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Jivi indigenous peoples: family functioning and health care, an analysis from Community Health Nursing practices

Indígenas Jivi: función familiar y cuidado de la salud, un análisis en la práctica de Enfermería en Salud Comunitaria

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ABSTRACT

Objective To explore the meaning of beliefs and practices related to family functioning and health care in a Venezuelan indigenous group.
Materials and Methods A qualitative research study was conducted using a focused-ethnography (FE) method. The techniques implemented during data collection were focus group and observer-as-participant. Twenty-seven people distributed into four groups were included in the study. The qualitative content analysis method was selected for the interpretation stage.
Results The most significant findings revealed that Jivi people's customs were mixed with modern practices. Cultural practices such as maternity and childbirth are processes in which the formal healthcare system has a secondary role. Moreover, participants showed flexibility in terms of responsibilities without association to sex.
Conclusion Training of human resources with an intercultural approach is a measure that could strengthen the practices of ethnic groups in terms of healthcare.

Key Words: Family; role; health; indigenous populations; transcultural nursing; community health nursing *(source: MeSH, NLM).*

RESUMEN

Objetivo Explorar el significado de las creencias y prácticas relacionadas con la función familiar y el cuidado de salud en un grupo indígena venezolano.
Métodos Se realizó una investigación cualitativa razonada con el método de Etnografía Enfocada (EE), las técnicas implementadas fue el grupo focal y la observación participante. Participaron N=27 personas distribuidas en cuatro grupos. El método seleccionado para la fase de interpretación fue el Análisis Cualitativo de Contenido.
Resultados Los hallazgos mostraron que las creencias del pueblo Jivi se mezclaron con las prácticas modernas; las prácticas culturales como la maternidad y el parto se asumieron como un proceso en el cual el Sistema de Salud formal tiene una relación secundaria. Además, los participantes mostraron flexibilidad de responsabilidades sin referencia al género.
Conclusión Una medida para fortalecer las prácticas de los grupos étnicos en términos de atención de salud es la capacitación de recursos humanos en el enfoque intercultural.

Palabras Clave: Familia; rol; salud; poblaciones indígenas; enfermería transcultural; enfermería en salud comunitaria *(fuente: DeCS, BIREME).*

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After five decades —with the development of transcultural nursing as a subfield— our discipline looks to the future to bring nursing interventions closer to cultural values, beliefs, and behaviors. This could be interpreted as an

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approach to adjusting the care relationship with each cultural group, being respectful of our patient's decisions and the natural environment (1,2).

In general, some health systems have made progress with the integration of three main types of intervention strategies: education and training of the health workforce; culture-specific health programs; and recruitment of an indigenous health workforce (3,4). However, empirical evidence related to indigenous population in nursing sciences has shown shortcomings in terms of cultural care, including the lack of culturally-appropriate health service delivery, which is a barrier for access to the formal healthcare system in these communities (5).

Recent literature on family nursing support indicates that family functioning provides a way to understand the influence of the belief system in individuals/families/communities. This concept can offer information about the intents and purposes of families to determine cultural practices such as socialization, reproduction, cooperation to meet economic needs, and the relationship with society in general; in this study, the latter aspect involves exchanges with healthcare services (6).

Essentially, the authors agree with the principle that the family is an important agent for socialization. For this reason, knowing its structural and functional characteristics will serve as a contribution to address the relationship between family functioning among indigenous peoples and their values, roles, spirituality, and the individual or collective capacities of healthcare. With this in mind, the objective of this study is to explore the meaning of beliefs and practices related to family functioning and healthcare in a Venezuelan indigenous group.

MATERIALS AND METHODS

This is a qualitative research study conducted using a Focused-ethnography (FE) method in order to understand the cultural diversity of a Venezuelan ethnic group, along with the context of family functioning, roles, and family healthcare practices, as these elements guide nursing care interventions. This approach was selected because the "characteristics of focused ethnographies are that they are time limited, usually do not involve extensive periods of living in the field, and have research questions that are narrower in scope than traditional ethnographies" (7-8).

The researchers complied with the expected ethical aspects the Bioethics and Biosafety Code (9). Participants were informed of the study aims, collective benefits, and the open nature of the investigation, including the possibility of leaving the group or interview if they felt uncomfortable during the process. After providing all the necessary information, participants continued and signed an informed consent.

The interventions were carried out by the Todos por la Vida Foundation, which is a non-profit humanitarian organization that provides free healthcare to Venezuelan indigenous communities. The team was made up of volunteer health professionals, professors and students of the Faculty of Health Sciences of the Universidad de Carabobo (FCS-UC), who supported the researchers during their field work.

The study took place in territories that are part of the Amazon rainforest and have the highest proportion of indigenous peoples living in Venezuela. Two researchers went into the field in August 2016 and interacted with the community for 2 weeks, thus establishing good communication and a close relationship with them, and exploring the Jivi people's lifestyle.

The participants from the indigenous communities were informed about the procedures of the study. Time, dialogue and cultural sensitivity were required for all the interactions between researchers and indigenous people in relevant positions within their groups. Researchers covered the following areas: data collection, use of the collected data, final report plan, and privacy protection of research participants.

After confirming that both sides felt secure, the researchers invited the indigenous men and women of 1 ethnic group (Jivi) who expressed interest in participating in the research. The invitation to participate followed a sequential design methodology based on the gradual selection known as chain or snowball sampling (10). The inclusion criteria were: participants over 18 years of age, interested in participating in the study, and members of the Jivi ethnic group.

The techniques implemented during data collection were focus group and observer-as-participant. The selection was based on recommendations for performing FE (7,11) and on previous qualitative research approaches (12-13). The researchers planned focus group distribution, requesting the participation of 12 persons in each group, although meetings were finally attended by groups of 6-9 people. In total, there were 27 people distributed among four groups.

Each focus group was labeled as FG1, FG2, FG3 and FG4, and the ending -P with a number was added to indicate the opinions from the participants of the focus groups. The participant observation technique enriched the data analysis process, since this role was compatible with the study conducted within specific time frames: "participant observation is discrete and can be limited" (12-14).

As the study progressed, communicative process techniques were stimulated with open, semi-structured questions. Theoretical orientation of the Calgary Family Assessment Model (CFAM) (9,15) were included in semi-structured questions. Internal elements of the family structure were evaluated, such as family composition, sex, subsystems and sexual orientation; external elements such as ethnicity, religion and broader system, were also assessed.

Phillip Mayring's approach was selected for qualitative content analysis during the data collection and evaluation stage because it served as a guide for text interpretation. It also offered a reliable way to construct the categories framework, based on two central approaches: deductive category application and inductive category development. The first approach sought to determine exactly under what circumstances a text passage can be coded with a category, and the second approach consisted of a group of categories that are closely derived from the material to express them in shape of the material (16).

The process began with the establishment of the determined categories based on the research questions and the theoretical definitions of the Calgary Model. Then, the research group validated the categories, examples for categorization and coding rules (Table 1). Inductive categories are fortuitous findings that complement the research.

Table 1. Calgary Model using Mayring's approach, criteria after validation of studies and focus groups

Description of determined category	Definition	Coding rules
C1 Family functioning	Determining the meaning of the biological and social function of the family. It includes structure, procreation, affective relationships, family economy, and socialization with other systems or community members.	The four subcategories described in the definition have to point to the coding process.
Development of inductive categories	Definition	
C0 Romance and rituals	Describing customs and beliefs of the ethnic group when people are in amicable relationships with each other.	

Table 2 presents the demographic characteristics of the 27 people that participated in the four focus groups. This information also includes a characterization of educational attainment.

The Jivi population's primary language is Guahibo with some particularities as the FG3 and FG4 indigenous communities speak the dialect Newütjü, which derives from this language; however, this is not an obstacle to communication among groups. All groups

Table 2. Demographic characteristics

Predictors	Men		Women	
Age	N=	(%)	N=	(%)
18-24	03	(27.27)	08	(50.00)
25-44	05	(45.45)	06	(37.50)
45-64	02	(18.18)	02	(12.50)
+ 65	01	(9.10)	-	-
Total (n)	11	100	16	100
Marital Status				
Single	02	(18.18)	-	-
Married / living with partner	09	(81.82)	16	(100.00)
Total (n)	11	100	16	100
Highest level of education				
Less than high school	07	(70.00)	14	(87.50)
High school graduated	03	(30.00)	02	(12.50)
Total (n)	11	100	16	100

Source: Own elaboration based on the information obtained during the study

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The inductive category *Co Romance and Rituals* emerged from the focus groups and described the feelings of people and rituals prior to getting married and starting a family. The participants made several relevant statements in this regards:

> FG2-P2: Nowadays we select our partners freely. We try mutual agreement. If a woman does not want to get married to her suitor, then she does not do it. It was different before because marriage was mandatory, it was arranged, women for sale. For example: I gave my daughter for a *conuco* (small family farm which usually produces sugarcane, banana and cassava).
>
> FG4-P4: Yes, that is right but also if a man wants us as his wife, he must speak with our parents. He then says that he has a *conuco*, then we know each other, and then we can live together.

Women said that they expect and are ready to get married after they turn 13-14 years old. Participants described a traditional ceremony held to introduce the women of the community who are available for reproduction and are able to care for a family. Before the ceremony, girls go through a 1- to 3-month isolation period, during which time they learn to cook, collect palms to weave baskets and mats, and learn and practice other domestic chores. However, it was pointed out that women had learned to make their own decisions regarding marriage. In fact, 2 of the 4 ethnic groups talked about the current trend of women waiting for some time to get married.

The *C1 Family Functioning* category attempts to understand the narratives of the participants. They spoke about rituals or traditions related to healthcare, economy, and social interactions between family members and community systems. Participants described different everyday life experiences. Family structure descriptions included

a familiar composition which was heterosexual, nuclear (father, mother, children) with a polygamous tendency (in both men and women) depending on the territory in which the indigenous communities were located. These practices were more frequent in communities with a lower population density.

> FG4-P5: Our tradition allows a man to have two or three women, and a woman can have two or three men. This cultural norm means that one man is actively engaged in hunting and another in fishing or agriculture in the *conuco*, and that they are all part of the same family (sisters of the wife or brothers of the husband). This helps avoid conflicts between spouses. Women are responsible for cooking or domestic chores. They help each other and the most important thing is avoiding gossip and conflicts.

To the Jivi people, the sub-category *Procreation* means a blessing from their gods, the meaning of life as well as passing on their culture. Cultural practices such as maternity and childbirth were regarded as processes in which the formal health system has a secondary role. Jivi women teach other women to assist the birth; the mother-to-be also receives preparation with the community shaman, who is expected to provide spiritual support. Causes of complications during pregnancy or maternal and child deaths are often attributed to witchcraft, women's fear during childbirth or physical violence from the husband during pregnancy.

Some communities have their own outpatient healthcare service. If it is available in the community, after childbirth, the new mother and baby attend this service for immunization. According to the participants:

> FG3-P1: All drinks and instruments are clean, (for example, scissors used to cut the umbilical cord as well as treads that clamp the umbilical cord), the shaman blows on the mother and baby to protect their health (…). After delivery, time, date, weight and length are recorded for control. Then the mother visits the doctor for immunization and provides him all this information. The doctor keeps a record of the child's health and the mother keeps a copy of this record. If mothers or babies have health problems, they are sometimes transferred to the nearest outpatient care center.

A fortuitous finding related to sexual and reproductive health was the contraception method used by the FG1 focus group of the indigenous community. This experience was not reported in other groups.

> FG1-P6: We can have all the children that we want but sometimes we use condoms to prevent pregnancy. We obtain condoms in consultation with the outpatient care center. Condoms may or may not be available, like medicine. Sometimes condoms and medicine are available, sometimes they are not.

In this study, participants frequently identified affective relationships in the family as a strength of their culture. They did not manifest preference for male or female in terms of gender relationships; both are seen as significant, necessary, and complementary to raising a Jivi child into a future Jivi man or woman.

> FG3-P2: The Jivi culture treats men and women as equals. If the younger brother does something wrong, the older brother or sister calls him and says: "Brother, what did you do? You should obey our parents." The older sibling gives advice, which is our custom.
>
> FG4-P1: In our culture, children learn by looking what the parents do. When a child breaks the rules at home, the father or mother does not hit them, but gives them a lesson through work. Children go with their father to the countryside —never alone— to harvest the forest, to fish, to hunt, to work the soil. The child can also stay at home with the mother, cooking, grating casava, and weaving baskets.

In contrast, during the discussion some participants of the FG2 and FG4 focus groups expressed a different view.

> FG2-P3: Sometimes families have conflicts. There are families with problems, sometimes there is violence, but the *Cacique* (person who governs and represents each community; also called captain) mediates to seek a solution.

In further conversations about *family economy*, participants self-identified as small agricultural producers and artisan workers, who produce baskets and mats that are commercialized in towns with larger markets. Fishing, hunting, and some agricultural activities support each family's subsistence. This aspect relates to food consumption, which is mostly based on fish and cassava. Family activities are organized by gender. Activities done by men include agriculture, harvesting trees, fishing and hunting, while women cook and collect palms to weave baskets or mats.

However, all focus groups stated that sometimes the family requires the involvement of its members in activities different from the customary roles. According to the information collected, men and women are able to exchange roles as needed during the normal routine because they learn different skills. The most significant views obtained from the four focus groups are detailed below:

> FG2-P1: We as Jivi share the tasks of managing our homes; women and men make decisions about finances (…), raising children, caring for babies. Women have a greater burden with babies but they are not alone, we men help them. Women give advice to the girls, and we men do as well.
>
> FG3-P3: Sometimes women go fishing or hunting; it is not a big hunt, and we do the normal things at home, washing dishes or clothes, sweeping. When help is needed, we men do it.
>
> FG4-P7: We share the money, for example, if my wife works with me I tell her: "This money is yours". She receives her part.

The sub-category *socialization* was about the exchange between the Jivi people and other communitarian systems such as the education and health systems, religion and shamans. Discussions in focus groups revealed that family is the foundational structure in which children learn their culture's morals, rules and customs.

Similarly, as in other sub-categories, groups residing in towns with higher population density have more contact with the general culture of these larger developed communities and, often, use state-offered services, including education and health services. Children that attend school in these larger *pueblos* or towns learn the subjects contained in the curriculum of the Venezuelan education system in a bilingual context (Jivi, Guahibo or Spanish). They may become literate, and some of them can read and write basic pieces. Adults have the possibility of accessing this system as well. Participants stated:

> FG1-P5: In high school level classes, for example, you receive a certificate as a mid-level technician; you can learn agricultural sciences, administration, planting, ceramics and social communication.
>
> FG2-P5: In our community, we have only elementary schools; if the family wishes, children continue their studies. Our sons go to the city (Puerto Ayacucho) early in the morning and return in the afternoon.

Some communities self-identify as Protestant Christian (or Evangelic). At the same time, during the discussion, participants said that there was a similarity between these religious practices and their ancestral practices. Above all, the community trusts the shaman as the protector from evils caused by supernatural powers:

> FG2-P1: We are Christian, but we do not pray to the Virgin and the saints. We only believe in Jesus. We get married in the church (…). We also have a shaman; for example, when a pregnant woman gets sick from washing outside, we say she gets cold, or if our children have fever, we follow the advice of the shaman, who sometimes is involved with occult practices.

The organization of the Venezuelan health system offers two categories of services to the Jivi people. The FG1 focus group reported that their community accesses a "common medical consultant" (outpatient assistance) and "Comprehensive Diagnostic Centers" (hospital assistance). All focus groups participants expressed their respect for their culture, customs and ancestors. However, each family within the focus group has its own filter; the researchers consider this is an important cultural expression regarding how and when to use the services available.

The shaman is some kind of physician who treats natural illnesses and spiritual sickness. In spite of the effect of modern Christian practices, education experiences and knowledge, the shaman is the most important influence for their culture. If a session with a shaman does not occur for some reason, the family may consult a shaman in another community.

If a family does not receive the expected results from the shaman, the family goes to the local outpatient healthcare center. With respect to healthcare services and shamans, participants said:

> FG1:P2: I go with my baby to the physician because she needs to receive her vaccines.
>
> FG1-P3: I gave birth to two children at home and my other five children were born at the hospital. I prefer to seek assistance at the hospital.
>
> FG2-P4: The shaman provides spiritual protection and has skills to cure certain diseases when we do not find medicine at the outpatient center; we use the medicinal herbs that he indicates.
>
> FG4-P1: If you go to the hospital and the doctors cannot cure your illness, you go to the shaman. He says you are sick, someone is hurting you, someone is jealous of you, it can be a man or a woman, and then the shaman gives you some brew or medicinal herbs, then you recover your health.

DISCUSSION

This study's results indicate similarities and differences among the groups of Jivi people. Attention was focused on the indigenous people's traditional customs, which were mixed with modern practices. Regarding family composition, the heterosexual union with a nuclear structure (father, mother, children) was prevalent, as well as monogamy and women's free choice to marry. The analysis showed that religion was a structural aspect of the family, and that, in many cases, they were Christians. The evident mix between the doctrine of Jesus and the deities and beliefs of the Jivi people is especially relevant.

Another important point for the group studied was their relationship with the external system, considering the community resources and services available to them. On this matter, some members of the Jivi community expressed that both men and women used contraception methods and that they used the health services provided by the State. In addition, they mentioned that indigenous children and adults have access to the educational system. The use of these services is dominant in indigenous communities geographically located in places with a higher population concentration.

Nevertheless, the indigenous families in communities with low population density showed other characteristics. They demonstrated propensity towards polygamy, allowed for both genders, greater use of ancestral medicine, less knowledge of the Spanish language, and an economy based on agricultural and artisanal production, mainly items for

family consumption. Their food supply came from hunting, fishing and gardening from *conucos* or family farms.

In this context, transcultural nursing seeks to create responses to the health needs of patients and their diversity. This perspective was relevant to understand what was meaningful to the Jivi in matters of individual worldview, family organization, beliefs, values, language, nutrition, behaviors, health practices, and decision-making. Transcultural nurses are responsible for demonstrating skills that avoid preconceived notions, thinking through communication with patients, and providing adapted care while avoiding offensive practices (17–19).

The Jivi people studied had serious income limitations. Due to these limitations, many of the families appreciated the support offered by the Todos por la Vida Foundation. According to the records obtained, the services most requested by these groups were related to gastrointestinal illness, respiratory problems and dental issues. Participants expressed many challenges with the medical service offered because of the language difficulties. The results of this study are comparable to a previous study in the Wayúu people, in which the first healthcare access-related cultural barrier for this group was language as well (20,21).

While providing the care service, in all cases, families acted as some sort of filter and, according to the circumstances, alternated their health decisions with ancestral customs. Another similarity found in participants was related to the division of work, which was distributed according to gender of the worker; for example, care responsibilities in the household were mostly performed by women, while economic support for the household was provided by men.

However, the narratives of the participants showed flexibility in terms of responsibilities, without reference to gender. As stated earlier, cooperation was a dominant notion among family members. These findings were in line with a previous study in which the task of primary nurturer in the family is attributed to women and is linked to sociocultural issues —derived from an ideologically determined and accepted social construction—, thus constituting a moral obligation (22).

The assessment of family functioning, daily routines, sense of harmony, emotional communication and support roles within the family group, suggests normality in family relationships. This balance inside the family structure is projected towards a better functioning of the community; this result is consistent with previous studies (23). A particular behavior exposed by Jivi family members is their willingness to help one another. Couples are in charge of primary family roles.

In Venezuela, pregnancy and birth is a medical practice supervised by physicians and controlled by the National Health System (NHS). Nevertheless, in the group studied, home birth is an ancestral practice and delivery is assisted by women from the indigenous community. In many cases, other family members provided assistance. There was no exchange between the Sexual and Reproductive Health Program of the NHS and the people who assisted births in the ethnic groups. In this regard, a previous study remarked that "the lack of knowledge reveals the predominance of the biomedical model, founded on scientific knowledge to the detriment of cultural competence" (20,24).

Intercultural understanding is critical for delivery comprehensive care to all indigenous populations. Some Latin American countries, such as Ecuador, take this practice into account in their National Health Policies (25). Additionally, a recent study on the reduction of barriers in aboriginal communities suggested that circumventing waiting times and providing culturally appropriate services are necessary to improve access to healthcare services (26).

Understanding the function of the family among the Jivi provided a framework to understand, agree upon and appreciate indigenous traditions and the influence of the cultural context on well-being, health or illness. This is essential for strengthening health approaches that incorporate social and cultural diversity. This approach must be considered in the nursing practice because it allows discovering diversity within the same ethnic group, as was the case of this study.

From a nursing point of view, one measure to strengthen the practices of ethnic groups in terms of healthcare would be the training of human resources in the transcultural approach. This strategy stimulates the health team's attitudes to ensure an interaction with patients, respecting their knowledge and traditional health practices. In addition, active participation by the practitioners of ancestral medicine must play a key role •

Conflicts of interest: None.

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edited the theoretical contributions of the co-authors. YZ, MNdS, PU and HF validated the categorical framework, and performed a critical reading and discussed the implications of the results; they also contributed to the preparation of the manuscript at all stages.

REFERENCES

1. Leininger M. Culture care theory: a major contribution to advance transcultural nursing knowledge and practices. J Transcult Nurs. 2002; 13(3):189-92-1.
2. Sitzman K, Eichelberger LW. Understanding the work of nurse theorists: a creative beginning. 3th ed. Burlington (Canada): Jones & Bartlett Learning Publishers; 2017. p. 245.
3. Clifford A, McCalman J, Bainbridge R, Tsey K. Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. J Qual Health Care. 2015; 27(2):89–98.
4. Davy C, Kite E, Aitken G, Dodd G, Rigney J, Hayes J, et al. What keeps you strong? How primary healthcare and aged care services can support the wellbeing of older Indigenous peoples: a systematic literature review protocol. JBI database Syst Rev Implement reports. 2016; 13(12):47–58.
5. Nielsen A-M, Stuart LA, Gorman D. Confronting the Cultural Challenge of the Whiteness of Nursing: Aboriginal Registered Nurses' Perspectives. Contemp Nurse. 2014; 4063–74.
6. Kaakinen JR, Coehlo DP, Steele R, Tabacco A, Hanson SMH. Family health care nursing: theory, practice, and research. 5th ed. Philadelphia (USA): F.A Davis Company; 2015. p. 614.
7. Knoblauch H. Focused ethnography. Forum Qual Sozialforsch. 2005; 6(3). Avialable from: http://bit.ly/2GuxYsi.
8. Leahey M, Wright LM. Application of the Calgary Family Assessment and Intervention Models. J Fam Nurs. 2016; 22(4):450–9.
9. Ministerio del Poder Popular para Ciencia Tecnología e Industrias Intermedias, Fondo Nacional de Ciencia Tecnología e Innovación. Código de Bioética y Bioseguridad. 3ra Edición 2008 p. 1–35.
10. Martínez-salgado C. El muestreo en investigación cualitativa. Principios básicos y algunas controversias. Cienc Saúde Colect. 2012; 17(3): 613-9.
11. Wall SS. Focused Ethnography: A Methodological Adaptation for Social Research in Emerging Contexts. Forum Qual Sozialforsch / Forum Qual Soc Res. 2014; 16(1):1-15.
12. Medina-Maldonado V, Landenberger M, Rondón R, Osio Patrizzi M. Experiencias de enfermeras en prevención de la violencia de género y asistencia a mujeres afectadas. Rev Cubana Enferm. 2015; 31(4). Available from: http://bit.ly/38Gk4PG.
13. Medina-Maldonado V, Torres-Torres L, Navarro M. Focus group discussion as tool to study gender relations in urban community members. Enferm Glob. 2013; 12(1). Available from: http://bit.ly/2U76y3L.
14. Medina-Maldonado V. La mujer en la organización comunitaria y su articulación con instituciones del sector público y privado. Av en Enfermería. 2014; 32(2):228–34.
15. Morse J. How different is qualitative health research from qualitative research? Do we have a subdiscipline? Qual Health Res. 2010; 20(11): 1459-64.
16. Wright LM, Maureen L. Nurses and families: A guide to family assessment and intervention. 6th ed. Philadelphia (USA): F. A. Davis Company, editor; 2013. p.351
17. Mayring P. Qualitative Content Analysis Theoretical Foundation, Basic Procedures and Software Solution. Klagenfurt: Social Science Open Acces Repository; 2014 p. 143. Available from: http://bit.ly/36y5kAQ.
18. Aguilar-Guzmán O, Carrasco-González M, García-Piña M, Saldivar-Flores A, Ostiguín-Meléndez RM. Madeleine Leininger: un análisis de sus fundamentos teóricos. Enfermería Univ. 2006; 4(2):26–30. Available from: http://bit.ly/3aN0lQg.
19. Busher Betancourt D. Madeleine Leininger and the Transcultural Theory of Nursing. Downt Rev Iss. 2015; 2(1):1–7. Available from: http://bit.ly/2U2PJGW.
20. Rosário-Lima M, Almeida-Nunes M, Pinheiro-Klüppel B, de Medeiros S, Duarte-Sá L. Nurses' performance on indigenous and African-Brazilian health care practices. Rev Bras Enferm. 2016; 6969(55):788–94.
21. Patiño-Londoño S, Mignone J, Castro-Arroyave D, Gómez Valencia N, Rojas Arbeláez C. Guías bilingües: una estrategia para disminuir las barreras culturales en el acceso y la atención en salud de las comunidades wayuu de Maicao, Colombia. Salud Colect. 2016; 12(3):415. Available from: http://bit.ly/2t73SrK.
22. Falkenberg Benites M, Shimizu Eri H, Bermudez Diaz X. Social representations of the health care of the Mbyá-Guarani indigenous population by health workers. Rev Lat Am Enfermagem. 2017; 25(0).
23. Flexa Souza TC, Lavareda Costa CM, Nunes Carvalho J. Calgary Family Assesment Model Applied in Riverside Context. J Nurs UFPE. 2017; 11(12):4798–804.
24. Wu C, Chao RK. Parent-Adolescent Relationships among Chinese Immigrant Families: An Indigenous Concept of Qin. Asian Am J Psychol. 2017 Dec; 8(4):323–38.
25. Ministerio de Salud Pública del Ecuador. Manual del Modelo de Atención Integral de Salud-MAIS. Ecuador: Ministerio de Salud Pública. Quito; 2013. Available from: http://bit.ly/2RQZlBW.
26. Young C, Tong A, Gunasekera H, Sherriff S, Kalucy D, Fernando P, et al. Health professional and community perspectives on reducing barriers to accessing specialist health care in metropolitan Aboriginal communities: A semi-structured interview study. J Paediatr Child Health. 2017; 53(3):277–82.