Interprofessional education in indigenous health: the experience of the “Huka Katu” project – FORP-USP in Xingu

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ABSTRACT

To achieve the principles of the *Sistema Único de Saúde*, it is necessary to improve health professionals’ education who are integrated into the health network and who recognize the need for different Brazilian realities, such as indigenous peoples’ health care. The objective is to present an experience report for the reorientation of the educational model prioritizing the teaching-service-community integration and the contribution of the Ribeirão Preto School of Dentistry, University of São Paulo, to the implementation of Public Education and Health Policies, exploring its interface with the National Health Care Policy for Indigenous Peoples and the National Oral Health Policy. The education actions proposed in the “Huka Katu” Project involve the reorientation of the training and assistance model to the community. The preparatory and operational stages are developed in the open elective courses - Oral Health Care in Indigenous Populations I and II. During COVID-19 pandemic, Course I was carried out in a virtual environment using active teaching-learning methodologies and an approach to intercultural care. Course II is developed in the context of primary care in the villages of the Xingu Indigenous Park, with emphasis on comprehensive health care and learning through the experience of working in indigenous health, together with multidisciplinary teams. The Project has contributed to the training of health professionals for collaborative teamwork, with graduates directly involved in health care or management in the indigenous health subsystem.

Descriptors: Health of Indigenous Populations. Interprofessional Education. Oral Health. Cultural Competence.

1 INTRODUCTION

The health of a population, a clear expression of its concrete conditions of existence, is the result, among other aspects, of how the relationship between the State and society is established. The Constitution of 1988[1], or the Citizen Constitution, recognizes health as everyone's right. The state provides quality of life to the citizens through public policies of social protection, such as health and education.

The process of building these policies is dynamic and subject to the forces of change. Based on historical facts, it is evident that the Brazilian health system has been built through the political, ideological and technological clash between the various social actors, against the background of macroeconomic demands and hegemonic value systems in each period of time[2].

It is indisputable that promotion and assistance to indigenous health is the target of attacks and setbacks of hard-won rights, and to obtain the effectiveness and equity that the *Sistema Único de Saúde* (SUS) indicates, it is urgent to incorporate a strong humanitarian orientation in the training of health professionals[2]. In this sense, it is urgent to broaden the sanitary reform to indigenous territories, including the training of oral health professionals involved.

In a better understanding of the interrelationship between health and territory, and the role of the State in the prevention of health inequities, including violence and alcoholism, it is necessary to emphasize the ‘territoriality’ of these peoples, which involves both the dispute for their lands, as well as the impediment to freely manifest their cultural assumptions[3].

The Constitution of 1988[1] recognizes Indians right, regardless of their degree of contact with nationals, to develop themselves as ethnically differentiated groups, imposing to the Union the obligation to complete the demarcation procedures of the identified lands and maintain their integrity. It is important to highlight that at the end of the last century the discussion was about the end of a protectionist model of Guardianship that became extremely inappropriate and unfair, since it did not fulfill its legal role of protecting the interests and rights of the Indians and it ignored their will and self-management ability and only provided assistance to them.

However, the State has a social duty with everyone, including the indigenous peoples[1,2]. The recognition and respect for the sociocultural organizations of indigenous peoples assured them full civil capacity, no longer of guardianship, but also legislating and dealing with their health issues in line with the fundamental principles and guidelines of decentralization, universality, equity, community participation and social control.

In addition to ensuring access to health for indigenous peoples, the National Policy for Health Care of Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas*- PNASPI)[4-13] includes: “social, cultural, geographical, historical and political diversity in order to overcome the factors that make this population more vulnerable to health problems of greater magnitude and transcendence among Brazilians, recognizing the effectiveness of their medicine and the right of these peoples to their culture.”

Only after several and complex conformations these population groups were able to access the Brazilian health system, composed of multiprofessional health teams, a defined territory, a specific budget structure of the resources of this sector and several policies that aim to contribute to the fight of these populations against prejudice, exploitation, and territorial disputes.

The Special Secretariat of Indigenous Health, responsible for the current coordination of the PNASPI, was implemented late, after numerous setbacks, based on a model of sanitary responsibility and management. Aligned with the guidelines of SUS, but also with the needs of indigenous peoples, its special characteristics aim at a decentralized model, and the articulation between states, municipalities and non-governmental organizations in indigenous health care actions to strengthen the social control of the 34 Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas*-DSEI) of Brazil.

Even in view of the advances obtained from PNASPI[4], the challenge is for strengthening Primary Health Care (PHC) as an entity that organizes care, especially regarding the construction of bonds between the staff and the population, which shows gaps in the training of professionals for indigenous health work[5].

Thus, to accomplish the Health Reform and consolidate the special care subsystem according to the multiethnic cultural specificities, present in PNASPI[4], these peoples need differentiated approaches in health, as well as investments in the education of health professionals to understand the sociocultural context and intercultural care and value traditional knowledge in the health-disease-care process.

In addition to these rights, the National Oral Health Policy[6] provides the access of more vulnerable populations to oral health by encouraging care with the State's financial support, to reorient the education and care model. With this guideline, the School of Dentistry of the University of São Paulo (*Faculdade de Odontologia da Universidade de São Paulo* - FORP-USP) has been developing the activities of the "Huka Katu" Project and expanding its commitment and social role[7].

In view of the above, this article aims to present an experience report to reorient the educational model prioritizing teaching-service-community integration and the contribution of FORP-USP *Preto* to the implementation of Public Policies on Education and Health, exploring its interface with PNASPI and the National Oral Health Policy.

2 EXPERIENCE REPORT

The Context

In 1957, the ethnologist Darcy Ribeiro published a calculation of the indigenous population of that time, which he elaborated based on the documentation available in the Indian Protection Service. At the time it was not always easy to ascertain whether a given ethnonym corresponded to a society or a subunit of another larger unit, so, he preferred to give them the neutral expression "tribal group"[8]. Also, due to the lack of information about most tribal groups, a minimum and a maximum population were estimated for each of them. The sum of all minimums was 68,1 thousand individuals, and the maximum was 99,7 thousand. The actual indigenous population of Brazil should be between these two numbers. He also warned of a decrease in the indigenous population, which in 1900 was distributed in 230 tribal groups and in 1957 was reduced to 143[8].

Currently the numbers are very different from those released by Darcy Ribeiro sixty-four years ago. Both the population and the number of indigenous groups have grown. And these are some of the reasons that led to this new picture: some unknown groups at the time of the survey and groups thought to be extinct contacted the Brazilian society; new highways; airlines, expansion of telephony; the worldwide network of computers enabled the provision of healthcare to the indigenous peoples more frequently which allowed them to access goods and services more quickly[9].

Another important factor contributing to the increase in both the population and the number of ethnic groups is the recent claim of indigenous identity by groups that had left and were persecuted by those who desired or occupied their lands.

The 2010 census showed that about 817,000 indigenous people live in the national territory[10]. Of this total, more than 500,000 lived in rural areas, far from large cities, while the rest lived in the cities. This number is subdivided into more than 300 ethnic groups with more than 200 different languages. Among the largest ethnic groups, we can mention Tikúna, Guarani-Kaiowá and Kaingang.

Despite these differences in terms of quantity, the number of indigenous peoples in Brazil has increased considerably in recent years. In 1991, the total was 214,000 inhabitants, which means an increase of 205% comparing that year and today. Even though, they represent only 0.5% of the Brazilian population[11].

In this context, the Xingu Indigenous Park (*Parque Indígena do Xingu* - PIX), located virtually in the center of Brazil, gathers 16 peoples and is a symbol of Brazilian sociodiversity. With its territory and population threatened by the colonizing front of the country, the park was created in 1961 because of a mobilization of Brazilian personalities, with the Villas Bôas brothers ahead and Darcy Ribeiro in the delimitation of the space reserved for indigenous peoples.

Currently, indigenous peoples are also present in the urban context, frequenting the cities around the PIX. Most of the 16 peoples who live there recovered the population level they had before the contact, overcoming epidemics aftermath and the ghost of extinction. Thus, involved in the globalized world that surrounds them, the Xingu Indians have apprehended new instruments for strengthening their ethnic and cultural identity.

The estimate of ethnicities and demographic composition in the PIX shows a total population of 5529 indigenous, distributed as follows: Aweti (195), Ikpeng (495), Kalapalo (385), Kamaiura (467), Kawaiwete - Kaiabi (1193), Kisedje - Suiá (330), Kuikuro (522), Matipu (149), Mehinako (254), Nafukua (126), Naruvotu (69), Tapayuna (60), Trumai (97), Waurá (409), Yawalapiti (156), Yudia-Juruna (348)[11].

Reorientation of the Educational Model at FORP-USP

The launch of the National Policy of Permanent Education in Health (*Política Nacional de Educação Permanente em Saúde* - PNEPS)[12], in 2004, elaborated by the Secretariat of Labor Management and Health Education, guided the training of health professionals in the daily life of health services, with education processes based on the problematization of the work process, reflection and meaningful learning.

In this sense, since 2004, the FORP-USP Pedagogical Project[7] and the activities to be developed with undergraduate students have aimed to qualify training for health promotion, prevention, and rehabilitation, with professionals who respond to the needs of the Brazilian population. Also, with regard to Undergraduate Education, FORP-USP has been involved with public policies aimed at the training of health professionals in the country, particularly by participating in the *Pró-Saúde* and *PET-Saúde* Programs of the Ministries of Education and Health, to stimulate the approximation of educational institutions to health services of SUS, training professionals capable of facing the social reality of Brazilian society and public health services, as well as the qualification of those who already work in the services.

Thus, since the first edition of the *Pró-Saúde* notice, the Unit has promoted the insertion of students in the basic health network earlier, with increasing complexity, through courses in the field of Collective Health together with the various courses of the Health Area of the Ribeirão Preto Campus; it has diversified the practice scenarios, covering Family Health units, Social Equipment, secondary and emergency outpatient units and pre-hospital emergency, as well as the indigenous context[7].

The Special Indigenous Sanitary District of Xingu (*Distrito Sanitário Especial Indígena do Xingu*-DSEI-Xingu), in partnership with the Federal University of São Paulo (UNIFESP), drives the devices and interventions that respond to the needs present in these scenarios and contribute to the reorientation of the care model. So, the educational model of FORP-USP is based on the construction of knowledge and acquisition of skills, competences and attitudes that accompany the social diversity of indigenous territories and on the development of a new model of oral health care.

In line with the above-mentioned, the project “Huka Katu” (Nice smile in Tupi-Guarani) has been developing academic activities and assistance by inserting students in a scenario of practices (PIX villages) to contemplate comprehensive care according to the National Policy of Primary Care (*Política Nacional da Atenção Básica*-PNAB)13 and the National Oral Health Policy[6]. In agreement with the proposal of education for intercultural context, present in the premises of PNASPI[4], it seeks to stimulate collaborative work in an interprofessional team to serve the population of this DSEI.

The activities are carried out both in the villages and in health centers, recognized as Base-poles (Leonardo, Pavuru, Diauarun and Wawi), that are spaces equivalent to the Basic Health Units in the Family Health Strategy (*Estratégia de Saúde da Família*-ESF) which count with higher technological density and the performance of a Multiprofessional Indigenous Health Team (*Equipe Multiprofissional de Saúde Indígena*-EMSI), composed mainly of Doctor, Nurse, Nursing Assistant, Dentist, Indigenous Health Agents (IHA), interconnected to a city of reference.

Oral health actions are developed in the villages and are based on comprehensive care with actions of health promotion, in the prevention of injuries, and health recovery, while clinical practice is based on the strategy of controlling oral diseases, with the resource of Atraumatic Restorative Treatment (ART), restorative surgical treatment and prosthetic rehabilitation.

Training for Collaborative Practice

By multiprofessional work we understand different health professionals who work together, side by side[14]. But working in the same environment and being together in an activity or action does not mean that we will achieve integral care to the population. For many professionals, including dentists, integrating work in PHC can mean the rupture of professional isolation and the path to the production of new relationships with the team, becoming a more active professional in the field of health and who can go beyond a multidisciplinary work, to a perspective of interprofessionality, in which, in this case, the indigenous population is the center of care, a central point for exchanges and collaborative work.

In interprofessional meetings, each health professional brings their possibilities and limits regarding the users’ healthcare and the learning happens in the exchange of one with the other, with the difference, and in indigenous health,

with interculturality. For working in SUS, including the Indigenous Health Subsystem, there is the need for people-centered health care and therefore, for an educational model of health professionals that can be integrated and carried out in teams.

To this end, Interprofessional Health Education (IHE) is being stimulated in Brazil by international[15] and regional organizations[16] aiming at the quality of health care and “it occurs when two or more professions learn from each other, with and over others, to improve collaboration and quality of care”[17].

Thus, IHE is incorporated in health education policies in Brazil as a device for reorienting the training of health professionals in SUS, with the objective of integration and learning among professionals from different areas and exchange of knowledge for collaborative and person-centered care, to qualify the services provided to the population[12]. At the same time, it allows students to experience tools such as expanded clinic and multiprofessional teamwork, and integrated and interdependent rearrangements considered interprofessional[18]. This may favor overcoming the weaknesses faced regarding interculturality in the indigenous health team, together with the IHA and traditional health professionals of these peoples.

In this perspective of integrated training, collaborative practices stand out, that is, moments in which several health professionals from different professional backgrounds work together with communities focused on the quality of care[15], improving responses to these needs[14].

Therefore, to strengthen differentiated care to indigenous peoples, achieving the principles of SUS, it is necessary to invest in an initial educational model that induces teaching-service integration in DSEI, with experiences in the indigenous health subsystem, together with EMSI, as in the “Huka Katu” Project.

The historical dissociation between the training of health professionals, including the dentist, and the needs of the Brazilian reality, caused health inequalities including the field of indigenous oral health with its social determinants related to ethnic specificities and vulnerabilities. The project is developed with this problematizing perspective and the premise that education is an instrument of social transformation, developed not only through formal education, but also through all experience that fosters reflection, reformulation of habits and acceptance of new values.

The competencies and skills built on the “Huka Katu” Project consider intercultural experience as experience knowledge[19], something that passes through students, which happens to them, and affects them significantly and causes transformation, since the experience lived in indigenous health care is the core of training. And the experience can guide the practice of these future professionals, especially regarding the attributes necessary for collaborative teamwork, since the indigenous culture favors aspects such as dialogue, community-centered care, and conflict negotiation.

It is important that the educational process contemplates praxis and begins to be considered as a social, cultural and individual process. To cause behavioral changes in this direction, it is necessary to create or change perceptions, use motivating forces and make decisions to act. This process brings the possibility of acquiring knowledge (technical and technological knowledge that can operate actions), skills (which lead to knowing how to do), values (beliefs) and attitudes (positive or negative evaluations, feelings, and techniques) through socialization.

This education for human development,

full and integral, proposed by the Huka-Katu project, is based on the Four Pillars of Education[20], the first of which is Learning to Know, with emphasis on the instruments that enable students to understand the world around them for the development of their professional capacities, arousing intellectual curiosity, critical sense and understanding of the real, acquiring autonomy and discernment through deductive and inductive chaining.

The reflection on the cultural issues that permeate indigenous health, with a worldview that often differs from students' training, requires this path of understanding the world[21], in a Freirian conception of education[2]. This possibility puts on the agenda the acceptance and respect for the difference so that the encounter with the other, or with the difference, can be “disturbing”[23] and also allows the self-confrontation when entering an ethno-space that challenges their own limits.

However, according to the pillars of education[20], it is not enough to be in contact and in communication with different groups, it is necessary to progressively discover the other, living the diversity, encountering points of convergence and interdependency, and therefore, building common goals in this process: learning to live (together).

Thus, training in and for indigenous oral health in the “Huka Katu” Project contemplates the needs of the context in question and expands to the diversity present in our country. This movement towards otherness, in an anthropological and social view, offers possibilities of individual existence through the contact with the other: learning to be; self-discovery in a continuous process in and for health education[20].

Upon having the knowledge, the student is situated in the movement of doing, so that this pillar of learning is the professional training itself to be a dentist for the reality that surrounds them, in this case the indigenous reality. Regarding learning to do[20], that is, putting into practice the knowledge in training and for the future, the focus is on qualification skills, and much more, on those related to social behavior, aptitude for teamwork, the capacity for initiative and the desire for exposure.

Training Products

Since 2004, the project has been developing teaching-learning activities that seek to re-signify the health-disease-care processes from an intercultural perspective, developing interdisciplinary and transdisciplinary activities that stimulate interprofessional collaborative work in indigenous communities of PIX.

The main direct quantitative results, for the education, qualification and updating of students and professionals, are the products of the Training Process in the Project “Huka Katu” of FORP-USP from 2004 to 2012: 163 undergraduate students, 10 graduate students, 21 graduates directly involved with the indigenous health subsystem, 58 indigenous attending the course, 10 teachers and 3 technicians in dental prosthesis.

Initially, a didactic-pedagogical material was developed through a digital platform (Cybertutor) in the format of two online courses. In the period of the COVID-19 pandemic, the project was developed within the scope of the open elective Oral Health Care in Indigenous Populations courses I and II of FORP-USP, in which Course I was the preparatory phase, with 42 students in 2021.

The methodologies used are active teaching-learning in a virtual environment, allocated on the Moodle platform of USP (e-courses). It is divided into two theoretical modules with an approach in sociology, anthropology, collective health, public policies

and health surveillance, which include the National Primary Care Policy[13], National Oral Health Policy[6] and National Health Care Policy of Indigenous Peoples[4].

The content of Course I has 7 topics: History of Brazilian Health; Public Health Policies; Institutionalization of Indigenous Health; Structure and Organization of Indigenous Oral Health Care; Oral Health in Primary Care as a Model for Indigenous Health; Professionals and Indigenous Oral Health; General Guidelines of the "Huka-Katu" Project. In the preparatory phase, the students' learning process is evaluated by means of periodic productions (critical-reflexive narratives, poems, etc.) uploaded on the e-courses platform of USP.

Course II constitutes the operational phase, in which the students are immersed in the territory of PIX with the team of professionals in the area (IHA, doctors and nurses of the DSEI-Xingu) and FORP-USP undergraduate and graduate students and professors. The actions developed seek to promote, prevent and recover health in the 140 villages and a population of approximately 7,000 Indians in the upper, middle and lower Xingu regions. In the operational phase, the field diary is used as a tool for evaluating students, who write critical-reflexive reports about the experience lived and share them with the other members in open conversation. The project is evaluated by means of a report that includes the planning, management, technical and care activities of each entry, with analysis of oral health indicators in historical series.

The "making", within the sanitary specificities of indigenous territories, is unique even regarding the health workers involved. Currently emphasized by the Pan American Health Organization[16], the learning and collaborative practices supported by the experiences of different professionals for a better quality of care justify the important role of the IHA that make up the EMSI, since these professionals become the link between traditional and biomedical knowledge and have the support of leaders and representatives of the Local and District Councils of Indigenous Health[24].

Training the Indians to be IHA is present in PNASPI[4] as a strategy that favors the empowerment of these peoples regarding the appropriation of knowledge from Western medicine, to add them to their traditional cultural practices. This training process is directed to the construction of competences and skills that facilitate the continuation of professionalization at the middle (technical) and higher (technological) levels[4].

In 2007, the students and graduates of the "Huka Katu" Project participated in the organization and on-site development of the Oral Health Module of an IHA training course, with a workload of 140 hours, being 50 hours of dispersion and 90 hours of concentration, held at the Wawi Base Pole, in which 58 IHA from 27 DSEI-Xingu villages were trained. The Oral Health and Nutritional Surveillance Module[25] aimed to train the IHA to act in health surveillance in their communities, identifying health problems, specifically those related to oral health, nutritional surveillance and food safety. Developed in a continuous mode, articulated by UNIFESP, FORP-USP and DSEI-Xingu, oral health training took place in modules that will be described below.

As an integral part of the "Huka-Katu" project and a fundamental strategy for the acquisition of new competences and skills by students and for the construction of a new model of oral health care in the territory of the DSEI-Xingu, its principles were meaningful learning, reflexivity and problematization as recommended in the PNEPS[12], considering the reality of the indigenous territory, and the

conception of sanitary practice based on the Health Surveillance model.

Inserted in the Curricular Area I – “Knowing the indigenous family/Promoting the exchange of experiences”, the Module of Oral Health and Nutritional Surveillance was divided into thematic axes: Axis 1 - Perceiving our reality, about traditions and intercultural care; Axis 2 - Understanding the health-disease process, with conceptual aspects; Axis 3 - Promoting health and intervening in the health-disease process, focusing on health promotion actions; Axis 4 - Knowing and organizing health services with an approach to longitudinal follow-up[25].

This experience aimed at experimenting the principles of problematizing education, the guidelines of PNASPI[4], and the training of human resources to act in an intercultural context strengthening the role of IHA. The students lived the integration with indigenous and non-indigenous professionals in open conversations based on dialogue, reflection, respect for traditional practices and situational strategic planning, considering the singularities of each village and base poles, which favored aspects such as the development of autonomy and empowerment of the population and learning about health promotion from the perspective of health surveillance[25].

Furthermore, the experience in indigenous communities, a scenario of practice different from which is developed in outpatient spaces, allows the understanding of the various Brazilian social realities. The training of professionals integrated to the expanded network of SUS services contributed to the reorientation of the educational model, favoring the development of skills and competences for health work, enabling the action of about 21 (twenty-one) graduates in the indigenous health subsystem[26].

Specifically, graduates worked on the health care of the Guarani M'byá peoples in the municipality of São Paulo, northern regions (Aldeia Jaraguá - Technical Supervision of Pirituba/Perus) and south (Aldeia Tenondé Porã and Aldeia Krukutu - Technical Supervision of Parelheiros), in partnership with the Municipal Health Secretariat of São Paulo and Social Health Organizations, and with the Indians in villages in the State of Rio Grande do Sul, in the South Coast DSEI. Other professionals, such as dentists were hired to work in PIX and oral health coordination at DSEI Xingu.

In this sense, the project directly contributed to the interiorization of work in indigenous health, with the performance of graduates in health care or management in eight of the 34 DSEI in the country, and indirectly, in the Midwest and north regions of the country, according to the program of Interiorization of Health Work (Programa de Interiorização do Trabalho em Saúde -PITS)[27], which aims to provide health care in locations that did not have oral health professionals and have scarce resources for the development of primary care.

FINAL CONSIDERATIONS

Based on health care that goes far beyond the performance of diagnostic and therapeutic procedures, the “Huka Katu” project was able to propose and implement a model of oral health care in DSEI-Xingu and thus stimulate permanent education, change the oral health conditions of those communities, build relationships and consolidate bonds between Indians and students, indigenous leaders and teachers. Regardless of distances, the Project was able to improve the use of communication technologies and social media resources where knowledge exchanges and respect for interculturality are nurtured.

The “Huka Katu” Project is aligned with public policies and the principles of Permanent

Health Education (PHE), so that education and health are integrated with the daily life of communities, and learning takes place experiencing the work in indigenous health, valuing it as a relational work, since it is based on the relationship with the other, and built in an intercultural context. Finally, this project showed that education is collective, and should include both indigenous and teams in an interprofessional work, considering the living work in action.

And what can we do to avoid separating work and health education, understanding that there is no education for work, but only education at work? This is what we wonder when we started thinking about the proposal of the “Huka Katu” project in the models of PHE in the movement[28]. Oh, and we still do.

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RESUMO

A formação interprofissional na saúde indígena: a experiência do projeto “Huka Katu” – a FORP-USP no Xingu

Para o alcance dos princípios do Sistema Único de Saúde é necessária a formação de profissionais de saúde integrados à rede de saúde e que reconheçam a necessidade das diferentes realidades brasileiras, como a atenção aos povos indígenas. O objetivo é apresentar um relato de experiência para a reorientação do modelo formador priorizando a integração ensino-serviço-comunidade e a contribuição da Faculdade de Odontologia de Ribeirão Preto da Universidade de São Paulo para a efetivação das Políticas Públicas de Educação e Saúde, explorando sua interface com a Política Nacional de Atenção à Saúde dos Povos Indígenas e a Política Nacional de Saúde Bucal. As ações formativas propostas no Projeto “Huka Katu” envolvem a reorientação do modelo formador e assistencial junto à comunidade. As etapas preparatória e operacional são desenvolvidas nas disciplinas optativas livres - Atenção à Saúde Bucal em Populações Indígenas I e II. No período da pandemia da COVID-19, a disciplina I tem se desenvolvido em ambiente virtual com uso de metodologias ativas de ensino-aprendizagem e abordagem do cuidado intercultural. A disciplina II é desenvolvida no contexto da atenção primária nas aldeias do Parque Indígena do Xingu, com ênfase na integralidade da atenção em saúde e aprendizagem pela vivência do trabalho em saúde indígena, junto a equipes multiprofissionais. O Projeto tem contribuído na formação de profissionais de saúde para o trabalho em equipe colaborativo, com egressos envolvidos diretamente na assistência ou na gestão de saúde no subsistema de saúde indígena.
Descritores: Saúde de Populações Indígenas. Educação Interprofissional. Saúde Bucal. Competência Cultural.

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