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CORPOREALITY AND HEALTH IN TRADITIONAL PEOPLES: INTERFACES BETWEEN CULTURE, IDENTITY, AND CARE PRACTICES

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SUMMARY

Objective: to analyze, in the scientific literature, how corporeality is understood in traditional peoples, emphasizing the interfaces between culture, identity, and health care practices. Method: this is an integrative literature review, developed from the analysis of 28 national and international studies selected for thematic adherence to the investigated object. The extraction and synthesis of data allowed organizing the findings into analytical axes related to corporeality, territoriality, ancestry, therapeutic pluralism, gender, and differentiated health care. Results: the literature evidenced that corporeality, in traditional peoples, is not restricted to the biological body, being understood as a relational, cultural, spiritual, territorial, and community experience. The studies demonstrated that indigenous, quilombola, and other traditional communities organize health care through plural systems that articulate ancestral knowledge, local therapeutic practices, family networks, community support, and biomedical services.It was also observed that the body constitutes a space for inscribing identity, collective memory, ethnic-cultural belonging, and the continuity of traditional ways of living, falling ill, and caring for oneself. Conclusion: the understanding of corporeality in traditional peoples expands the health debate beyond the biomedical model and reinforces the need for intercultural approaches and culturally sensitive health policies, capable of recognizing the diversity of therapeutic rationalities, territory, ancestry, and traditional care practices.

Keywords:corporeality; traditional peoples; cultural identity; care practices.

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INTRODUCTION

The health of traditional peoples has been progressively recognized in the scientific field as a phenomenon that transcends strictly biomedical definitions and requires an expanded understanding of the processes of living, falling ill, and caring. In different indigenous, quilombola, and native contexts, the body is not conceived as an isolated, fragmented, or exclusively biological entity, but as a relational reality, permeated by spiritual, territorial, familial, community, and cosmological dimensions (1-5, 10, 14, 17). In this perspective, corporeality assumes analytical centrality as it simultaneously expresses identity, belonging, collective memory, historical experiences, and culturally situated forms of care.

International literature demonstrates that, among traditional peoples, the notion of health is deeply linked to the integration of body, mind, spirit, family, and land. Among the Māori, for example, the expanded understanding of health has been systematized as a relational model that articulates bodily, emotional, spiritual, and familial dimensions, constituting a classic reference for the debate on indigenous health and cultural determinants of well-being (1,2). Subsequent studies have reinforced that bodily experiences, such as pain, cannot be interpreted solely under physiological parameters, as they involve cultural senses, social bonds, and spiritual references that modulate the perception of suffering and the therapeutic pathways adopted (3). Similarly, community practices of bodily strengthening, physical activity, and the construction of culturally oriented therapeutic environments demonstrate that care for the body, in traditional peoples, is embedded in collective values and deep relationships with territory, ancestry, and cultural identity (4,5).

This understanding also extends to other indigenous peoples. In Australian Aboriginal populations, culture has been described as a structural determinant of health, directly interfering with the experience of well-being, emotional protection, resilience, and subjective recomposition in the face of historical processes of colonization and exclusion (6,7). Among First Nations and other Indigenous groups in Canada, studies show that cultural connection, community belonging, and the continuity of traditional practices are positively associated with mental health and

to strengthening identity, especially among young people and indigenous women in contexts of social and institutional vulnerability (10,11,16). In S ámi populations, even in urban contexts, the maintenance of cultural identity remains an essential component of well-being, highlighting that corporeality, in these groups, is inseparable from experiences of ethnic belonging, collective memory, and social recognition (14).

In the Latin American context, the discussion becomes even more relevant in light of the persistence of historical inequalities, barriers to access, and tensions between traditional care systems and the hegemonic biomedical model. Studies with Mexican indigenous communities show that pregnancy and childbirth are bodily experiences influenced by gender, spirituality, cultural norms, and structural violence, revealing that reproductive care cannot be analyzed outside the social and political conditions that shape the lives of these peoples (13). In parallel, investigations into cultural safety in health services indicate that the lack of recognition of traditional conceptions of body, motherhood, territory, and collectivity compromises the quality of care and intensifies processes of institutional inadequacy, suffering, and discontinuity of care (8,9,15).

In Brazil, the theme takes on particular importance given the ethnic and cultural diversity of indigenous peoples, quilombolas, and other traditional communities, whose ways of life preserve their own systems of interpretation of the body, health, and illness. In the field of indigenous health, anthropological analyses indicate that the articulation between formal services and indigenous medicine remains one of the major challenges for the implementation of differentiated care, as the healthcare model often encounters difficulties in concretely incorporating the therapeutic pluralism present in the territories (17,28). Studies with health teams working with the Mbyá-Guarani population and in Special Indigenous Health Districts show that professional understanding of indigenous care does not always align with the meanings attributed by communities to bodily, spiritual, and therapeutic practices, thus generating significant intercultural asymmetries in the care process (26,28). Furthermore, research with indigenous elders reveals that care, throughout life, involves not only functional attention to the body

aged, but also respect for social roles, family ties, and cultural references specific to each people (27).

Among quilombola populations, studies also show that health is experienced from an expanded logic, situated in everyday life, family, work, territory, and community relations. Investigations with quilombola men show that health knowledge and practices are constructed in articulation with local experiences, sociabilities, and specific ways of perceiving the body and self-care (18). Among quilombola women, research on social representations of health indicates that care is strongly related to domestic life, family organization, the environment, and everyday practices of protection and maintenance of life (20). Women's therapeutic itineraries, in turn, reveal simultaneous circulation between traditional resources, community support, and formal services, showing that health care does not follow a linear logic, but is plural and negotiated (19).

Another relevant axis of the national literature refers to the use of medicinal plants, traditional knowledge and intergenerational transmission of care. Studies conducted in quilombola, indigenous, and traditional Brazilian communities demonstrate that the use of therapeutic resources based on plants, baths, oils, local preparations, and ancestral knowledge remains a structuring component of care practices, both in addressing ailments and in the daily maintenance of health (21-23,25). In Wajãpi communities, women's participation in the use and transmission of this knowledge reinforces the role of women as guardians of care and mediators of cultural continuity (25). Similarly, research with quilombola women on child feeding and breastfeeding shows that bodily and maternal practices are transmitted across generations as part of a broader system of social reproduction, identity, and belonging (24). Thus, corporeality, in these contexts, is not limited to the anatomical body but manifests as an embodied cultural experience, inscribed in routines, rites, memories, and community bonds.

Despite the advancement of this evidence, it is observed that scientific production is still dispersed among different disciplinary fields, such as

collective health, anthropology, nursing, ethnobiology, and indigenous health, which complicates an integrated understanding of the interfaces between corporeality, culture, identity, and care practices in traditional peoples. Furthermore, part of the literature favors specific cuts, such as childbirth, pain, medicinal plants, or mental health, without necessarily articulating these elements in a broader analysis of the body as a sociocultural and political category in the health field (3,8, 12, 19,21,23). In this sense, an integrative review becomes relevant as it allows for the critical synthesis of evidence produced in different contexts, methodologies, and populations, favoring the identification of convergences, singularities, and gaps in knowledge.

In light of this scenario, the present study aims to analyze, in the scientific literature, how corporeality is understood and experienced in traditional peoples, highlighting its interfaces with culture, identity, and care practices. It seeks to understand how studies have approached the body as a space for the production of meaning, memory, ancestry, resistance, and care, as well as to discuss the challenges posed to the organization of culturally sensitive health practices and policies, especially in contexts marked by historical inequalities and intercultural tensions. (6,7, 15, 17,26,28).

METHODOLOGY

This is an integrative literature review, conducted with the purpose of synthesizing and critically analyzing scientific evidence on corporeality and health in traditional peoples, with an emphasis on the interfaces between culture, identity, and care practices. This design was chosen because it is a method capable of gathering, evaluating, and integrating results from studies with different methodological approaches. It allows for an expanded understanding of complex phenomena in the field of health. The review followed the classic stages proposed for integrative reviews: problem identification, literature search, study evaluation, data extraction and analysis, and presentation of the synthesis, and was described in accordance with the PRISMA 2020 recommendations for transparency in the study selection process.

The guiding question of the review was formulated as follows: how has the scientific literature addressed corporeality in traditional peoples, especially in their relationships with culture, identity, and health care practices? Based on this question, a search strategy was structured to recover empirical, theoretical, and synthesis studies that encompassed indigenous peoples, quilombolas, and other traditional communities, considering different national and international contexts. To enhance the sensitivity of the search, descriptors and free terms in Portuguese and English were used, combined by Boolean operators. Among the main terms employed, the following stood out: “corporeality,” “body,” “embodiment,” “health,” “traditional peoples,” “traditional communities,” “indigenous peoples,” “quilombola,” “cultural identity,” “healing practices,” “traditional medicine,” “care practices,” and “cultural safety.”The combination of these terms sought to encompass both studies explicitly centered on the body and research that, although not using the term “corporeality” in the title or abstract, addressed the body as a cultural, spiritual, territorial, or relational experience. The integrative review, precisely because of its comprehensive nature, admits iterative and sensitive search strategies to capture the complexity of the investigated phenomenon.

The searches were planned for recognized databases in the health and related sciences field, prioritizing PubMed/MEDLINE, with additional coverage expected from multidisciplinary and regional databases such as Scopus, Web of Science, Embase, CINAHL, SciELO, and LILACS, in order to increase the coverage of international and Latin American studies. For the composition of the analytical base of this review, recoverable real studies indexed in databases were considered, with thematic adherence to the proposed object. The selection favored publications that directly or substantively addressed: a) cultural conceptions of the body and health; b) relationships between ethnic-cultural identity and well-being; c) traditional care practices, healing, and the use of local therapeutic resources; d) therapeutic itineraries; e) interfaces and tensions between traditional systems and biomedical services.

Inclusion criteria adopted were: original articles, qualitative, quantitative, mixed, case studies, ethnographic studies, scope reviews, narrative reviews, and theoretical-analytical articles with conceptual relevance for

The theme; publications available in Portuguese, English, or Spanish; studies focusing on traditional peoples, Indigenous peoples, quilombolas, First Nations, Māori, Aboriginal and Torres Strait Islander peoples, Sámi, and other culturally traditional populations; and works that presented a direct contribution to the understanding of corporeality, cultural identity, care practices, or cultural safety in health. Editorials, letters, comments, texts without substantive relation to the theme, exclusively biomedical studies without cultural interface, duplicate publications, and works whose central focus did not allow for relevant analytical extraction for the objectives of the review were excluded. The definition of explicit eligibility criteria and the documentation of the selection flow are aligned with PRISMA 2020.

Screening occurred in successive stages. Initially, the identified records were subjected to reading titles and abstracts for thematic relevance assessment. Subsequently, potentially eligible studies were analyzed in greater depth regarding their alignment with the object of the review. Finally, a final analytical sample of 28 studies was composed, selected for their thematic consistency and diversity.

of contexts and the ability to respond to the guiding question. The sample included 12 national studies and 16 international ones, covering different traditional populations and distinct methodological designs, which favored a comprehensive and comparative synthesis. The final presentation of the eligibility process may be accompanied by a flowchart in the PRISMA 2020 standard, detailing the number of records identified, excluded, and included at each stage.

For data extraction, a standardized matrix was constructed containing: authorship, year of publication, country or context, population or object of study, methodological design, dimension of corporeality addressed, care practices or cultural interface analyzed, and main findings. This procedure allowed for the systematic organization of evidence and comparison of studies of different methodological natures, which is compatible with the integrative review method. The analysis was guided by reduction, organization, comparison, and thematic synthesis of the extracted data, seeking to identify convergences, singularities, and gaps in the field. This type of organization

matrix is consistent with the use of the

integrative review as a method for incorporating evidence in health.

The synthesis of the results was conducted through integrative thematic analysis, based on the comparative reading of the included studies. The findings were grouped into emerging themes from the literature itself: corporeality, identity, and worldview of health; territory, ancestry, and spirituality in care practices; therapeutic pluralism and use of traditional resources; gender, motherhood, and intergenerational transmission of care; and differentiated attention, cultural safety, and institutional challenges. This strategy analytical allowed for the articulation of qualitative, quantitative, and theoretical studies in a common critical interpretation, preserving the specificity of each sociocultural context without losing the overall perspective.

As this is a literature review using exclusively secondary data, without direct involvement of human beings, there was no need for submission to an Ethics Committee in Research. Nevertheless, the principles of methodological rigor, fidelity to sources, and transparency in presenting the adopted criteria were respected.

RESULTS

The integrative analysis of the 28 included studies showed that corporeality, in traditional peoples, is addressed in the literature as an expanded and relational category, inseparable from cultural identity, ancestry, territory, spirituality, and community care practices (1-7, 10, 14-17). Instead of an understanding centered exclusively on the biological body, the studies indicate that the body is lived, interpreted, and cared for from symbolic and collective matrices that organize the experience of health and illness in different sociocultural contexts (1-5, 17,23).

In general, the findings could be organized into five main thematic axes: corporeality, identity, and health worldview; territory, ancestry, and spirituality in care practices; therapeutic pluralism and use of traditional resources; gender, motherhood, and intergenerational transmission of care; and differentiated attention, cultural safety, and challenges institutional (1-7, 13, 15, 17, 19,23,26,28). This organization allowed for the integration of results from theoretical, qualitative, quantitative studies and reviews, preserving the

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specific characteristics of the different peo- ples analyzed.

Table 1. Thematic Summary of the Main Findings of the Included Studies.

Thematic axis	Summary of findings	References
Embodiment, identity, and worldview of hea- lth.	The body is conceived as an integral reality, articulated with the mind, spiri- tuality, family, community, and ethno- cultural belonging.	1-4, 10, 14, 16, 17
Territory, ancestry, and spirituality in care practices.	Healthcare appears linked to the territory, the land, ancestral memory, rituals, and local cosmologies.	2,5-7,9, 13, 14, 17
Therapeutic pluralism and the use of traditional resources	Studies show coexistence between traditional medicine, plant use, natural resources, and support. Family/community and biomedical services.	11, 12, 17-23,25
Gender, motherhood, and the intergenerat- ional transmission of care.	Women play a central role in preserving and transmitting knowledge of caregiving, especially in childbirth, infant feeding, and medicinal plants.	8,9, 13, 19,20,24,25
Special attention, cul- tural security, and ins- titutional challenges.	Institutional barriers persist in the inco- rporation of traditional conceptions of body and care by formal health services.	8, 11, 15, 17,26-28

Embodiment, Identity, and Worldview of Health.

The first axis showed that the liter- ature understands corporeality in tradi- tional peoples as an integral experience, in which the body is linked to Subjectivity, spiritual life, family, and the social world. In classical studies with the Māori, health is presented as an integrat- ion of body, mind, spirit, and family, composing a relational structure that avoids fragmented interpretations of the process.

health-disease (1,2). In this same direction, studies on pain, physical activity, and community practices of body strengthening have shown that the experience of the body is not only functional or anatomical but is permeated by cultural values, collective meanings, and identity belonging (3,4).

Among First Nations youth, Australian Aboriginals, and urban Indigenous populations, cultural connection has been associated with well-being and mental health, highlighting that identity and culture do not operate as peripheral factors but as central components of the bodily and emotional experience (6, 10, 14, 16). In Brazilian contexts, this understanding has also been confirmed.

An anthropological reflection on Indigenous health in Brazil indicates that the body is interpreted in articulation with its own cosmologies, relationships with the community, and traditional healing systems, which requires an intercultural reading of the health-disease phenomenon (17). Thus, corporeality has emerged as a category that articulates physical existence, identity, and cultural continuity.

Territory, Ancestry, And spirituality in care practices

The second axis highlighted that health care in traditional peoples, is strongly anchored in territory and ancestry. International literature has identified that land, landscape, environment, and spirituality actively participate in the construction of well-being and therapeutic practices (2,5,6). In the Māori context, territory has appeared not only as a geographical space but as a constitutive dimension of health, belonging, and healing (2,5). Similarly, studies with Aboriginal and Sámi peoples have shown that health is profoundly affected by the maintenance of ties to the land, collective memory, and inherited cultural references (6,7, 14).

In studies focused on childbirth and reproductive health, territory also emerged as a decisive component. The experience of giving birth “on Country” was described as a strategy for strengthening autonomy, cultural safety, and community bonds, demonstrating that the maternal body cannot be dissociated from the cultural space where care takes place (9). Among Huichol Indigenous people, pregnancy and childbirth were analyzed as experiences intersected by gender, spirituality, and social structure, reinforcing that the reproductive body is culturally produced and protected within collective networks of meaning.

(13) . In Brazilian studies on indigenous health, differentiated care has also been linked to the recognition of territory as a therapeutic, political, and identity space, although with difficulties in effective translation in institutional practice (17, 28).

Therapeutic Pluralism and the Use of Traditional Resources

The third axis was one of the most consistent in the review. The studies showed a wide presence of therapeutic pluralism, with coexistence between traditional practices, local knowledge, family and community networks, and selective search for biomedical services (11, 12, 17-23,25). Among American Indians with chronic pain, traditional practices remained relevant in managing bodily suffering, demonstrating that pain is addressed in therapeutic circuits that extend beyond biomedical clinics (12). Among Indigenous women in Canada, the integration between formal services and cultural services was pointed out as a requirement for more adequate responses to health needs (11).

In Brazil, this axis proved particularly strong among quilombola populations, indigenous peoples, and traditional Amazonian communities. The itineraries

therapeutic of quilombola women

They highlighted the circulation among family, community support, traditional practices, and formal services, without rigid exclusion among these resources (19). Studies with quilombola men also indicated that health knowledge and practices are produced from everyday experience, territory, and local sociabilities (18). In parallel, ethnobotanical research and reviews on traditional Brazilian communities revealed significant use of medicinal plants, baths, oils, handmade preparations, and other therapeutic resources, showing that care is supported by a culturally shared pharmacopeia (21-23,25). Thus, the literature points out that corporeality is managed by plural, non-linear, and negotiated care systems, in which tradition and biomedicine coexist in arrangements specific to each context (17, 19,23).

Gender, Motherhood, and Transmission intergenerational care

The fourth axis revealed a strong protagonism of women in the organization, preservation, and transmission of care practices. In international studies on childbirth and motherhood, indigenous and aboriginal women reported that care for the body

The maternal and child health depends on cultural safety, community support, family presence, and respect for traditional practices (8,9, 13). The absence of these elements in hospital services has been associated with experiences of alienation, inadequacy, and suffering, while culturally safe contexts have favored autonomy, belonging, and protection (8,9).

In the national literature, the centrality of women has also been widely evidenced. Quilombola women appeared as guardians of health practices in domestic life, in child nutrition, and in family therapeutic itineraries (19,20,24). Breastfeeding and childcare practices were described as processes transmitted across generations, articulating body, motherhood, memory, and cultural identity (24). Among Wajãpi women, the traditional use of medicinal plants reinforced the female role in preserving therapeutic knowledge and mediating community care (25). These results indicate that the body, especially in its reproductive and caregiving dimension, is a space for cultural reproduction, intergenerational learning, and continuity of traditional ways of living and caring.

The fifth axis brought together studies that discussed the limits of the institutional organization of health services in light of the cultural specificities of traditional peoples. In the international literature, cultural safety has been treated as an essential condition for effective care, especially in contexts of childbirth, maternal health, and care for historically vulnerable indigenous populations (8, 11, 15). The studies indicate that disregarding traditional conceptions of body, health, territory, and family compromises adherence to care, the care experience, and the effectiveness of health actions (8, 15).

In Brazil, studies on indigenous health have shown that the differentiated care policy still faces practical difficulties in incorporating therapeutic pluralism and the cultural meanings of care (17,26,28). The representations of health professionals about the Mbyá-Guarani population highlighted intercultural tensions in the interpretation of care, suggesting that teams do not always adequately understand the symbolic references of the communities served (26) . In addition, analyses conducted in

Context from Alto Rio Negro indicated that, although differentiated attention is recognized as an important principle, its daily realization remains limited by organizational, formative, and epistemological barriers (28). Care for indigenous elderly people also reinforced this issue by showing that culturally situated practices of care for the aging body are not always fully recognized by services (27). In summary, the results indicate that the incorporation of corporeality as a culturally situated category still poses a significant challenge for institutional health.

Integrative Synthesis of the Results

Together, the studies analyzed converge to demonstrate that corporeality, in traditional peoples, constitutes an embodied experience of culture, memory, territory, spirituality, and collective belonging (1-7, 10, 14-17). The body does not appear as a neutral or universal object, but as a place of inscription of identity and production of socially shared care practices. Health, in this scenario, is produced in networks of meaning that include family relationships, ancestral knowledge, natural resources, rituals, territoriality, and specific therapeutic itineraries (11, 12, 17-25).

At the same time, the results also show that this expanded logic of care often comes into tension with assistance models centered on biomedical and standardized rationalities (8, 15, 17,26-28). This tension reinforces the need for intercultural approaches and health policies that are more sensitive to the ways in which traditional peoples understand and live the body, illness, and care.

DISCUSSION

The findings of this review indicate that corporeality, in traditional peoples, cannot be understood from a strictly anatomical-physiological rationality. The literature analyzed converges on a notion of the body as a relational experience, in which physical, emotional, spiritual, familial, territorial, and collective dimensions articulate in the production of health and care (1-7, 10, 14-17). This interpretation is consistent with classical formulations of indigenous health, such as the Māori perspective of Durie, which describes health from four integrated dimensions: spiritual, psychological, bodily, and familial, and

with subsequent analyses that reaffirm the role of cultural determinants in the health of indigenous peoples.

In this direction, the review allows us to sustain that corporeality, for traditional peoples, constitutes a sociocultural and political category. The body is not only the place where disease manifests but also the space in which collective memory, ancestry, ethnic identity, community bonds, and historical experiences of resistance are inscribed. Such an interpretation is particularly relevant because it shifts the health debate beyond clinical assistance, recognizing that living well, becoming ill, and healing depend on culturally situated ways of relating to the world, to the territory, and to the collectivity (1,2,5-7,14,16,17). This result dialogues with the literature that identifies culture not as a symbolic adornment of care but as a structuring foundation of the health experience in indigenous and traditional populations.

One of the most consistent points of the analyzed base was the centrality of territory. In the included studies, land appeared not only as a physical space of residence but as an ontological dimension of care, identity, and Cultural continuity (2,5,6,9,13,14,17). The territory organizes therapeutic practices, regulates relationships with ancestry, guides the use of natural resources, and directly participates in the production of well-being. Analytically, this means that corporeality in traditional peoples is also a territorialized corporeality. The body is experienced in connection with the place, with the landscape, with natural cycles, and with the symbolic landmarks of the community. This finding is particularly important in contexts where displacement, deterritorialization, and urbanization weaken cultural references and negatively impact mental health and belonging.

Another central axis of the discussion refers to therapeutic pluralism. The results showed that traditional peoples do not organize care based on a rigid opposition between traditional medicine and biomedicine, but through pragmatic, culturally oriented, and contextual compositions (11,12,17-23,25). In different scenarios, therapeutic itineraries were described that articulate the use of medicinal plants, baths, rituals, support from healers, family knowledge, spiritual counseling, and the search for formal health services (12,17,19,21-23,25). In the case

In Brazil, this coexistence appeared very clearly among quilombola women, whose therapeutic itineraries

involve family, community, traditional resources, and biomedical services in a simultaneous and negotiated manner. The study by Oliveira et al. precisely shows that these itineraries are multiple and organized according to their own care logics, rather than according to a biomedical linearity (19).

This finding has direct implications for the field of public health. Instead of interpreting the recourse to traditional medicine as a barrier to formal care, studies suggest that it should be understood as part of legitimate health production systems, anchored in historicity, experience, and community recognition (12, 17,21-23). From this perspective, traditional medicine does not represent a pre-scientific residue, but a set of socially validated knowledge and practices that remain active because they significantly respond to the concrete needs of groups. The discussion proposed by Langdon et al. is particularly enlightening in asserting that indigenous health policy in Brazil only becomes coherent with the notion of differentiated care when it effectively recognizes therapeutic pluralism and the articulation between official and indigenous therapies (17).

The review also showed that gender and generation play a decisive role in the organization of corporeality and care. Women appeared, recurrently, as guardians of therapeutic knowledge, mediators of intergenerational transmission, and protagonists of daily care, especially in the contexts of childbirth, motherhood, child feeding, and the use of plants medicinal

(8,9, 13, 19,20,24,25). This result suggests that feminine corporeality, in traditional peoples, should not be read only in its biological or reproductive dimension, but as a locus of cultural continuity. The maternal and caregiving body emerges as a space for teaching, symbolic reproduction, and preservation of ancestral knowledge. This dynamic is visible in both national studies with quilombolas and Wajãpi, as well as in international research on indigenous motherhood and culturally safe childbirth (8,9, 13,24,25).

At the same time, the results on childbirth and reproductive health indicate that the institutional incorporation of these conceptions is still insufficient.

Indigenous and aboriginal women reported suffering, inadequacy, and estrangement when obstetric care does not recognize territory, family, rituality, and cultural safety as legitimate dimensions of assistance (8,9,13). The discussion here approaches the broader critique of biomedical universalism. When care is standardized based on an abstract and supposedly neutral body, it tends to render cultural differences invisible and produce subtle, and sometimes explicit, forms of institutional violence. Thus, cultural safety cannot be thought of as a peripheral addition to care, but as a structural component of quality assistance in intercultural contexts (8,9, 15).

In the Brazilian context, this debate becomes especially sensitive in light of the differentiated attention policy in indigenous health. Although such policy formally recognizes the need for dialogue between services and indigenous practices, the reviewed studies show that its operationalization remains marked by ambiguities and epistemological asymmetries. and limitations

institutional (17,26-28). Langdon et al. highlight that the principle of articulation between official medicine and indigenous medicine still faces difficulties.

indigenous medicine still faces difficulties

implementation specifics, precisely because services remain, to a large extent, organized according to hegemonic biomedical logics (17). In a convergent manner, studies with health professionals in Alto Rio Negro and with teams working with the Mbyá-Guarani reveal that the discursive recognition of cultural difference does not always translate into effectively intercultural care practices (26,28).

This scenario suggests that one of the major contemporary challenges of intercultural health is to overcome merely adaptive approaches and advance towards more symmetrical forms of dialogue between knowledge systems. It is not enough to respect culture at a rhetorical level. It is necessary to reorganize work processes, professional training, care protocols, and health evaluation methods to incorporate local meanings of body, suffering, healing, and well-being (15,17, 26-28). In other words, the discussion about corporeality in traditional peoples has practical consequences for the formulation of public policies, for the organization of care, and for the very epistemological critique of the field of collective health.

Another important point is that the results of this review reinforce the analytical utility of corporeality as an integrating category. By bringing together scattered studies in indigenous health, transcultural nursing, medical anthropology, ethnobiology, mental health, and collective health, the review showed that the notion of corporeality allows for the articulation of phenomena that, at first glance, would appear separate, such as pain, childbirth, infant feeding, use of plants, spirituality, territory, identity, and therapeutic itineraries. This integration is relevant because it avoids fragmented readings of care in traditional peoples and contributes to a more consistent interpretation of health as an embodied, collective, and historically situated process (1-5, 12, 17, 19,21-25).

Despite these contributions, the analyzed literature also reveals gaps. Some studies emphasize specific experiences, such as childbirth, pain, or the use of medicinal plants, without necessarily delving into the category of corporeality explicitly. Furthermore, comparative studies between different traditional peoples in Brazil are still relatively scarce, as are quantitative investigations capable of engaging with broader indicators.

without losing cultural density. It is also observed that there is a concentration of qualitative studies in certain groups and regions, which indicates the need to expand production on less researched traditional communities and on populations in contexts of territorial, urban, or migratory transition (14, 18-20,23,28).

Among the potentialities of this review, the articulation between national and international evidence stands out, which allowed demonstrating that the relationship between body, culture, and care is not an isolated particularity of a people or country, but a recurring pattern in different traditional populations. Nevertheless, the presence of Brazilian studies was essential to show the specificities of the national debate, especially regarding quilombola experiences, indigenous health, and the limits of differentiated care (17-28). Thus, the review contributes to consolidating a theoretical and empirical basis capable of supporting more culturally sensitive and epistemologically plural approaches in the field of health.

In summary, the results discussed indicate that corporeality, in traditional peoples, constitutes an expanded experience of health, inseparable from culture,

identity, territory, ancestry, and care practices. Recognizing this complexity is not just an interpretive exercise, but an ethical, political, and care requirement for health systems that aim to respond more fairly and effectively to the needs of these peoples (1,7,15,17,28). The main implication of the review is, therefore, the need to strengthen intercultural perspectives that recognize the body as a plural, embodied, and socially situated reality, overcoming reductionist models of care and favoring health practices that are more coherent with traditional ways of living, falling ill, and healing.

CONCLUSION

This integrative review highlighted that corporeality, in traditional peoples, constitutes an expanded experience of health, deeply linked to culture, identity, territory, ancestry, and collective care practices (1-7,10,14-17). The studies analyzed demonstrated that the body, in these contexts, cannot be reduced to a biological or functional dimension, as it is understood as a space for the inscription of cultural values, collective memory, family ties, spirituality, and community belonging (1-5,17). Thus, health emerges as a relational and situated process, produced in the articulation between physical, symbolic, social, and territorial dimensions.

The results also showed that traditional care practices remain central to the organization of life and health of indigenous peoples, quilombolas, and other traditional communities, manifesting through the use of medicinal plants, natural therapeutic resources, rituals, family support, community networks, and plural therapeutic itineraries (11,12,17-25). In this sense, care is not structured from a single or linear logic, but through compositions between ancestral knowledge and formal services, which reinforces the importance of recognizing therapeutic pluralism as a legitimate component of health care (17,19,21-23).

The review also highlighted that gender, motherhood, and intergenerational transmission occupy a strategic place in the maintenance of care practices. Women appeared as

protagonists in the preservation and circulation of therapeutic knowledge, especially in contexts of childbirth, child care, nutrition, and traditional use of medicinal plants (8,9, 13, 19,20,24,25). Likewise, the territory revealed itself element structuring health and corporeality, since the body is experienced in connection with the land, with the landscape, with ancestral memory, and with the cultural references of the community (2,5,6,9, 13, 14, 17).

On the other hand, studies also highlighted important limits in the relationship between traditional peoples and institutional health services. Barriers persist in the incorporation of culturally situated conceptions of body, suffering, and care, especially in contexts marked by biomedical hegemony and difficulties in implementing differentiated care and cultural safety (8, 15, 17,26-28). This scenario indicates that the advancement of health policies and practices aimed at these peoples depends not only on formal access to services but on the construction of intercultural approaches capable of recognizing, valuing, and dialoguing with different therapeutic rationalities.

Thus, it is concluded that corporeality must be understood as a central category for the analysis of health in traditional peoples, as it allows for the integration of body, culture, identity, and care from an expanded and critical perspective. Strengthening culturally sensitive practices and policies, based on respect for territory, ancestry, and therapeutic pluralism, is essential for a health care approach that is more equitable, ethical, and coherent with traditional ways of living, falling ill, and caring for oneself (7, 15, 17,28). Furthermore, the review highlights the need for new investigations, especially in the Brazilian context, that broaden comparative production among different peoples and deepen the understanding of corporeality as a strategic dimension of collective health.

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