00019219
Souza PG et al (2018) Acute lower respiratory infection in Guarani indigenous children, Brazil. Rev Paul Pediatr 36(2):123–131. https://doi.org/10.1590/1984-0462/;2018;36;2;00017
Steil CA, Toniol R (2013) The crisis of the concept of religion and its impact on anthropology. In: Giumbelli E, Béliveau VG (eds) Religión, cultura y política en las sociedades del siglo XXI. Biblos, Buenos Aires, pp 137–158
Stewart S (2008) Promoting indigenous mental health: cultural perspectives on healing from native counselors in Canada. Int J Health Promot Educ 48(2):49–56. https://doi.org/10.1080/14635240.2008.10708129
Teixeira JS (1999) Spirit. In: Cabral R e colaboradores (ed) Logos: Enciclopédia Luso-Brasileira de Filosofia. Verbo, Lisboa/São Paulo, pp 238–248
Torzillo P, Chang AB (2014) Acute respiratory infections among indigenous children. Med J Aust 200(10):559–560. https://doi.org/10.5694/mja14.00649
United Nations (2007) Declaration on the rights of indigenous peoples. U.N. GAOR, A/61/L.67/Annex of General Assembly in 2007. Available via United Nations. https://undocs.org/A/RES/61/295. Accessed 23 Apr 2020
Valeggia CR, Snodgrass JJ (2015) Health of indigenous peoples. Annu Rev Anthropol 44:117–135. Available on https://doi.org/10.1146/annurev-anthro-102214-013831. Accessed 5 Apr 2020
Vilela PR, Freitas MH (2022) Lidando com a religiosidade indígena no contexto hospitalar: impasses, desafios e perspectiva. In: Dias RJL, Freitas MH (eds) Sofrimento psíquico e sentido da vida no mundo contemporâneo: Contribuições da Psicologia da Religião. CRV, Curitiba
Vukic A, Rudderham S, Martin-Misener R (2009) A community partnership to explore gaps in mental health services in first nations communities in Nova Scotia. Can J Public Health 100(6):432–435. https://doi.org/10.1007/BF03404339
Vukic A et al (2011) Aboriginal and Western conceptions of mental health and illness. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health 9(1). Available on https://journalindigenouswellbeing.co.nz/media/2018/12/4_Vukic.pdf. Accessed 5 Mar 2023

Wayhs ACD, Bento BAR, FAA Q (2019) Public policies on indigenous mental health in Brazil. Trayectorias Humanas Trascontinentales, Números especiales N°4: Políticas públicas: desafios nos contextos atuais. https://doi.org/10.25965/trahs.1577

Whitbeck L (2006) Some guiding assumptions and a theoretical model for developing culturally specific preventions with native American people. J Community Psychol 34(2):183–192. https://doi.org/10.1002/jcop.20094

WHO (1978) Declaration of Alma-Ata. International Conference on Primary Health Care, Alma-Ata, USSR. Available via WHO https://www.who.int/publications/almaata_declaration_en.pdf

WHO (2002) Estratégias de la OMS sobre medicina tradicional 2002–2005. World Health Organization, Genebra. https://apps.who.int/iris/handle/10665/67314

WHO (2013) Estratégias de la OMS sobre medicina tradicional 2014–2023. World Health Organization, Genebra. https://apps.who.int/iris/bitstream/handle/10665/95008/9789243506098_spa.pdf;jsessionid=7FA5E1FE9863475CFBEBD452320CCC36?sequence=1

Wolff E (2012) Unitatis redintegratio, Dignitatis humanae, nostra aetate: textos e comentários. Paulinas, São Paulo

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