Southeastern National Tuberculosis Center
SHARE • LEARN • CURE

BRAZIL

CULTURAL COMPETENCY AND TUBERCULOSIS CONTROL

A Practical Guide for Health Professionals
Working with Foreign-born Clients

GEOGRAPHIC LOCATION

- Brazil is located in Eastern South America.[1]
- The capital is Brasilia.[1]
- The country is bordered to the north by French Guiana, Suriname, Guyana, Venezuela, Colombia, and to the south by Uruguay. To the east the country is bordered by the Atlantic Ocean, and to the west by Peru, Bolivia, Paraguay, and Argentina.[1]
- In Brazil there are 26 states *(estados)* and 1 federal district *(Distrito Federal)*.[1]
- **States:** Acre, Alagoas, Amapá, Amazonas, Bahia, Ceará, Espírito Santo, Goiás, Maranhão, Mato Grosso, Mato Grosso do Sul, Minas Gerais, Pará, Paraíba, Paraná, Pernambuco, Piauí, Rio de Janeiro, Rio Grande do Norte, Rio Grande do Sul, Rondônia, Roraima, Santa Catarina, São Paulo, Sergipe, Tocantins.[1]

Note: The information provided within is an introduction only and does not characterize all individuals from this country.

BACKGROUND INFORMATION

OFFICIAL LANGUAGE(S):

- **Official language:** Portuguese[1]
- **Other languages:** Spanish, German, Italian, Japanese, English, and native languages among groups in the Amazon[1,59]

ETHNIC GROUPS:

- **Majority:** 53.7% White, 38.5% mixed White and Black[1]
- **Minority:** 6.2% Black, 0.9% other (includes Japanese, Arab, Amerindian), 0.7% unspecified (2000 census)[1]

Note: Within Brazil, a person's economic status is more significant than their race or ethnic background.[59]

DOMINANT RELIGION(S) WITHIN THIS COUNTRY:

- Roman Catholic (73.6%)[1]
- Evangelical Christians[59]

LITERACY OF CITIZENS: *Defined as persons ages 15 years and older that can read and write.*

- Total population: 89.0% (2005 estimate)[57]

  Male: 88.7%

  Female: 89.2%

MEDICAL SYSTEM:

- Brazil's health care system (*Sistema Unico de Saude* or *SUS*) is immense and decentralized.[4,60,61]
- Free health care is provided to all citizens by public providers or private providers, who receive reimbursement from the government.[3] Approximately 40% of the population has additional health benefits provided through private insurers or company support.[3] Yet, disparities in access to drugs and medical equipment exist among different income groups.[2]
- Among community members, the public health system is considered to be inferior to the private system.[59]

Last Updated on: November 25, 2008

Developed by: Joan Mangan, PhD, MST at The Lung Health Center at the University of Alabama at Birmingham, USA and The Southeastern National Tuberculosis Center at the University of Florida, USA.

MAJOR INFECTIOUS DISEASES WITHIN THE BIRTH COUNTRY:

- **Vector borne:** Yellow Fever (except in coastal cities), Malaria (higher incidence in jungle regions), Dengue Fever[5,6]
- **Food or water borne:** Hepatitis A[6]

FERTILITY RATE OF WOMEN RESIDING WITHIN THE BIRTH COUNTRY:

- 2.33 children born/woman[58]

According to 2007 Immigration and Naturalization and US Homeland Security Data, individuals who became naturalized citizens from this country indicated the following top 10 states as their intended state of residence.

The percentage of the total number of legal permanent residents by state:[9]

1. Florida – 22.0%
2. Massachusetts – 15.0%
3. California – 13.6%
4. New Jersey – 9.5%
5. New York – 8.2%
6. Texas – 5.4%
7. Georgia – 2.1%
8. Illinois – 1.9%
9. Virginia – 1.7%
10. Maryland – 1.6%

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING ANNUALLY TO THE UNITED STATES:

- According to data collected in 2000 by the US Census Bureau, approximately 181,076 individuals originating from Brazil reside in the United States.[7]
- 14,295 persons from Brazil obtained legal permanent resident* status within the US during fiscal year 2007.[8]
- The average number of persons from Brazil who have obtained legal permanent resident status annually (1998-2007): 9,984.[8]

**Legal permanent residents are foreign nationals who have been granted the right to reside permanently in the United States. Often referred to simply as "immigrants," they are also known as "permanent resident aliens" and "green card holders."*

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING ANNUALLY TO CANADA:

- 1,209 persons from Brazil were granted permanent resident status within Canada during fiscal year 2006.[10]
- The average number of persons from Brazil who became legal permanent residents of Canada annually (1997-2006): 824.[10]
- In 2006, Brazilian immigrants granted permanent residence in Canada accounted for 3.4% of all immigrants originally from South and Central America and the United States.[10]

THE ESTIMATED NUMBER OF INDIVIDUALS FROM THIS COUNTRY EMIGRATING TO COUNTRIES WITHIN THE EUROPEAN UNION:

- Statistics available through Eurostat (2006) indicate that the majority of Brazilian immigrants to the European Union have migrated to Spain, Portugal, and Germany.[11]

TUBERCULOSIS EPIDEMIOLOGY

BASED ON THE ESTIMATED INCIDENT CASES (ALL FORMS) OF TUBERCULOSIS IN 2006, THIS COUNTRY IS RANKED NUMBER 16 OUT OF 212 COUNTRIES WORLDWIDE.[12]

Estimated Burden of Tuberculosis (2006):

Incidence: 50/100,000[12]

Prevalence: 55/100,000[12]

Reported Cases of TB (2006):

77,632[12]

Estimated Burden of HIV Infection (2007):

Estimated prevalence: 0.6%[14]

Low estimate (adults): 0.5%[14]

High estimate (adults): 0.8%[14]

The WHO estimates 600,000-890,000 persons in Brazil are living with HIV.[14]

TB/HIV Co-Infection* (2006):

**HIV prevalence among incident TB cases*

Estimated co-infection: 12%[12]

Adults ages 15-49 yrs:

- **Incidence:** 6/100,000[12]
- **Prevalence:** 3/100,000[12]

LEVEL OF MULTIDRUG-RESISTANT TB*:

**Multidrug resistance is defined as resistance to at least Isoniazid and Rifampicin.*

- 0.9% of new TB cases are multidrug-resistant.[15]
- 5.4% of previously treated TB cases are multidrug-resistant.[15]

Note: These data are from 1996. More recent data are not available at this time.

STANDARD TB DRUG TREATMENT/TB MEDICATIONS READILY AVAILABLE FOR THE TREATMENT OF TB IN THIS COUNTRY:

R or RMP or RIF = Rifampicin or Rifampin	S or STM or SM = Streptomycin
H or INH = Isoniazid	Et = Ethionamide
Z or PZA = Pyrazinamide	CIP = Ciprofloxacin
E or EMB = Ethambutol	P or PAS = *p*-aminosalicylic acid

- Most frequently used treatment strategy:[18,19]

  I (2RHZ/4R_2H_2); **IR** (2RHZE/4RHE)

Notes: Previously, Brazil had not followed the WHO's four drug regimen which includes Ethambutol in the initial phase.[19]

According to the 2007 WHO Report "Global TB Control: Surveillance, Planning, Financing," Brazil began using patient kits for drugs, including the fixed-dose combinations (FDCs) in 2006.[20]

TB CONTROL/DOTS COVERAGE:

- According to the World Health Organization, 86% of the country's citizens are covered by DOTS (2006 estimate).[15]

TB MEDICATION AVAILABLE AT NO COST THROUGH TB PROGRAM:

■ Yes[17,60,61] ☐ No ☐ Information Not Found/Unknown

TB MEDICATIONS AVAILABLE ONLY THROUGH NATIONAL TB PROGRAM:

■ Yes[56] ☐ No ☐ Information Not Found/Unknown

Comments: With the support of the National TB Program, TB treatment is available in any Basic Care Unit in the country.[60,61]

TB MEDICATIONS AVAILABLE THROUGH PRIVATE PHARMACIES WITH A PRESCRIPTION:

☐ Yes ■ No[35] ☐ Information Not Found/Unknown

USE OF BCG VACCINE:

■ Yes[21] ☐ No

- BCG is administered at birth.[21,60,61]

Approximate percentage of the population that is covered by the BCG vaccine:

- 90% coverage (2007 estimate, WHO/UNICEF)[16]

NICKNAMES/COMMON NAMES FOR TB:

- The word for TB in Portuguese is *tuberculose*.[2]

COMMON ATTITUDES, BELIEFS AND PRACTICES RELATED TO TUBERCULOSIS

GENERAL COMMENTS:

- In the early 1990s the rate of non-adherence to TB treatment varied between 12% and 16% in large urban centers; non-adherence rates in major cities varied between 27% and 34%.

  The rise in non-adherence that occurred throughout the 1990s has been attributed to socioeconomic conditions, the dismantling of the public health system, and an increase in HIV infection.[25]

  Additional factors that impacted treatment adherence/default included:

  – An irregular supply of drugs due to: drug availability, acquisition, storage, unequal distribution, and quality assurance[17]

  – Patients' concerns about medication side effects/damage to the body caused by TB medications[23]

  – Lack of patient education[25]

- Seventy percent of TB cases in Brazil occur in urban and sub-urban areas.[32]

  – Psychiatric inpatients, prisoners, and indigenous Brazilians are particularly vulnerable to TB and have high incidence rates.

  – TB incidence among indigenous groups is estimated to be 10 times higher than the non-indigenous population. These indigenous groups are becoming increasingly migratory, moving into heavily populated areas of urban Brazil.[30,31,36]

- In Brazil, care of TB patients is largely provided on an outpatient basis, supervised by public providers.[2]

- In one survey, almost half of Brazilians thought TB was a rare health problem, but thought the disease had not yet been eradicated.[32]

Note: Brazil is the 5th largest country in the world and is home to a very heterogeneous population. The information provided in the following section does not characterize all individuals from this country.

COMMON MISPERCEPTIONS RELATED TO TB ETIOLOGY/CAUSE:

- TB is caused by poverty and poor sanitation.[34,35]

Note: While TB is associated with poverty, some individuals view poverty as the direct cause (or etiological agent) of tuberculosis disease.

COMMON MISPERCEPTIONS RELATED TO DISEASE TRANSMISSION:

- Within Afro-Brazilian cultures, the infectiousness of diseases is thought to be connected with everyday behavior or social interactions.[52]

  For example:

  – Individuals within the Afro-Brazilian cultures believe that if a person acts rebellious, or is envious of someone in the community, they may become sick.[52]

  – If a person has a fear of catching a disease or has a predisposition to a certain disease, they will become sick.[52]

MISPERCEPTIONS RELATED TO DIAGNOSTIC PROCEDURES:

Note: No information concerning misperceptions specific to the procedures used to diagnose TB was found in the literature.

CURES/TREATMENTS THAT MAY BE USED:

- In Brazil, most prescription drugs can be easily obtained over the counter (narcotics require a prescription). Pharmacists and pharmacy owners prescribe medications and treat illnesses – particularly for people in lower socioeconomic groups.[33]

  – Immigrant Brazilians often bring prescription medications from Brazil or send for them once in the US due to "convenience, familiarity, preference, and trust." In some instances medical care may be put on hold until the individual can return to Brazil.[24]

- Brazilians may self-medicate or seek an informal, family and community-based approach to the diagnosis and treatment of illness – in which family members, friends, neighbors, and pharmacy clerks are considered trustworthy and reliable sources of information and medications.[24]

- In Brazil, homeopathy is available through both the public and private sector.[53]

  – Homeopathic pharmacists are very common in Brazil, and they frequently prescribe medications and treat various illnesses.[21]

  – Examples of homeopathic medicines include: tonics, teas, juices, bottled brews. Plants may also be consumed as medicine.[51]

  – Homeopathic treatment may be used/preferred: (1) when patients' ideas of health and illness are related to the idea that a balance/imbalance in the body is influenced by interactions between the body and mind, (2) due to dissatisfaction with conventional treatments, (3) due to lower prices of homeopathic medicines, or (4) at the suggestion of family and others.[33,54]

    – An example of homeopathic treatment is acupuncture.[21]

- Common homemade medications include teas and salves made from plants, roots, and leaves. Herbal teas are frequently used as a treatment for colds, stomach aches, or other common ailments.[24]

Note: Herbs and other plants have the potential to interact with prescribed medications. Additional study of the pharmacological properties of herbs/plants used in traditional medicine practices is needed; however, these topics are beyond the scope of this guide.

MISPERCEPTIONS RELATED TO TREATMENT/MEDICATIONS:

- According to a report published by the Stop TB Partnership in 2006, a survey found 90% of Brazilians knew that TB is curable, yet only about half of surveyed Brazilians knew that treatment for TB lasted 6 months.[32]
- Published studies have also reported a variety of misperceptions related to medications among indigenous groups in Brazil. These misperceptions may lead to inappropriate usage of medications. Examples from the literature are below:
  - Members of the Wari' group (located in Western Brazil) believe that the only cure for "Western illnesses" (those illness introduced by outsiders during the 1950s to 1960s) are Western pharmaceuticals, so they may consume as many "Western medicines" as possible.[26]
  - The Kulina are very receptive to Western medications, but they view them as "largely undifferentiated" because of identical packaging.[26,27]

USE OF TRADITIONAL HEALERS:

- When seeking a cure for an illness, Brazilians may combine treatment provided by a physician with those offered by a traditional healer.[33] The use of healers or traditional cures/remedies is more common in rural areas, small cities, and interior regions of Brazil.[60,61]
- A person may first seek care from traditional healers for economic reasons.[59]
- Examples of traditional healers are provided below:
  - *Rezadeiras* are praying women who exorcise illnesses; *conselheiros* are counselors or advisors; *catimbozeiros* are sorcerers who perform possession rituals.[28,33]
  - The poor in Brazil may seek care from *curandeiros*. *Curandeiros* are faith healers or divinely gifted healers (they may also be referred to as witch doctors), who form close personal relationships with the patients, acknowledging patients' religious and cultural beliefs – this acknowledgement is appreciated by the patient.[33,34]
  - Within African-Brazilian cultures, a person may seek a cure for an illness from a *mae* or *pai de santo* (head priestess or priest). Also from the African culture, *santeros(as)* and *espiritistas* practice *espiritismo* to rid patients of spirits.[34] *Note:* Espiritismo *is also a religion, known as* Kardecismo.[60,61]

Stigma and Stigmatizing Practices Surrounding TB in this Country

- A diagnosis of TB may come as a surprise to a person from Brazil, since TB is thought to be unusual or a disease of the past.[32,34,35]
- A diagnosis of TB may also cause an individual to be rejected by others due to fear of infection. Thus, even if a person is receiving treatment and is not infectious, the patient may feel shame for having the disease.[32,34,35]
- Brazilian families provide support to sick family members, but concerns related to the family's social status may generate pressure to keep the illnesses secret. Wealthier families, in particular, may be more secretive about a TB diagnosis.[34,59]

IMPORTANT TUBERCULOSIS EDUCATION POINTS:

- Brazilian immigrants may be offended if healthcare providers do not make an effort to understand their personal points-of-view or situations. Allocate a few minutes to ask a patient why they think they have become ill, how the illness is affecting their daily life, and what type of treatment they think they need.
- When providing patient education, take time to explain the rationale behind what you are asking the client to do.
  - When discussing medication regimens and dosing of medication, explain why the prescribed medication regimen was chosen to treat the patient and the rationale for the length of treatment regimen.
  - Stress the rationale for HIV testing to identify co-infection with TB.[59]
  - Most patients will be very concerned about the health of their contacts; explain the reasons for contact tracing.[59]
- A client from Brazil may feel discriminated against if a provider (following clinic protocol) insists that the client undergo a tuberculin skin test, when the individual has been vaccinated with BCG.[24]

  Be sure to explain how the BCG vaccine is different from other childhood vaccines and that the test will be interpreted taking the vaccine into account – prior to placing the skin test.
  - If the client is diagnosed with LTBI or active disease, reiterate the difference between BCG and other vaccines when providing additional patient education.

Reminder: Literacy levels are low in some areas of Brazil. Printed educational materials/reminders may be an ineffective approach to educating some patients or ensuring treatment adherence.[59]

COMMON ATTITUDES, BELIEFS AND PRACTICES RELATED TO HIV/AIDS

GENERAL COMMENTS:

- Brazil alone accounts for more than one third of the estimated 1.8 million people living with HIV in Latin America.[37]
- Information about safe sex to prevent HIV/AIDS is frequently sought among Brazilians.[33]
- Knowledge/awareness of HIV/AIDS among individuals from different states within Brazil may vary widely.[29]
  - Soap operas have incorporated story lines about HIV/AIDS. This has helped to raise awareness of the disease.[59]
- According to a report published by the WHO in 2004, Brazil has the most advanced national HIV/AIDS treatment program among developing nations.[41]
  - Highly active antiretroviral therapy (ARV) was first introduced in Brazil in 1996.[40]
  - Brazilians have free access to HIV/AIDS medications and medical care within the public health system.[37,40]

COMMON MISPERCEPTIONS RELATED TO HIV/AIDS ETIOLOGY/CAUSE:

Note: No information concerning common misperceptions specific to the etiology/cause of HIV/AIDS was found in the literature.

COMMON MISPERCEPTIONS RELATED TO DISEASE TRANSMISSION:

- In a large population-based study of HIV knowledge among Brazilians, the majority of persons ages 15-24 demonstrated correct knowledge related to HIV transmission; however, some survey respondents believed HIV could be transmitted through:[38]
  - Insect bites
  - Use of public toilets
  - Sharing cutlery
  - Sharing glasses
  - Sharing meals

Note: These beliefs may be found throughout Brazil, among both educated and uneducated individuals.[60,61]

- According to another study, young adults were not aware that HIV transmission can occur through oral sex.[39]

MISPERCEPTIONS RELATED TO DIAGNOSTIC PROCEDURES:

Note: No information concerning misperceptions specific to the procedures used to diagnose HIV/AIDS was found in the literature.

CURES/TREATMENTS THAT MAY BE USED:

Comments: See "Cures/Treatments that May be Used" in the "Common Attitudes, Beliefs and Practices Related to Tuberculosis" section for general cures and treatments.

STIGMA AND STIGMATIZING PRACTICES SURROUNDING HIV/AIDS IN THIS COUNTRY:

- According to some reports, Brazilian women with AIDS have faced discrimination in finding and keeping a job.[40]
- In some instances, children in Brazil have been denied their right to education due to AIDS-related stigma.[40]

IMPORTANT HIV EDUCATION POINTS:

- Assess clients' knowledge of HIV and AIDS. Prepare to provide basic/general information.
  - Young women may be embarrassed or fear seeking information related to their bodies, sex, contraception, condoms, and AIDS due to concerns related to being labeled as sexually active.[42]
- Discuss stigma and concerns related to discrimination.

GENERAL PRACTICES

CULTURAL COURTESIES TO OBSERVE:

Note: An influx of European immigrants over the past centuries has led to remarkable ethnic and cultural diversity in Brazil. This diversity is unequaled by any other Latin American country.[55]

- Greetings play an important role in establishing relationships. If a client is accompanied by family members or friends, an individual greeting and handshake should be offered to everyone with your client upon arrival and departure. When possible, engage in small talk before and after a meeting with a client. This will let your client know that your relationship with them takes priority over the business of TB control.[33,43,44,55]

Men Greeting Men

In greeting one another, men shake hands while maintaining steady eye contact and may also slap each other on the back.[33,43,44]

Women Greeting Women

In greeting one another, women often kiss on both cheeks (kissing the right cheek first, then the left – to avoid bumping noses) when arriving and departing.[33,59]

Women Greeting Men

If a woman wishes to shake hands with a man, she should extend her hand first.[43]

- Close friends will often embrace.[44]
- Recognition and status are important in Brazil; therefore, titles should be used with surnames whenever appropriate.[55]
  - Professional titles are often combined with first names, rather than last names.[45]
  - *Doutor* (male) or *Doutora* (female) are respectful and affectionate terms for healthcare personnel.
  - Doctors are addressed as *Doutor(a)* followed by their first name.
  - Nurses are addressed as *Enfermeira* followed by their first name.[21,33,45]
- In Brazil, people quickly move to a first-name basis. Do not, however, use first names until you are invited to do so.[45]
  - *Seu* or *Senhor* (a more respectful title than *Seu*) may precede the first name of a man, and *Dona* may precede the first name of a woman.[33]
  - Younger people address mothers, grandmothers, or respected women as *A Senhora*, and fathers, grandfathers, and respected men are addressed as *O Senhor*. This is a very formal tradition.[33,59]

Is there a need to match client and provider by gender?

☐ Yes ■ No ☐ Information Not Found/Unknown

Comments: Generally, Brazilians prefer good health care, regardless of gender. Some women prefer female gynecologists and obstetricians.[33]

FAMILY:

- In Brazil, family is of utmost importance.[43]
- Families tend to be large (although family size is currently decreasing), with the extended family being quite close.[43]
- The family structure is the basis of stability for most people. Often, the family forms the basis for social and business endeavors. In times of need, an individual draws upon the family's social network and assistance.[43]
- Regarding illness, discussions are initiated and decisions are made within the family unit. Families often choose a well-educated, influential, or authoritative member of the family to speak on behalf of the patient and family.[21,33]
- Families are usually eager caregivers and can be taught to assist with medical procedures. Families tend to make arrangements to stay around the clock at a sick relative's bedside.[21,33]

NAMES:

- Brazilian names typically consist of a first name, mother's family name, and then father's family name. When a woman marries, she may drop her mother's and father's family name, or she may keep them both.[21,33]

Note: When asked to sign documents, Brazilians from interior regions of the country who are illiterate may be accustomed to using their thumbprint as a signature. There is quite a bit of stigma associated with using a thumbprint in place of a signature.[33,59,60,61]

CULTURAL VALUES:

- Brazilians are especially sensitive to embarrassment, and criticism in social settings is frowned upon.[43]
  - Criticizing an individual causes that person to lose face with others.[43]
  - The person making the criticism also loses face, as they have disobeyed this social rule.[43]
- In Brazil dressing well is important and Brazilians pride themselves on their appearance. Persons from higher socioeconomic brackets may judge others based on their clothing. It is better to be over-dressed rather than under-dressed.[43,46,55,59]
  - "Casual" dress is more formal in Brazil compared to many other countries. Casual wear for men includes khakis or other pants with a nice long-sleeved shirt; casual wear for women includes a nice pair of pants or skirt.[43,46,55]
- Brazilians often view time as uncontrollable and place greater importance on meeting relationship demands over following strict schedules.[43] As a result, tardiness is expected and people make plans accordingly in Brazil.[21,33]

  Because Brazilians tend to be relaxed about time and punctuality; it may be helpful to discuss schedules and meeting times when making initial arrangements for DOT.

  During these conversations, consider using the term *tempo hora Americana* ("American time") to ensure that schedules and appointments are clearly understood.[59,60,61]
  - *Daqui um pouco* ("a little while from now") is a commonly used phrase that may mean 5 minutes, a half hour, or perhaps not until the next day.[33]
  - In Brazil, it is not uncommon for people to take unexpected holidays. Discuss holiday plans with clients when making arrangements for DOT.[33]
- The manner in which physicians or other healthcare professionals address a patient can convey either respect or disrespect. To establish a strong personal rapport with a patient, allow time for friendly conversation during encounters with clients from this country. Listen patiently when a client answers a question.[59]

COMMUNICATION PATTERNS (VERBAL AND NONVERBAL):

- Brazilians may keep their feelings to themselves for fear of hurting someone. Additionally, individuals from Brazil may try to avoid confrontations or giving the appearance that they are frustrated.[33,43]
- Be aware that Brazilians consider their personal lives to be private topics.[55]
- Brazilians tend to speak quickly; expect fast-paced conversations.
  - Do not take offense if a client with whom you are talking interjects some information, or if you are "cut off" when speaking. In Brazil, communication tends to be informal and it is acceptable to interrupt someone who is speaking. These interruptions are a way of displaying interest and enthusiasm for the subject under discussion.[43,55]
- Use steady eye contact when conversing with a client from Brazil; it is considered an insult to break eye contact.[55]
- During conversation, frequent touching (of the arms, hands, or shoulders), hand motions/gestures, and facial expressions are the norm. Brazilians also tend to stand in close proximity to the person with whom they are speaking.[33]
  - To add emphasis to what is being said, a person from Brazil may snap their fingers and/or wave their hands up and down.[44,55]
  - To convey not knowing or not understanding the answer to a question, a person from Brazil may scrape their fingertips under the chin. (This is sometimes used when responding to a question).[44,55]
  - To beckon someone, a person from Brazil may wave their fingers towards their body with palm facing down.[44]

The following gestures may also be considered inappropriate or offensive to a patient from this country:

- Yawning or stretching in public is frowned upon.[44]
- The "O.K." sign (using your first finger and thumb to form a circle) is considered vulgar.[44,55]

Phrases or terms to avoid:

- Brazilians consider themselves to be "of America"; therefore, avoid saying "in America" when referring to the United States.[47,55]
- Brazilians do not consider themselves Hispanic and may take offense if addressed in Spanish.[44]

DIET AND NUTRITION:

- The traditional Brazilian diet consists of rice, beans, meat (fish, roast beef, chicken, seafood), and manioc flour/meal (a staple carbohydrate resembling a potato).[33,48]
  - Breakfast foods include: *café com leite* (half coffee and half hot milk), fruit juices, fruit, scrambled eggs, bread, yams, couscous.[21,33]
  - At midday, the main meal *almoco* (dinner) is eaten. This meal may consist of rice, beans, manioc, farina (finely ground wheat), mashed potatoes, pasta, and meat or fish.[21,33]
  - In the late evening, Brazilians eat a light meal called *jantar* (supper); this meal may consist of soup or leftovers from lunch.[21,33]
- Brazilians living in the US tend to object to fast foods.[33]
- Young Brazilian women may try to remain thin by using vitamins instead of eating a heavy diet.[33] Discuss this practice with patients and explain the reasons why TB medications need to be taken with food.

MISCELLANEOUS:

- Brazilians tend to talk only about serious illnesses (rather than minor illnesses); generally, illness is only discussed within the family.[33]
- Many Brazilians feel that talking about an illness can make the condition worse.[33]
- Brazilians don't like to talk about pain or discomfort.[33]

TRANSLATED EDUCATIONAL MATERIALS AVAILABLE THROUGH THE WORLD WIDE WEB

The following materials are in Portugese.

TUBERCULOSIS SPECIFIC MATERIALS (TITLES PROVIDED IN ENGLISH)

BROCHURES AND FACT SHEETS

General disease information

- **Taking the Fear Out of TB:**
  http://www.mhcs.health.nsw.gov.au/mhcs/publication_pdfs/3450/BHC-3450-POR.pdf
- **Someone I Know has TB: What do I do now?:**
  http://www.findtbresources.org/scandocs/AD30272.pdf
- **Your TB Test: Answers to Questions People Ask Most Often:**
  http://www.findtbresources.org/scandocs/AD30275.pdf
- **The Patients' Charter for TB Care:**
  http://www.worldcarecouncil.org/pdf/PatientsChartePT2006.pdf

Diagnostics

- **Instructions for Collecting Sputum for Tuberculosis:**

  http://www.mhcs.health.nsw.gov.au/mhcs/publication_pdfs/7620/DOH-7620-POR.pdf

Treatment

- **Tuberculosis:**

  http://www.mhcs.health.nsw.gov.au/mhcs/publication_pdfs/7600/DOH-7600-POR.pdf

TB/HIV

- **HIV and TB:**

  http://www.findtbresources.org/scandocs/AD31469.pdf

HIV/AIDS SPECIFIC MATERIALS (TITLES PROVIDED IN ENGLISH)

BROCHURES AND FACT SHEETS

- **Rai: A man who almost died from a scare and now uses the condom:**

  http://db.jhuccp.org/mmc/media/bra203.pdf

- **Join the Fight Against AIDS:**

  http://db.jhuccp.org/mmc/media/PLBRA273.pdf

**Please note that this resource list is not exhaustive and does not represent all the resources available for this subject. Additional TB educational resources may also be found at www.findtbresources.org*

REFERENCES

1. Central Intelligence Agency. (2008). The 2008 World Fact Book. Retrieved September 8, 2008 from https://www.cia.gov/library/publications/the-world-factbook/geos/br.html

2. Library of Congress. (2005). Country Studies. Brazil: Health status and health care, the health care system. Retrieved May 11, 2007 from http://lcweb2.loc.gov/frd/cs/brtoc.html

3. Jardim JR & Nascimento O. (2007). Respiratory health in Brazil. *Chronic Respiratory Disease, 4*(1), 45-49. [abstract only]

4. World Health Organization. (2008). WHO Report 2005: Global tuberculosis control - surveillance, planning, financing (Annex 1: Brazil). Retrieved May 11, 2007 from http://www.who.int/tb/publications/global_report/2005/annex1/en/index2.html

5. World Health Organization. (2007). International Travel and Health. Retrieved February 8, 2008 from http://www.who.int/ith/en/

6. Centers for Disease Control and Prevention. (2008). Health Information for Travelers to Brazil. Retrieved February 8, 2008 from http://wwwn.cdc.gov/travel/destinationBrazil.aspx

7. US Census Bureau. (2008). American FactFinder. Fact sheet for a race, ethnic, or ancestry group, 2000 census data. Retrieved September 8, 2008 from http://factfinder.census.gov/

8. US Department of Homeland Security. (2008). Yearbook of Immigration Statistics. Persons obtaining legal permanent resident status by region and country of birth: fiscal years 1998 to 2007. Retrieved August 27, 2008 from http://www.dhs.gov/ximgtn/statistics/publications/LPR07.shtm

9. US Department of Homeland Security. (2008). Profiles on Naturalized Citizens: Fiscal Year 2007. Persons naturalized during fiscal year 2007 by region/country of birth and selected characteristics. Retrieved November 25, 2008 from http://www.dhs.gov/ximgtn/statistics/data/dsnat.shtm

10. Citizenship and Immigration Canada. (2008). Facts and Figures 2007. Immigration Overview: Permanent residents from South and Central America and the United States by top source countries. Retrieved February 8, 2008 from http://www.cic.gc.ca/english/resources/statistics/facts2007/permanent/15.asp

11. Statistical Office of the European Communities. (2008). Eurostat: Immigration by sex, age group, and citizenship. Retrieved August 27, 2008 from (primary link) http://epp.eurostat.ec.europa.eu (direct link) http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=MIGR_IMMIAGEC

12. World Health Organization. (2008). WHO Report 2008: Global tuberculosis control - surveillance, planning, financing (Annex 3: Global). Retrieved July 29, 2008 from http://www.who.int/entity/tb/publications/global_report/2008/xls/annex3_global.xls

13. World Health Organization. (2007). WHO Report 2007: Global tuberculosis control: surveillance, planning, financing (Annex 2: The Americas). Retrieved February 11, 2008 from http://www.who.int/tb/publications/global_report/2007/xls/amr.xls

14. UNAIDS/WHO. (2008). Report on the Global AIDS Epidemic, Annex 1: HIV and AIDS estimates and data, 2007 and 2001. Retrieved October 6, 2008 from http://data.unaids.org/pub/GlobalReport/2008/080815_gr08_annex1_table_en.xls

15. World Health Organization. (2008). Global Health Atlas Predefined Reports: TB Country Profile, Brazil. Retrieved September 8, 2008 from http://www.who.int/GlobalAtlas/predefinedReports/TB/PDF_Files/bra.pdf

16. World Health Organization. (2008). Reported Estimates of BCG Coverage. Retrieved September 9, 2008 from http://www.who.int/immunization_monitoring/en/globalsummary/timeseries/tscoveragebcg.htm

17. Kritski AL & Ruffino-Netto A. (2000). Health sector reform in Brazil: Impact on tuberculosis control. *International Journal of Tuberculosis and Lung Disease, 4*(7), 622-626.

18. da Silva Oliveira VL, da Cunha AJLA, Alves R. (2006). Tuberculosis treatment default among Brazilian children. *International Journal of Tuberculosis and Lung Disease, 10*(8), 864-869.

19. Cavalcante SC, Soares ECC, Pacheco AGF, Chaisson RE, Durovni B, the DOTS Expansion Team. (2007). Community DOT for tuberculosis in a Brazilian favela: Comparison with a clinic model. *International Journal of Tuberculosis and Lung Disease, 11*(5), 544-549.

20. World Health Organization. (2007). WHO Report 2007: Global tuberculosis control: surveillance, planning, financing (Results). Retrieved February 11, 2008 from http://www.who.int/tb/publications/global_report/2007/results/en/index.html

21. D'Avanzo CE & Geissler EM. (2003). *Cultural Health Assessment*. St. Louis: Mosby.

22. Reverso Software (2001). Collins Online Dictionary. Retrieved June 21, 2007 from http://dictionary.reverso.net/english-portuguese/tuberculosis

23. Goncalves H, Costa JS, Menezes AM, Knauth D, Leal OF. (1999). Tuberculosis treatment adherence in Pelotas, Brazil, from the patient's perspective. *Cadernos de Saúde Pública, 15*(4), 777-87. [abstract only; article in Portuguese]

24. Hilfinger Messias DK. (2002). Transnational health resources, practices, and perspectives: Brazilian immigrant women's narratives. *Journal of Immigrant Health, 4*(4), 183-200.

25. Rabahi MF, Rodrigues AB, Queiroz de Mello F, de Almeida Netto JC, Kritski AL. (2002). Noncompliance with tuberculosis treatment by patients at a tuberculosis and AIDS reference hospital in Midwestern Brazil. *The Brazilian Journal of Infectious Diseases, 6*(2), 63-73.

26. Conklin BA. (1996). Reflections on Amazonian anthropologies of the body. *Medical Anthropology Quarterly, 10*(3), 373-375.

27. Pollock D. (1996). Personhood and illness among the Kulina. *Medical Anthropology Quarterly, 10*(3), 319-341.

28. Morris B. (2006). *Religion and Anthropology: A Critical Introduction*. London: Cambridge University Press.

29. Bacon O, Pecoraro ML, Galvao J, Page-Shafer K. (2004). Country AIDS policy analysis project: HIV/AIDS in Brazil. Retrieved February 18, 2008 from http://ari.ucsf.edu/programs/policy/countries/Brazil.pdf

30. da Costa HC, Malaspina AC, de Mello FA, Leite CQ. (2006). Tuberculosis in a psychiatric hospital in the state of Goiás, Brazil. *Jornal Brasileiro de Pneumologia, 32*(6), 566-572.

31. Basta PC, Coimbra CE, Escobar AL, Santos RV, Alves LC, Fonseca Lde S. (2006). Survey for tuberculosis in an indigenous population of Amazonia: The Suruí of Rondônia, Brazil. *Transactions of the Royal Society of Tropical Medicine and Hygiene, 100*, 579-585.

32. Stop TB Partnership. (2006). Mass media campaign to help eliminate TB in Brazil. Retrieved June 26, 2007 from http://www.stoptb.org/wg/advocacy_communication/

33. Purnell LD & Paulanka BJ. (Eds.). (2003). *Transcultural health care: A culturally competent approach*. Philadelphia: F.A. Davis.

34. Chong N. (2002). *The Latino Patient: A Cultural Guide for Health Care Providers*. Yarmouth: Intercultural Press.

35. Santos-Filho ET. (2006). *TB Policy in Brazil: A Civil Society Perspective*. New York: Open Society Institute.

36. Abrahão RMCM, Nogueira PA, Malucelli MIC. (2006). Tuberculosis in county jail prisoners in the western sector of the city of São Paulo, Brazil. *International Journal of Tuberculosis and Lung Disease, 10*(2), 203-208.

37. UNAIDS/WHO. (2005). AIDS Epidemic Update: Latin America. Retrieved February 13, 2007 from http://www.who.int/hiv/epi-update2005_en.pdf

38. Szwarcwald CL, Barbosa-Junior A, Pascom AR, de Souza-Junior PR. (2005). Knowledge, practices and behaviours related to HIV transmission among the Brazilian population in the 15–54 years age group. *AIDS, 19*(suppl 4), S51–S58.

39. Trajman A, Belo MT, Teixeira EG, Dantas VC, Salomão FM, Cunha AJ. (2003). Knowledge about STD/AIDS and sexual behavior among high school students in Rio de Janeiro, Brazil. *Cadernos de Saúde Pública, 19*(1), 127-133.

40. Abadía-Barrero CE & Castro A. (2005). Experiences of stigma and access to HAART in children and adolescents living with HIV/AIDS in Brazil. *Social Science & Medicine, 62*, 1219–1228.

41. World Health Organization. (2004). The 3 by 5 Initiative: Treatment Works. Retrieved February 13, 2007 from http://www.who.int/3by5/en/treatmentworks.pdf

42. World Health Organization. (2003). Gender and HIV/AIDS. Retrieved February 13, 2007 from http://www.who.int/gender/documents/en/HIV_AIDS.pdf

43. Kwintessential Language and Culture Specialists. (nd). Brazil - Language, Culture, Customs and Etiquette. Retrieved January 18, 2007 from http://www.kwintessential.co.uk/resources/global-etiquette/brazil-country-profile.html

44. Executive Planet. (2006). Brazil: Public Behavior. Retrieved January 18, 2007 from http://www.executiveplanet.com/index.php?title=Brazil:_Public_Behaviour

45. Executive Planet. (2006). Brazil: First Name or Title? Retrieved January 18, 2007 from http://www.executiveplanet.com/index.php?title=Brazil:_First_Name_or_Title%3F

46. Executive Planet. (2006). Brazil: Business Dress. Retrieved January 18, 2007 from http://www.executiveplanet.com/index.php?title=Brazil:_Business_Dress

47. Executive Planet. (2006). Brazil: Conversation. Retrieved February 1, 2007 from http://www.executiveplanet.com/index.php?title=Brazil:_Conversation

48. Library of Congress. (2005). Country Studies. Brazil: Health status and health care, infectious and chronic diseases. Retrieved May 11, 2007 from http://lcweb2.loc.gov/frd/cs/brtoc.html

49. Diniz LS, Gerhardt G, Miranda JA, Manceau JN. (1995). Efetividade do tratamento da tuberculose em oito municípios de capitais brasileiras. *Boletim de Pneumologia Sanitária, 3*(1), 6-18.

50. I Consenso Brasileiro de Tuberculose (1997). *Jornal de Pneumologia, 23*, 279-346.

51. Mendes FR & Carlini EA. (2007). Brazilian plants as possible adaptogens: An ethnopharmacological survey of books edited in Brazil. *Journal of Ethnopharmacology, 109*, 493–500.

52. Caprara A. (1998). Cultural interpretations of contagion. *Tropical Medicine & International Health, 3*(12), 996-1001.

53. de Andrade Monteiro D & Bernstein Iriat JA. (2007). Homeopathy in the unified national health system in Brazil: Users' representations of homeopathic treatment. *Cadernos de Saúde Pública, 23*(8), 1903-1912.

54. Patriani Justo CM & Dé Andrea Gomes MH. (2008). Conceptions of health, illness and treatment of patients who use homeopathy in Santos, Brazil. *Homeopathy, 97*(1), 22-27 [abstract only].

55. Sabath AM. (2000). *International business etiquette, Latin America: What you need to know to conduct business abroad with charm and savvy.* Franklin Lakes: The Career Press.

56. Rodrigues LC, Pereira SM, Cunha SS, Genser B, Ichihara MY, de Brito SC, et al. (2005). Effect of BCG revaccination on incidence of tuberculosis in school-aged children in Brazil: The BCG-REVAC cluster-randomised trial. *Lancet, 366*, 1290-1295.

57. Brazil Ministry of Health. (2006). Basic Data Indicators (Indicadores de Dados Básicos – IDB, 2006). Retrieved June 6, 2008 from http://tabnet.datasus.gov.br/cgi/idb2006/matriz.htm

58. Republica Federativo do Brasil. (2007). Brazilian Institute for Geography and Statistics (Instituto Brasilerio de Geografia e Estatística). Retrieved June 6, 2008 from http://www.brasil.gov.br/pais/indicadores/categoria_demograficos/categoria_view/

59. Margaret Rohter. Public Health Educator, TB Control, Cook County Department of Public Health. (Personal Communication April 7, 2008)

60. Valdir de Souza Pinto. Technical Consultant, Tuberculosis Division, Epidemiological Surveillance Center, Sao Paulo, Brazil. (Personal Communication June 6, 2008)

61. Vera Maria Neder Galesi. Coordinator of Sao Paulo State's TB Control Program, Sao Paulo, Brazil. (Personal Communication June 6, 2008)

NOTES

NOTES

Staff–to–Staff Tips and Insights

Do you have experience working with clients who were born in this country?

Share your insights with your colleagues.