CHARACTERISTICS OF THE WORK PROCESS IN A HEALTH SUPPORT CENTER FOR THE INDIAN

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ABSTRACT
The attention of health can be considered as a work. The intervention object is the human being and the community. In the attention of Indigenous health, the process of work is peculiar due to socio cultural context. This way, this qualitative study aimed to characterize the working process of health in an institution, which gives support to Indigenous people, through the Flow Diagram Analyzer. The research was done at a Health Support Center to Indians, in Mato Grosso do Sul State, Brazil. Ten nursing professionals participated at the investigation. The working process was used as a theoretical reference. As data collection techniques, the non-participant systematic observation and the document analysis were used. The Flow Diagram Analyzer guided the observation. The results were analyzed by the technique of the thematic content analysis and organized into the following topics: entrance of Indigenous person, reception of Indigenous person; decision of classification: HSCI patient or patient in transit; menu: from logistical support to the Indigenous follow up; the exit of the Indigenous person. It was concluded that there is a working process centered in procedures and a unique menu of interventions, but with a weak implementation of singularized attention. The relational technologies are important to provide the care according the Indigenous needs.

Keywords: Work. Indigenous Health. Nursing.

INTRODUCTION

The practice of health care is considered as work and its object of intervention is the human being and the community. It materializes in a micro-space with a specific micro-politics and it is focused in live work, because the production and consumption of health care occur concomitantly[1].

The micro-politics of the work process in health has several forces that do not always act in the same directions. There is a set of coercive capitalist's elements and aspirations of the organizational structure, besides the existence of many processes 'desirer' of the agents in action - health workers and users[1,2].

The arrangement of these factors sets up a production process centered on live work or in dead work, with their production of emancipatory actions that value the uniqueness and subjectivities or assistance focused on procedures[2].

The intercultural context involving Indigenous health care[3] predisposes to a work process with certain peculiarities of the different perceptions that health workers, Indigenous and non- Indigenous, have about care, health and disease. The care is full of different and remarkable subjectivities.

Within Indigenous health context, workers face particular perspectives and experiences different from those related to the biomedical model[3]. Considering that Indigenous people have their own care needs[3,4], the National Policy for Health of Indian People states that there is a special attention to this population to be provided by the Special Indian Health Districts (DSEI). This type of care includes taking strategies for the articulation of Indigenous health practices and public health system. Thus, health professionals should take into account the particularities of Indians cultural communities and respect their traditional health practices[3,5].

With the peculiarities that is needed in the Indigenous' health care, we ask the following questions: How is the work process organized within the Indigenous care context? What technologies are used? On a micro space that is assumed restricted by cultural differences, this article aims to characterize the organization of

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the work process in a health institution support to Indigenous health.

MATERIALS AND METHODS

This is a descriptive study with a qualitative approach and case study method. It was held in a Health Support Center to Indian (HSCI) in the District DSEI in Mato Grosso do Sul, because it is a place where ethnic and cultural relational meetings between workers and Indigenous patients occur.

In Brazil, the Indigenous health attention organized in 34 DSEI[6], which corresponds to the organizational unit, established from a population and territory determined by socio-cultural aspects and service access[5,6].

The flow of assistance in the DSEI starts at the Polo base (primary health unit in the village). In the complex cases, the Indigenous patient is referenced for services associated to SUS. During the treatment and/or recovery outside the village, patients and caregivers are accompanied by HSCI with a nursing team[6].

The DSEI in Mato Grosso do Sul covers a population of 67,574 Indigenous people of eight ethnicities distributed in 75 villages. The HSCI investigated has 35 beds available. The flow of monthly attendance averages 344 Indigenous people[11].

The data collection was done in January and February 2011, consisted of the observation, during 400 hours of approximately 30 employees of the institution (nursing staff, drivers, cleaning staff, cooks and security) in different shifts (morning, afternoon and evening) and days of the week (including weekends and holidays).

For this, we used the non-participating systematic observation, which is selective, since the researcher observes a facet of natural and social reality. As guide observation, we used the Flowchart Analyzer described by Merhy[1]. It consists of the drawing of how to organize the work processes related to each other around a specific production line[7].

Concerning the graphical representation, the Flowchart aims to describe five inherent actions to the work process[1] that are: ellipse - user´s entrance moment; rectangle – user´s desk; lozenge – decision time; square - menu of interventions provided by the service; eclipse –

user´s end time and/or exit of the work process[1,7]. We used a field journal to record the observations.

In addition, document analysis was developed, getting the relevant institutional records rules and regulations available at the HSCI to collect data and understand the local operation. As main documents used in the institution, we found the following records: Health Care Politics of Indians People[8]; Annual Management Report 2008: Special Indian District -DSEI/MS[9]; Annual Management Report 2009: Special Indian District - DSEI/MS[10]; Annual Management Report of HSCI (DSEI/MS): 2010[11]. These documents were used in the analysis and interpretation of data to complement, support and/or contrasting evidence found in the observations.

In the data analysis, the intellectual operationalization of the information addressed: i) material readings; ii) clipping of the information concerned; iii) grouping according to the research objectives and theoretical framework[12].

The Ethics Committee Human Research of the Federal University of São Carlos under No. 384/210 protocol approved the study.

RESULTS AND DISCUSSION

From the results, it was possible to build a flowchart of the process analyzer working of HSCI as below.

The work process in HSCI is structured fundamentally in the act of nursing staff, whose work is separated in scheduling/planning and nursing center. In the first, activities are planned related to care provided to Indigenous people and therefore, certain actions of the staff of the nursing center are determined, whose function is to provide direct care to the user. Thus, the analysis of the working process in HSCI is structured in the following topics: reception, a decision-making process, and exit menu.

The entrance of Indigenous person

Users entering in the HSCI come from villages in the DSEI of Mato Grosso do Sul and sporadically from out of state[10]. The arrival of the natives is scheduled or spontaneous[9]. They come seeking for support to do examination, visit a medical specialist or returning in other health institutions[10].
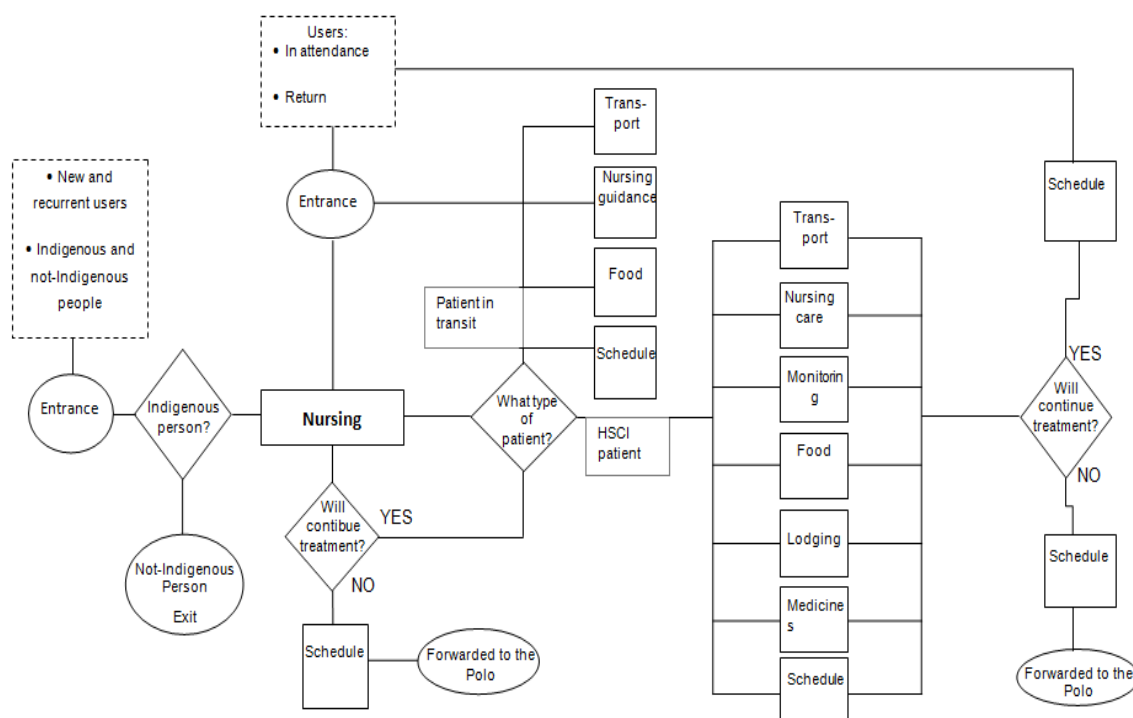
Figure 1 - Flowchart analyzer of user-centered work process of the Health Support Center to Indians.

There are two physical entrances. The main one, which is open during the day (6am to 6 pm). The other, it is located in the back and it is closed with a lock. In both, there is the presence of a continuously security not allowing user´s entrance. Here, begins the process of health work in the institution, where the security is a health care worker to meet with the user and make the decision on how to receive him and/or welcome him[1].

> All participate in the work process [...] the securities receive the Indigenous people, make radio call, receive calls and are important to control who enters and who exits and who is coming to HSCI. (Field Journal)

The security also is attentive to the Indigenous do not leave because of the risk of "escape" because they are forbidden to enter and exit freely from The Support Center. They leave only with a health worker or under authorization of the Head of the HSCI or Nursing. There is use of soft technology[1], such as creativity, patience and the ability to address, convince and keep the natives in HSCI. Despite the use of relational tool, it is clear the subsumption of the materiality standards of the institution. To convince the

Indigenous people not to leave the HSCI equates to limit and/or curtailing its governance.

The process of working in the institution is a bureaucratic environment, i.e., there is crystallization of live work by dead work (pre-established norms). In this context, there is not recognition of the historicity of the subject, the worker reduces the person to an object and understands that its decision and institutional rules are absolute and unique in care[2].

The special care adopts the respect and integration of Indigenous life in health care[13]. However, the organization of work, whether in Indigenous and non-Indigenous health service, based on the stiffness of the legal-organizational[2,3] apparatus will produce a care that does not respect nor enhances the autonomy of the user/citizen.

The reception of Indigenous person

After going through one of two entrances, the Indigenous people are welcomed by nursing team. Typically, the reception occurs at the nursing center, where Indigenous patients are standing in the hallway where everyone passes.

> [...] Long time ago that I watch that the technicians are noting nursing procedures in the

book of nursing report and the records. They seem unhappy with the activity, even when an Indigenous person comes from the village. When the Indigenous person comes to HSCI and goes to his room, we did not observe any history and/or physical examination of him. Their documents are collected to photocopy and recording their entry. Nursing professionals go together to the room with him, ask if they are feeling well, if they have any allergies and about the medicines in use; but soon they need to return to the nursing center, because they need to make photocopies and continue the records [...]. (Field Journal)

On the admission, the nursing staff request the user´s document and follow a routine of "data collection" (where the Indigenous person came from, how his state is, how he came). Not a medical history neither interview was observed in order to identify the Indigenous health needs.

The impartiality, neutrality and little involvement required of a researcher in their experimental studies are required of the employee in the process of health shaped by biomedical model. That is, there is dehumanization, depersonalization, subjection/objectification of the person, and their submission to the rules and routines[2].

At the reception, however, it is important the welcome[14]. Although the nursing staff is helpful and demonstrates solidarity in the dialogue, the reception is taken in hard technology, the routine procedures described. The act of welcoming them occurs, most often without privacy or comfort.

[...] In some cases workers demonstrate not to know the whole history relating to the Indigenous health problem. That is, even understandable, because without the historical record there is difficulty to remember details of many different situations [...] (Field Journal)

Without information obtained from the clinical history in a deeper conversation dialogue with the Indigenous patient, it is not possible to understand her or his health needs in order to manage the care. The reception provides a more appropriate answer to the user, considering their history[1,14]. Particularly in the Indigenous case, the reception has the potential to minimize cultural differences.

The classification decision: HSCI patient or patient in transit

Various decision-making moments occur. Most decisions are taken by the head and by the nursing staff. Two key decision-making processes in directing the course of the flowchart are described. The others are listed in the menu offer.

At the entrance are usually drivers and always securities, he makes the "classification" of the one arriving. (Field Journal)

The verified requirement is if the individual is Indigenous person or not. If perhaps, the person is not a native, their entrance in the institution is not allowed. At the reception at the nursing center, the decision-making process occurs that will define if the user is in transit patient or HSCI patient. This is a classification adopted by the institution to distinguish users with a specific care (patient in transit) and those with a long-term care.

The decision making process has a purely instrumental, functional logic. This is an organizational norm, whose function is to ensure optimization of working time. No spaces for conversations between workers and Indigenous people were observed. The criterion to be prioritized is not concerned with user´s subjectivities.

While in the Indigenous special attention is recommended[8], there is the influence of the capitalist work focused on rigid organization of the act of workers[15]. In this context, without knowledge of Indigenous diversity, the care process will be a "shock" of culture, cultural estrangement between the actors of care.

Many times cultural differences make conflicted caregivers act together with the Indigenous patients[4,13,16]. Conflicts constitute a cultural barrier from the attitude of workers "in Eurocentric tradition" to apply knowledge of biomedicine, hygiene and sanitation according to scientific principles"[17:13].

Menu: from logistical support to the Indigenous follow up.

According to the type of patient that the user is considered, he will follow different directions in the healthcare flow. It was possible to show three main types of intervention described below.

Assistance offer, work centered in the disease

The menu offered to HSCI patients includes transportation by health technicians and nursing procedures (administration of medicines,

dressings, checking vital signs, bed bath and sprinkler) services. To patients in transit are offered mainly transport and some nursing care to include guidance on the location and type of procedure by any doubts of the users.

Another element provided on the menu of HSCI patients is food. In the institution, there is a kitchen and a dining room where, respectively, six daily meals are made and offered that the Indigenous people have access[10]. The nutritionist prepared the diet but the nursing staff is who specifies the type of diet for each clinical case[9]. The lodging is other menu item because HSCI welcomes Indigenous people full-time since the stage of the first consultation until the end of treatment[11].

There is also the availability of medicines of the Secretary of the Indian Health Service. Pharmaceutical care is to ensure essential drugs for the Indigenous people from needs and local specificities[10].

In HSCI, not medical consultations or examinations are offered. The technical procedures performed are produced by nursing. The staff does not perform conversation or other activities that could extend care beyond the disease.

The offer of new health practices can provide links, listening, self-esteem and self-governance of the users. It can also enable the appointment of new ways for care management and trails adequate to an organizational and institutional organization for real needs of users[2,14,18].

> [...] An Indigenous woman who arrived from the interior of the State was taken and remained alone during the exams to which her six months son. When she came back to HSCI, she could not report what had happened and the reasons which justified the examinations of her baby. In the health service, any worker had given some information from the return or the examination [...]. (Field diary)

In this quotes, it is possible to highlight two features. The first referring to the lack of dialogue between the employee of the nursing center and the Indigenous patient, because there was no using of relational technology that would enable the understanding of the Indigenous need. She needed a nursing worker to support her and inform her of the procedures to which his son was undergoing. The other characteristic is

related to the lack of communication between scheduling and nursing center and also between scheduling and the Pole Base staff (village). It seems to have been exchanging information on the real needs of Indigenous woman because there was no record showing the need of being with a worker.

Without the production of decentralized procedures of the disease, the link and accountability are compromised during the care process. The production of a care that enhances the cognitive and affective knowledge involves issues beyond the technical and scientific context based on the biomedical model and this context is a major challenge to the organization of public health services[2,18].

Accompanying, a different act.

It constitutes a differentiated practice inherent in the nursing care provided in HSCI and is crucial to the Indigenous people who have difficulties with communication and misinformation regarding the functioning of health services.

> [...] They came today, accompanied by the driver, an Indigenous woman, 46 years old, and her baby, two months. She has brought her son to the second screening test. In a conversation between the technical nursing and the mother, she could not say the reason for that they were in HSCI. (Field Journal)

The nursing staff accompanies the indigenous during consultations, returns and procedures (imaging, laboratory, among others). Including hospital visits are made to HSCI hospitalized patients[11]. The accompanying is a device that provides the special attention, because it cares of a need of HSCI indigenous, which is unfamiliarity about the workings of the NHS care networks, as evidenced in the situation previously reported of the mother and her child.

Accompanying is a lightweight technology of the work process and reveals the potential of it. Health work concerned with the improvement of the individual bases its actions on creativity with logic rescue / keep stepping the user's life[1].

Although the accompanying be performed and recorded by Nursing, there is no patient history monitored at least in the service network of the DSEI. The information is referenced, but there is no accompanying of the evolution of the health problem. The records arise from the

organization of work in process in HSCI and DSEI.

> [...] The referral and post referral work, the information is passed to the HSCI to the Polo, and vice versa. But, from what I observe, this information does not accompany the patient, there is no single medical record, there is no accompanying of the clinical history [...] (Field Journal)

In the referral and post referral system, it is not enough to establish a flow and post flow, it is necessary to recognize that the information of quality of care and ensuring the comprehensiveness of care are being transferred in the unit[19].

Although the referral and post referral are important strategies in redirection to the completeness in health care, the system is still in some stage of development, both in the theoretical framework as the dissemination of experience of its use[19]. In this perspective, the HSCI reality seems to reproduce the general context of healthcare in the country.

Logistical support governed by scheduling.

Logistical support includes the organizing procedures (consultations, examinations, among others) that the Indigenous undergo and transportation to the place of the implementation of such activities, and nursing records necessary for such organization.

Through the Day Agenda tool, where the records of the user information are registered (like the village and town of origin), the scheduling plan daily work routine in the HSCI. There are control on the next dates of return, if any.

> [...] The nursing technique seems to be very busy. There are several schedules [in this context, procedures that users are forwarded] that were confirmed, but need to be checked with the day agenda and then be passed to the book of nursing report [...]. (Field Journal)

The structured micro policy of the institution, does not allow the preparation of planning activities through the health profile of clients assisted. Not only the user´s needs, but the act of workers is also streamlined.

In work relations, drivers and nursing staff are the one who most talk. Since nursing is responsible for issuing the request for transportation. Drivers must notify and request authorization to take or get users from one place to another. Even if they are on the street, there is consultation with the nursing staff for permission to go, as there are control by authorization guides.

> It is different the way of acting of the drivers, it seems they are subjected to the scrutiny of nursing. Everything that involves decision (whether to seek the patient or not in the place, for example) is acting by Nursing radio. (Field Journal)

The work of drivers is dominated by nursing. The traffic of cars and ambulances of the institution is linked to the transportation of the Indigenous people. The coordination of the transportation is under the "responsibility" of nursing.

This dependence is naturalized in the working process of the HSCI, drivers see the control by the nursing as normal and the nursing staff has certain status by the hierarchy that drivers are submitted. Institutional rules were absorbed by workers.

There is a concentration in the development of the procedure, without considering the desiring user´s processes[2]. Thus, in this menu, it is necessary to offer more relational tools, such as dialogue, accountability and bond. So, it could be built care focused on the individual, considering their subjectivity and singularity[2]. Therefore, there will be production-centered care in health and disease of the Indigenous process.

The exit of Indigenous person

The exit of the Indigenous patients may occur for their better health situation and consequently, treatment completion. It can also be for abandonment or death. Or even, by transferring the treatment of health problems for the city of origin or residence (village)[11].

On the exit of any Indigenous person, nursing staff need to follow these steps:

> The exit registration on the book of entrance and exit in the book of nursing report, fill in the post referral, send it via fax and archive the records in the folder. (Field Journal)

Moreover, it is necessary to guide users to the possible return on the prescription, if any, and to health care.

Since HSCI is an integration bridge between primary care and referral centers in serving the Indigenous people[20], the work process is designed to achieve this goal. This situation, coupled with the transience of most Indigenous people who are treated at HSCI favors that the exit is understood as a "rite of going forward," simply mediating communication between instances of care. It seems to be reducing the Indigenous causes and effects of their health problems[2].

According to the observations made in this study, the exit of the Indigenous patient is guided by the soft-hard technology. It is structured clinical knowledge, in which the person is understood as passive object without recognizing the different dimensions of the human being[2]. Within the context of the Indigenous health attention, it is also necessary to consider cultural his peculiarities of care and sick.

FINAL CONSIDERATIONS

The analyzer flowchart is shown as a tool that enabled some features of the work process in health research in the area studied. However, as the Indigenous people were not direct participants in the research, the study has limitations regarding the type of care to the comprehension produced in the working process of the HSCI.

The working process of the institution is crossed by the materiality of the normative and organizational apparatus and the subsumption of the individual rules of the health service, which seems to reduce the Indigenous person to be patient, with minimal self-government and almost no historicity. The instrumental logic that governs the decisions in the work process aims to optimize the act of workers and leads to the capture of the subjectivities of the actors care. Thus, care becomes cultural estrangement, with consequent barrier to the expression of needs and user perspectives.

The HSCI sets a context of health care with cultural peculiarities by watching people walk the ways of life different from those traditionally accepted, however, in a way, it reproduces similar to other health problems of the country.

It is observed the enhancement of the biomedical model, especially in institutional standards, with little regard for traditional Indigenous medicine and operationalization of little special care.

In order to improve service to the Indigenous people at HSCI, we recommend greater use of relational technologies, in order to consider the cultural differences that exist between those who care and who are cared. In this sense, the host outlined in solidarity and human being has the potential to allow the bond to minimize cultural differences between actors and foster care practices decentralized health disease.

The reception in HSCI needs to acquire character of differentiated technology, i.e. a centralized practice in need of the Indigenous person. As evidenced, the reception has contributed, in a way, with the inclusion of users in the process of subjection and non-personification characteristic of the biomedical model.

CARACTERÍSTICAS DO PROCESSO DE TRABALHO EM UMA CASA DE APOIO À SAÚDE DO ÍNDIO

RESUMO

A prática do cuidado em saúde pode ser considerada como trabalho, cujo objeto de intervenção é o homem e coletividade. No cuidado ao indígena, o processo de trabalho apresenta peculiaridades devido ao contexto sociocultural. Assim, objetivou-se caracterizar a organização do processo de trabalho em saúde em uma instituição de apoio à saúde indígena por meio do Fluxograma Analisador. Estudo descritivo com abordagem qualitativa, modalidade estudo de caso. A pesquisa foi realizada em uma Casa de Apoio àSaúde do Índio, no Mato Grosso do Sul, Brasil. Utilizou-se como referência teórica, conceitos de processo de trabalho e como técnicas de coleta de dados, a observação sistemática não participante e análise documental. A observação foi orientada pelo Fluxograma Analisador e a informações foram analisadas e organizadas nos seguintes tópicos: entrada do indígena; recepção do indígena; decisão da classificação: paciente Casa de Apoio à Saúde do Índio ou paciente em trânsito; cardápio: do apoio logístico ao acompanhamento dos indígenas; saída do indígena. Considerou-se que há um processo de trabalho centrado em procedimentos, com um cardápio de intervenções

peculiar, mas com pouca operacionalização da atenção diferenciada. Recomenda-se maior utilização de tecnologias relacionais com vistas ao cuidado centrado no indígena.

Palavras-chave: Trabalho. Saúde Indígena. Enfermagem.

CARACTERÍSTICAS DEL PROCESO DE TRABAJO EN UNA CASA DE APOYO A LA SALUD DEL INDIO

RESUMEN

La práctica de la atención a la salud puede ser considerada como trabajo, cuyo objeto de intervención es el hombre y la colectividad. En la atención al indígena, el proceso de trabajo presenta peculiaridades debido al contexto sociocultural. Con ello, este estudio tuvo como objetivo caracterizar la organización del proceso de trabajo en salud en una institución de apoyo a la salud indígena a través del Diagrama del Flujo Analizador. Estudio descriptivo con enfoque cualitativo, modalidad estudio de caso. La investigación se realizó en una Casa de Apoyo a la Salud del Indio, en Mato Grosso do Sul, Brasil. Se utilizó como referencia teórica los conceptos del proceso de trabajo y como técnicas de recolección de datos la observación sistemática no participante y el análisis documental. La observación fue conducida por el Diagrama de Flujo Analizador y las informaciones fueron analizadas y organizadas en los siguientes asuntos: entrada del indígena; recepción del indígena; decisión de la clasificación: paciente Casa de Apoyo a la Salud del Indio o paciente en tránsito; menú: desde el apoyo logístico hasta el acompañamiento a los indígenas; salida del indígena. Se consideró que existe un proceso de trabajo que se centra en los procedimientos, con un menú de intervenciones particular, pero con poca implementación de la atención diferenciada. Se recomienda una mayor utilización de las tecnologías relacionales, pretendiendo el cuidado dirigido al indígena.

Palabras clave: Trabajo. Salud del Indígena. Enfermería.

REFERENCES

1. Merhy EE. Em busca do tempo perdido: a micropolítica do trabalho vivo em saúde. In: Merhy EE, Onocko R, organizadores. Agir em saúde um desafio para o público. 3a ed. São Paulo: Hucitec; 2007. p. 71-112.

2. Ceccim RB, Merhy EE. Intense micropolitical and pedagogical action: humanization between ties and perspectives. Interface (Botucatu). 2009; 13 Sup1:531-542.

3. Novo MP. Política e intermedicalidade no Alto Xingu: do modelo àprática de atenção àsaúde indígena. Cad saúde pública. 2011 jul; 27(7):1362-1370.

4. Rissardo LK, Monilertno ACM, Borghi AC, Carreira L. Práticas de cuidado ao recém-nascido: percepção de famílias Kaingang. Cienc cuid saúde. 2011; 10(4):634-641.

5. Langdon EJ. Diversidade Cultural e os Desafios da Política Brasileira de Saúde do Índio. Saúde Soc. 2007; 16(2):7-12.

6. Garnelo L. Política de Saúde Indígena no Brasil: notas sobre as tendências atuais do processo de implantação do subsistema de atenção àsaúde. In: Garnelo L, Pontes AL. organizador. Saúde Indígena: uma introdução ao tema. Brasília (DF): MEC-SECADI; 2012. p.18-59.

7. Reis VM, David HMS.O fluxograma analisador nos estudos sobre o processo det rabalho em saúde: uma revisão crítica. Rev APS. 2010 jan-mar; 13(1):118-125.

8. Ministério da Saúde(BR). Fundação Nacional da Saúde. Política de atenção àsaúde dos povos indígenas. 2a ed. Brasilia(DF): Fundação Nacional da Saúdea; 2002.

9. Ministério da Saúde (BR). Fundação Nacional da Saúde. Coordenação Regional de Mato Grosso do Sul. Relatório anual de gestão 2008: Distrito Especial Indígena – DSEI/MS. Campo Grande; 2008.

10. Ministério da Saúde (BR). Fundação Nacional da Saúde. Coordenação Regional de Mato Grosso do Sul. Relatório anual de gestão 2009: Distrito Especial Indígena –DSEI/MS. Brasil. Campo Grande; 2009.

11. Ministério da Saúde (BR). Secretaria Especial de Saúde Indígena. Coordenação Regional de Mato Grosso do Sul. Relatório anual de gestão da CASAI (DSEI/MS): ano de 2010. Campo Grande; 2010.

12. Bardin, L. Análise de conteúdo. 4a ed. Lisboa: Edições 70; 2009.

13. Diehl EE, Langdon EJ, Dias-Scopel RP. Contribuição dos agentes indígenas de saúde na atenção diferenciada àsaúde dos povos indígenas brasileiros. Cad saúde pública. 2012 maio.; 28(5):819-831.

14. Sá ET, Pereira MJB, Fortuna CM, Matumoto S, Mishima SM. O processo de trabalho na recepção de uma Unidade Básica de Saúde: ótica do trabalhador. Rev gaúch enferm. 2009. [citado 2014 fev 27]; 30(3):461-7. Disponível em: http://seer.ufrgs.br/RevistaGauchadeEnfermagem/article/view/8690/6967.

15. Faria HX, Dalbello-Araujo M. Precarização do trabalho e processo produtivo do cuidado. Mediações. 2011 jan-june; 16(1):142-156.

16. Ferraz L, Boehs AE, Fernandes GCM. Percepções das equipes de saúde da família sobre o cuidado profissional às crianças indígenas. Cienc cuid saúde. 2013 jan-mar;12(1):032-039.

17. Fóller M. Intermedicalidade: a zona de contato criada por povos indígenas e profissionais de saúde. Tradução de Moon J. In: Langdon EJ, Garnelo L. organizadores. Saúde dos povos indígenas: reflexões sobre antropologia participativa. Rio de Janeiro (RJ): Contra Capa Livravia/Associação Brasileira de Antropologia; 2004. p. 129-147.

18. Uchôa AC. Innovative care experiences at Family Health Program (PSF): potential and limits. Interface (Botucatu). 2009; 13(29):299-311.

19. Fratini JRG, Saupe R, Massaroli A. Referência e contrarreferência: contribuição para a integralidade em saúde. Ciênc cuid saúde. 2008; 7(1):65-72.

20. Gonçalves LJM. Na fronteira das relações de cuidado em saúde indígena. São Paulo: Annablume; 2011.

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