Rethinking cultural competence in healthcare practices in Brazil: towards cultural sensitivity in care

Repensando a competência cultural nas práticas de saúde no Brasil: por um cuidado culturalmente sensível

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Abstract

Planning and implementing health policies and practices in countries with Primary Health Care-oriented systems must recognize and manage social inequality issues in health, which hinder comprehensive and equitable care. A widely advocated strategy for detecting and dealing with such challenges is the notion of cultural competence (CC). In this article, we will present the notion of CC, its criticisms, and theoretical-practical alternatives and, then, a narrative review of Brazilian publications related to healthcare in the Family Health Strategy. Recognizing sociocultural diversity in planning health interventions in Brazil is essential, given that it is an extremely diverse country, whose health system is organized on the premises of the Health Reform but that presents important inequities still. We argue that the inclusion and the negotiation of sociocultural differences in health practices would benefit from the observation of the social-historical context and the reflection on the Brazilian health care experiences and the everyday care practices within the communities.

Keywords: Cultural Competence; Primary Health Care; Cultural Diversity; Intercultural Competence; Health Status Disparities.

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Resumo

O planejamento e a implementação de políticas e práticas de saúde em países com sistemas orientados para a Atenção Primária em Saúde devem reconhecer e manejar as questões de desigualdade social em saúde que interferem no cuidado integral e equânime. Uma estratégia amplamente defendida para detectar e lidar com tais desafios é a noção de competência cultural (CC). Neste artigo, apresentaremos a noção de CC, suas críticas e alternativas teórico-práticas e, em seguida, uma revisão narrativa dessa noção em publicações brasileiras relacionadas à assistência em saúde na Estratégia Saúde da Família. O reconhecimento da diversidade sociocultural no planejamento de intervenções em saúde no Brasil é fundamental, dado que se trata de um país extremamente diverso, cujo sistema de saúde é organizado a partir das premissas da Reforma Sanitária, mas que, ainda assim, apresenta importantes iniquidades. Argumentamos que a inclusão e a negociação das diferenças socioculturais nas práticas de saúde se beneficiariam da observação do contexto histórico-social e da reflexão acerca das experiências brasileiras de assistência em saúde e das práticas cotidianas de cuidado utilizadas nas comunidades.

Palavras-chave: Competência Cultural; Estratégia Saúde da Família; Diversidade Cultural; Competência Intercultural; Iniquidades em Saúde.

Introduction

Since the Alma Ata Conference, it has been argued that healthcare based on Primary Health Care (PHC) and oriented toward the community would be associated with improving the health outcomes of populations and would result in the reduction of social inequalities and health inequities (Alencar et al., 2014; Almeida, 2018; Williams; Gutierrez; Soranz, 2020).

In the case of the Brazilian public health system, the reorganization of healthcare has been oriented towards the structuring of PHC using the Family Health Strategy (FHS). It is understood that the FHS qualifies care practices for families and communities by identifying needs and organizing activities in the territories under its responsibility (Alencar et al., 2014; Brasil, 2017; Gusso, 2011; Schneider; Pereira; Ferraz, 2020).

FHS teams are multidisciplinary, consisting, at least, of a physician (preferably family and community medicine), a nurse (preferably a family health specialist), a nursing assistant and/or technician, and a community health worker (CHW) (Brasil, 2017). It is believed that the inclusion of CHWs enhances the mediation between health services and the population, ensuring greater cultural sensitivity in the interventions developed in the community (Morosini; Fonseca, 2018; Nunes et al., 2002; Ortega; Wenceslau, 2020).

According to Starfield (2002), the attributes of PHC are the principles that shape health actions in the FHS and, in combination, are unique to this logic of healthcare. They consist of first-contact care, longitudinality, comprehensiveness, and coordination of care. The aspects that qualify the actions include family-centered care, cultural competence (CC), and orientation to the community. Finally, the characteristics that are essential, but not exclusive, are: continuity and quality of care, professional-patient communication, patient protection, and medical record format.

CC is recognized as a strategic notion for reducing health inequities and recommended in the training of family and community physicians and other professionals who are part of the multidisciplinary teams (Gusso; 2011; SBMFC, 2015; Schneider; Pereira;

Ferraz, 2020; Starfield, 2002). This article aims to analyze how the notion of CC has been discussed in the Brazilian literature using a narrative review. Initially, the definition of CC, critical readings, and alternative proposals in the international literature will be exposed. Then, the results of the review will be presented. We argue that the adoption of the CC framework is inadequate in the articulation of historical and social context, care experiences, and communities' daily practices that include sociocultural differences in the negotiation of care. Expanding the debate around culturally sensitive healthcare in our reality is key to advancing social inclusion and reducing health inequalities.

Contextualizing cultural competence

It can be said that the study by Cross et al. (1989)—"Towards a culturally competent system of care: a monograph on effective services for minority children who are severely emotionally disturbed"—aimed at adapting the interventions offered to Black children victims of violence in the United States, offered a first definition of *cultural competence.* In this study, the authors understand CC as a set of behaviors, actions, and health policies in which systems, services, and professionals act in a congruent way to recognize and include cultural diversity in multicultural care settings (Cross et al., 1989; Horvat et al., 2014) and to address health inequities (Fleckman et al., 2015; Lekas; Pahl; Fuller Lewis, 2020).

The choice of the terms culture and competence for the construction of the notion of CC is based on the understanding that culture would imply an integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The term competence would imply the ability to recognize the cultural diversity of the communities served and provide tools to students and healthcare providers to act with cultural sensitivity in their practice (Cross et al., 1989).

CC development, as in other competencies, occurs over time with experience, training, mentoring, and self-assessment, which requires attitudes, policies, and practices. Attitudes can be cultivated by training, role modeling (learning from the example of teachers/preceptors), and experience during training and in service. Policy evolves with research, goal setting, and advocacy; practice grows with information, capacity building, and development of alternative options (Cross et al., 1989).

Culturally sensitive healthcare practices are related to the ability to recognize cultural diversity and to the observation that diversity shapes the care-seeking process. Although all people share basic needs, we can observe big differences in how people deal with those needs. It is essential not only to recognize the different patterns of care-seeking, but also the ways of communicating, defining, and evaluating health and support networks.

To notice these differences, professionals should acknowledge the role of culture in their own lives and notice its influence on how they act and think, developing critical awareness about their own ethnocentric attitudes. Thus, the complexities of interactions can be fully considered (Cross et al., 1989). Moreover, specific knowledge about the patient's culture becomes very important for the care process since it enables the recognition of significant symbols and the understanding of how health is defined and how primary support networks are configured (Cross et al., 1989).

Family, according to the definition of each cultural context, is the main support system and the preferred intervention point. Other social networks, such as neighbors, churches, and healers, can be included, and the system should identify and incorporate, in some cases, cultural knowledge into health practices to support and strengthen communities (Cross et al., 1989). Professional training attentive to these values, in turn, should be guided by curiosity and willingness to treat patients from different backgrounds and should develop communication skills and differentiation of symptomatology and suffering related to cultural patterns—languages of suffering (Cross et al., 1989).

CC training has been consolidated in the United States as a course in undergraduate health professions education and medical residency programs. Various models of teaching and application in care have been implemented to increase cultural sensitivity (Fleckman et al., 2015). These programs are centered on an individualized approach, in which clinicians address

the illness experience from the patients' perspective, helping them to understand the physicians' perspective and the need to negotiate a common ground (Fleckman et al., 2015; Saha; Beach; Cooper, 2008). Ignoring cultural differences in the clinical encounter would create a barrier to effective communication, resulting in patient dissatisfaction, poor compliance, and worse health outcomes (Teal; Street; 2009).

The critique of the notion of cultural competence

The discussion around CC has progressed, acquired different features, and generated important debates. The following observations allow us to glimpse conceptual limitations and practical repercussions of CC (Kirmayer, 2012; Kleinman; Benson, 2006; Taylor, 2003).

The first limitation, perhaps the most important, concerns the naive incorporation of the concept of culture in the field of health. In general, culture was understood to be synonymous with ethnicity, nationality, and language and thus could be reduced to a technical skill in which health professionals could be trained. Therefore, it would be summarized as training on what to do, or not to do, when dealing with patients from a certain background (Kleinman; Benson, 2006; Lekas; Pahl; Fuller Lewis, 2020; Taylor, 2003).

The application of CC in healthcare practices reveals yet a second aspect: healthcare providers and services tend to refer to the culture of the patient or the community, assuming the perspectives and practices of professionals and services as standard. Professionals, services, and undergraduate and postgraduate courses belong to the biomedical field, but they do not recognize it as belonging to a specific culture (Taylor, 2003). Therefore, they fail to reflect on the biomedical culture and the limits of this approach, which considers the human body as universal and amenable to standardized diagnostic and treatment interventions.

The third line of criticism of CC concerns its overvaluation, stating that patient/family characteristics and needs would be automatically interpreted as a result of their origin and context, preventing a more practical or diverse understanding of the case (Kleinman; Benson, 2006). Examples include professionals who automatically translate complaints from people who attend a certain religion as a variation of rites and spiritual experiences, failing to address them in their entirety.

Kleinman and Benson (2006) also point out that an approach without a reflective framework could generate a feeling of invasion or even contribute to the feeling of isolation and stigmatization in patients and their families since it would single them out as being different within the health system.

Finally, the very definition of a person is a cultural construct and presents important variations in what each person considers relevant, what constitutes their identity, and what is indicative of health. These variations are not just abstract conceptual schemes but are grounded in bodily experiences and broad cultural structures (Kirmayer, 2012).

Alternatives to cultural competence

The critical movement triggered by the debate around CC allowed the development of other notions attentive to the impact of cultural insensitivity on health practices. Therefore, alternatives to CC have been developed, progressing in approaches that include the power relations involved in the debate around cultural diversity, as well as those that introduce the structural socioeconomic aspects more incisively (Foronda et al., 2016; Metzl; Hansen, 2014).

Cultural humility, a framework developed from discussions in North American medical education, criticizes the notion of CC for presuming the complete and permanent acquisition of knowledge and competence about cultural diversity and for not questioning the inequality of power existing in the professional-patient relationship. The notion of humility is understood to be important in recognizing power imbalances from the patient's perspective, thus enabling the development of beneficial and non-paternalistic partnerships with communities (Foronda et al., 2016; Lekas; Pahl; Fuller Lewis, 2020; Tervalon; Murray-Garcia, 1998).

The term cultural humility has been used in a variety of contexts, regarding differences in ethnic, racial, sexual orientation, social status, interprofessional relationships, and the doctor-patient relationship. The following attributes have been associated with a

practice characterized by cultural humility: openness (to diversity), self-awareness (of one's own cultural trajectory and position in relationships), absence of ego (egoless – personal quality of the healthcare worker to be less self-centered for the establishment of a more balanced professional-patient relationship), supportive interactions (interventions that recognize differences and special needs of each case), and self-reflection and criticism about clinical encounters and their effects (Foronda et al., 2016). Cultural humility is also understood as a continuous process to be developed individually by healthcare providers and encouraged by healthcare services and systems (Foronda et al., 2016; Lekas; Pahl; Fuller Lewis, 2020; Tervalon; Murray-Garcia, 1998).

The notion of cultural safety emphasizes issues of power, representation, and discrimination as essential complements for professionals (Brascoupé; Waters, 2009; Curtis et al., 2019; Kirmayer, 2013). Cultural safety was developed from the practice of New Zealand nurses caring for the Maori population, and it recognizes the current conditions of Aboriginal peoples as a result of their history of colonization and assimilation (Brascoupé; Waters, 2009). It argues that providing quality care to people from different ethnic and cultural backgrounds requires healthcare providers to act within the cultural values and norms of these groups. This can be accomplished by acquiring knowledge (as in CC) and by letting patients define the quality of care criteria according to their ethnic, cultural, and individual norms (Brascoupé; Waters, 2009).

The introduction of the concept of cultural safety into the debate on cross-cultural healthcare has been significant in broadening the discussion, focusing less on the benefits of cultural sensitivity and more on the risks associated with its absence. It is essential that healthcare providers, services, and systems develop a critical awareness of power structures and, fundamentally, of their own culture, and that they recognize and transform their own practices rather than prioritize becoming "competent" in the cultures of others (Curtis et al., 2019). Moreover, cultural safety explicitly emphasizes tolerance for the unknown and uncertainty as a professional framework and ethical stance towards others (Kirmayer, 2013).

The idea of structural competence (SC) was also conceived in North American medical education and seeks to highlight the importance of training healthcare providers aware of the structural nature of stigma and health inequalities. Contrary to CC, which focuses on identifying clinical bias and improving communication in clinical encounters, SC encourages clinicians to recognize how social, economic, and political conditions produce health inequalities (Metzl; Hansen, 2014). Thus, it prioritizes the influences observed at higher levels over individual interactions and proposes training healthcare providers in five main competencies: recognizing the structures that shape clinical interactions; developing an extra-clinical language; reframing "cultural" formulations in structural terms; observing and planning structural interventions; and developing structural humility (Metzl; Hansen, 2014).

Addressing stigma and inequality in clinical settings requires healthcare providers to recognize the social structures that shape and produce the assumptions underlying stigma. These structures are often invisible or barely addressed in health education. Evidencing structural power is a first step in the process of validating the influences of interpersonal networks, environmental factors, and political/socioeconomic powers on clinical encounters (Metzl; Hansen, 2014).

The second and third components of SC indicate the need to reformulate the so-called "cultural" clinical presentations in interdisciplinary terms, emphasizing the interconnection of different levels in the social structure (Metzl; Hansen, 2014). The fourth element of the SC indicates that the structures that shape health and disease are neither timeless nor immutable but reflect political-economic decisions in specific contexts. Finally, the adoption of the notion of humility is valued due to the recognition of the limitations of SC and the development of a critical awareness of professional training (Metzl; Hansen, 2014).

Metzl and Hansen (2014) insist that this approach has not removed the importance of interpersonal communication in clinical interactions, especially when forms of cultural, linguistic, economic, or other differences are evident. However, they point out that biomedicine has traditionally focused on the clinical encounter as the main area of care practice,

neglecting the structural factors that shape the health and illness process.

Intercultural competence (IC) is an extension of the notion of interculturality. Interculturality, debated in the field of public health policies in Latin-American countries, advocates for the acknowledgment that each society has its own health practices, which are culturally rooted, be it of a religious, ethnic, or scientific nature. The encounter between different traditions of care happens whenever societies interact and reconfigure their practices. Consequently, interculturality implies recognizing the relationship between health, illness, and care (Guilherme; Dietz, 2014; Menéndez, 2016).

IC aims to recognize and transform the structural framework that has given rise to political, socioeconomic, and cultural inequalities, contributing to the resolution of intercultural conflicts. The particularities of sociocultural contexts and the challenging of domination relationships that exclude, subordinate, and discriminate against social actors can become visible by addressing cultural diversity using a positive recognition of difference (Fleckman et al., 2015; Veliz-Rojas; Bianchetti-Saavedra; Silva-Férnandez, 2019).

Different from CC, based on a unilateral approach that allows for substantial knowledge of another culture, IC would be better suited to health training contexts since it promotes learning oriented towards the processes of interaction between professionals and patients and their communities (Fleckman et al., 2015). Recognizing the knowledge and experience within an intercultural context is a result from emphasizing social practices rather than studying social and ideological representations, highlighting the interactive and negotiated articulations that are often unconscious (Guilherme; Dietz, 2014; Menéndez; 2016).

Cultural safety, structural competence, and intercultural competence all criticize the CC notion that healthcare providers can be "taught" to recognize the cultural particularities of their patients in diagnosis and treatment planning. They also highlight the challenges of care practices, such as structural violence, naturalization of inequality, and the understanding that structural vulnerabilities assume unique forms in specific cultural contexts (Martinez-Hernaez et al., 2021).

Cultural competence in Brazil – a narrative review of the literature

Training in family and community medicine in Brazil is considered essential for the development of good practices in the FHS, and it indicates the incorporation of cultural sensitivity in the residency curriculum, in research, and in discussions in the field since it helps to recognize sociocultural determinants (Sarti et al., 2019; SBMFC, 2015; Schneider; Pereira; Ferraz, 2020; Targa; Oliveira, 2012). Using cultural competence in training can help reflect on the paradigms necessary for transforming care. This, in conjunction with person-centered practices (Targa, 2010), can improve the decision-making process (Schneider, Pereira, and Ferraz, 2020).

We conducted a review of Brazilian literature from 2010 to 2020 to understand how CC has appeared in Brazilian literature, as shown in Figure 1.

We found a total of 17 references. Seven articles were excluded for being duplicates in the databases, being theses/dissertations, focusing on other countries, or not referring to the topic of CC. Therefore, 10 articles remained, which were analyzed according to the type of study, objective, and population (Chart 2).

Table 1 – Literature search strategy

Electronic library	Terms	Search fields	Found articles
Bireme/BVS	Cultural competence, Family Health Strategy, Brazil	Title, abstract, subject	9
PubMed	Cultural competence, Family Health Strategy, Brazil	All fields*	8

* The search was expanded to all fields due to the scarcity of articles if only title/abstract was selected.

Table 2 – Articles on cultural competence in the Family Health Strategy in Brazil, 2010-2020

Article	Study design	Objective	Population
Aguiar and Martins, 2012	Editorial	Presentation of PHC attributes	Not applicable
Chomatas et al., 2013	Quantitative study	A study evaluating the attributes of PHC in the healthcare network of Curitiba (PR) using the PCATool-Brazil	Healthcare providers
Oliveira and Pereira, 2013	Essay	Descriptive study about the attributes of PHC and FHS	Not applicable
Fracolli et al., 2015	Quantitative study	A study evaluating the attributes of PHC in the FHS in Quatá (SP) using the PCATool-Brazil	Healthcare providers
Lima et al., 2016	Qualitative research	Analysis of the narrative of FHS nurses about care practices of Afro-descendants and Indigenous people in Conde (PB)	Healthcare providers
Gouveia et al., 2016	Qualitative research	A Delphi study indicating and promoting the systematization of education in rural medicine by family and community medicine residencies	Healthcare providers
Prates et al., 2017	Literature review	A systematic review study on the application of the PCATool instrument from the perspective of the user, at the international level	Not applicable
Veperino, Gomes, and Leite, 2017	Quantitative study	A study assessing the PHC attributes in dental care in a health unit with multiprofessional residency in family health, in Juiz de Fora (MG), using the PCATool-Brazil.	Users
Gouveia, Silva, and Pessoa, 2019	Literature review	Discussion of the application of CC in family and community medicine education	Not applicable
Rezende et al., 2020	Qualitative research	Analysis of the care practices of FHS nurses with quilombola populations in Belo Horizonte (MG)	Users and healthcare providers

All ten publications highlighted the significance of culturally sensitive education and health practice and identified CC as a useful tool to support these efforts. No methodological prevalence was found among the studies (three qualitative, three quantitative, two editorials/essays, two literature reviews), and the sociocultural dimension was shown to be static or constant in all of them, rather than the result of dynamic and interrelated processes (Menéndez, 2016). Furthermore, it is interesting to note that a slight preference was given to the perspective of healthcare providers (four studies), whereas only one study explored the perspective of users, and one study compared the experiences of users and healthcare providers.

We observed that the studies did not problematize the introduction of the notion of CC in our socio-health context, nor the strategies for its application, regardless of the methodologies used. In the texts classified as editorials or essays, we observed the defense of this notion as an attribute of PHC (interchangeably with the FHS). Authors argue that CC is an important tool for professional training in health and for evaluating healthcare services and systems (Aguiar; Martins, 2012; Oliveira; Pereira, 2013).

All the studies that used quantitative methodologies (Chomatas et al., 2013; Fracolli et al., 2015; Veperino; Gomes; Leite, 2017) used the Brazilian version of the Primary Care Assessment Tool (PCATool-Brazil). This instrument is recommended by the World Health Organization (WHO) to assess the quality of PHC services, empirically assessing their attributes by applying a structured questionnaire among users, healthcare providers, and public administrators (Prates et al., 2017). The reading of these studies (Chomatas et al., 2013; Fracolli et al., 2015; Veperino; Gomes; Leite, 2017) revealed that no specific or critical discussion was developed regarding CC, which raised questions about the limits and challenges posed by importing evaluation instruments into the Brazilian healthcare scenario, which presents a diverse character.

Two studies conducted a literature review. Prates et al. (2017) investigated the application of PCATool and found few mentions of CC among their results. Gouveia, Silva, and Pessoa (2019) reviewed the notion of CC and its importance for the culturally sensitive training of healthcare providers to work in PHC.

Finally, only three articles used qualitative methodology. The first study presented the results of a Delphi study to define the competencies needed for rural medicine subspecialization within the family and community medicine career (Gouveia et al., 2016).

Lima et al. presented the results of interviews with FHS nurses from a community strongly marked by African (descendants of quilombolas) and Indigenous (Tabajaras) traditions in northeastern Brazil. However, they observed great difficulty on the part of professionals in recognizing and valuing the experience and knowledge of these populations, disqualifying the use of objects (medicinal herbs) and care practices. Rezende et al. (2020) also analyzed the practices of FHS nurses in monitoring quilombola populations, arguing that cultural sensitivity should be combined with political competence in training and nursing practice, making issues of social vulnerability visible.

Even though this search is not extensive, from the results presented, we can observe that the debate around the CC is still in its early stages in Brazil, without problematizing the term or presenting other ways of understanding the sociocultural dimension in healthcare. It is interesting to note that qualitative studies bring to light, albeit timidly, aspects of daily life that are usually invisible in individual consultations and that relate to the difficulties experienced by patients and the significant people around them. These approaches show the possibility of incorporating the experiences of the population and healthcare providers in a contextualized way, adding guidelines in line with the Brazilian Health Reform, such as community orientation and social participation (Almeida, 2018). Enriching the debate with "greater theoretical depth and methodological elaboration" is fundamental (Sarti et al., 2019, p. 3; our translation).

Incorporating the intercultural dimension into health practices in Brazil: a necessary discussion

The phenomena related to the process of health, illness, and care are strongly linked to sociocultural, historical, and political aspects that shape not only the individual subjective experience, but also that of communities and society as a whole (Martinez-Hernaez et al., 2021; Menéndez, 2016).

Some dimensions of culture, such as norms, values, and ideologies, are visible in individual behavior and choices, but most cultural influence is implicit and is shaped by beliefs, knowledge systems, and practices, which, in turn, constitute social systems, ranging from social microgroups (families) to communities and societies (Kirmayer; Gómez-Carrillo, 2019).

Awareness of these patterns occurs in encounters between differences—or intercultural encounters—that are often expressed in everyday conflicts and in the negotiation of care practices between different social groups in the context of healthcare services (Menéndez, 2016). This recognition is important since it indicates aspects related to social and political determinants that cut cross communities and go beyond the individual (Metzl; Hansen, 2014; Menéndez, 2016).

The difficulties and obstacles experienced by patients and teams can be interpreted as effects of intercultural encounters themselves, thus becoming material for reflection and development of culturally sensitive practices (Kirmayer; Gómez-Carrillo, 2019; Menéndez, 2016; Nunes et al., 2002).

A reduced understanding of culture as synonymous with ethnicity, nationality, and language, translated

into automatic training for CC, can have the opposite effect, such as reproducing stigma and health inequities among minorities and undervalued groups (Foronda et al., 2016; Kleinman; Benson, 2006; Lekas; Pahl; Fuller Lewis, 2020). Furthermore, it limits the questioning of the sociocultural character that permeates biomedical knowledge and practices (Fernandez, 2014; Taylor, 2003).

The neglect of culture in health practices contributes to "making contradictions, gaps, and ethnocentric assumptions invisible" (Pedrana et al., 2018, p. 2). This invisibilization may be associated with the way that health courses in Brazil transmit the notions of social and cultural determinants of health, reflecting the impoverished view of the historical and social context and cultural determinants (Targa; Oliveira, 2012) and the devaluation of the practices on which the social imaginary about health, illness, and care phenomena is based. This invisibility might also stem from the influence of the notion of cultural uniformity in Brazilian society, the emphasis on socioeconomic determinants at the expense of cultural ones, and the effect of Marxism on the scientific production of Brazilian public health (Ortega; Wenceslau, 2020). Furthermore, we can note a historical tendency to be critical of biomedical practices and to advocate for more comprehensive healthcare with discussions of care practices and integrality in the Brazilian Unified Health System (SUS) (Kalichman; Ayres, 2016).

The critiques for CC presented in this study indicate important aspects regarding power relations in care interactions and in the production of knowledge. They also help us consider how these relationships reflect the historical and political trajectories that emerged during colonization, as well as contemporary processes of migration and economic dependence.

To fulfill its emancipatory role, the training of professionals and the organization of care must be guided by observing care practices that are undertaken individually, in social microgroups, and in therapeutic negotiations, considering the territories in which they take place. The processes of incorporating the different logics of care are manifested in everyday behavior. Focusing on negotiations allows us to value the role of social actors in these exchanges, as well as to better understand aspects related to access and quality of care (Fernandez, 2014; Menéndez, 2016). It is not possible to understand health and disease processes without considering the subjects, inserted in their historical and social contexts, and the differences they embody (Fernandez, 2014).

The development of culturally and socially sensitive practices must be thought of in a relational and contextual way (Guilherme; Dietz, 2014; Menéndez, 2016; Pedrana et al., 2018), being aware of the unfinished nature of knowledge (Fernandez, 2014; Lekas; Pahl; Fuller Lewis, 2020). These practices must also benefit from interdisciplinary discussions and articulations between different research and teaching methodologies (Sarti et al., 2019; Tervalon; Murray-Garcia, 1998).

Final considerations

The orientation towards culturally sensitive care practices has grown, driven by criticism of the biomedical model and broader social changes around issues of social justice and human rights. Examining cultural competence (CC) allowed us to consider its use in Brazil and encouraged us to critically reflect on its application in the FHS considering the particularities of Brazilian PHC.

We did not intend to do an extensive review of the notion of cultural competence in the Brazilian FHS. A larger review, including other terms, such as cultural diversity, medical pluralism, stigma, or intersectionality, could lead to more results with different themes, subjects, methodological, and theoretical approaches. Despite the mentioned limitations, the results suggest that the notion of CC has not been incorporated in Brazilian health practice and education. Although, in principle, this notion seems to be useful for problematizing questions about access and equity in health, it is insufficient in the Brazilian context, given our cultural diversity and social inequality. The emphasis on the social determination of health and disease processes has contributed significantly to the knowledge and healthcare developed in Brazil; however, an intercultural perspective can help in understanding the relationship between the social and cultural dimensions that define health phenomena.

We argued that conflicts, tensions, and therapeutic negotiations can be examined as a reflection of the social and cultural dimension, broadening

the recognition of differences and inequalities in healthcare contexts. Reflecting on the notions and experiences of care will qualify the professional training processes and the construction of more inclusive healthcare public policies. This article has provided elements that allow us to improve ways of thinking and developing culturally sensitive care practices that are attentive to social and economic determinants.

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Authors' contribution

Müller participated in the conception and design of the study; analysis and interpretation of the data; writing of the article; critical review and approval of the version to be published. Lima and Ortega participated in the conception and design of the study; writing of the article; critical review and approval of the version to be published.

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