Ciência & Saúde Coletiva
cienciaesaudecoletiva.com.br
ISSN 1413-8123. v.29, n.12
DOI: 10.1590/1413-812320242912.10262024EN

Meeting of Knowledges: Critical Interculturality and Collective Health

THEMATIC ARTICLE

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Abstract *The National Policy for the Care of Indigenous Peoples (NPCIP) faces an enormous challenge in operationalization regarding the training and qualification of health professionals to work in an intercultural context. In this article, we open a dialogue with the proposal of a Meeting of Knowledges (MK) as a teaching and learning strategy capable of promoting a critical intercultural education. We seek to reflect on the possible impact of MK in the health field for transforming the university environment, as well as healthcare for Indigenous communities, towards an entrenched, democratic, pluriepistemic, and transdisciplinary perspective.*
Key words *Health Indigenous Service, Interculturality, Traditional Medicine, Education*

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Introduction

The National Policy for Healthcare for Indigenous Peoples (NCPIP)[1] establishes healthcare for Indigenous communities based on differentiated care. One of the enormous challenges that this care encounters is the training of healthcare professionals. Although the training of human resources for the intercultural context is a guideline of the NCPIP, attempts to include the theme of interculturality in the curricula of undergraduate and graduate healthcare courses are still timid at best.

The NCPIP and the structuring of the Indigenous Healthcare Subsystem (*Subsistema de Atenção à Saúde Indígena* - SasiSUS) are the result of a long process of struggle by the health and Indigenous movement for the construction of differentiated, continuous, intercultural, and democratic healthcare. The NCPIP and the SasiSUS represent advances in relation to the integrationist and paternalistic healthcare model implemented by the Indian Protection Service (*Serviço de Proteção aos* Índios - SPI) and FUNAI in its Mobile Health Teams (*Equipes Volantes de Saúde* - EVS). The participation of the Indigenous movement in the 8th National Health Conference (CNS) (1986) led to the creation of the first 1st National Conference for the Protection of Indigenous Health (CNPSI), which reaffirmed the defense of a universal health system and a specific health policy for the Indigenous population[2,3]. This process led to the approval of the Arouca Law (Law No. 9,836/1999), responsible for founding SasiSUS and, later, establishing NCPIP in 2002.

Although the NCPIP and the creation of SasiSUS represent major advances towards intercultural Indigenous health care, there are still major challenges to be overcome. A critical reading of the limits of the current policy, as well as its operationalization, allows us to propose ways to advance towards an intercultural, territorialized, and decolonized perspective of the health system.

Using Walsh's concept of critical interculturality[4], we seek to reflect on the impasses faced by the training and qualification of health professionals for work in an intercultural context. Considering the NCPIP, we also assess the need for new arrangements for the insertion of critical interculturality in undergraduate and graduate health courses. In this sense, our study seeks to analyze the Meeting of Knowledges (MK) as a theoretical-practical response to the promotion of a multi-epistemic, decolonized, anti-racist, and rooted university space. This text seeks, based on dialogue with the MK, to present new perspectives for teaching interculturality in health courses, understanding that the acceptance of the MK proposal represents a great innovation, both pedagogical and theoretical, for our field of knowledge.

Indigenous Health and Critical Interculturality

The NCPIP establishes health care for Indigenous communities based on differentiated care, taking into account the cultural, epidemiological, and operational specificities of these peoples. Among the enormous challenges that exist for providing care to Indigenous populations is the qualification of healthcare professionals, most of whom have no training to work from an intercultural perspective[5,6]. The operational scenario of the NCPIP "[does not favor] the production of healthcare actions in line with the cultural logic and effective demands of Indigenous communities"[7] (p.2). As a consequence, the term "differentiated care" ends up not being realized in practice and becomes empty.

This study begins with the definition of critical interculturality proposed by Walsh[4] to reflect the challenges for teaching and learning intercultural skills. From this perspective, the exchange of knowledge and experience starts from the search for a space in between, in conditions of intercultural respect, legitimacy, symmetry, equity, and equality. Furthermore, it "points to and requires the transformation of structures, institutions and social relations and the construction of distinct conditions of being, thinking, knowing, learning, feeling, and living"[4] (p.78). Critical interculturality is opposed to the idea of functional interculturality, coined by Fidel Tubino[8], in which the recognition of diversity serves only as a step towards the integration of the other, following the logic of neoliberal multiculturalism. Here, difference is neutralized, devoid of meaning.

The absence of interculturality in training can be seen as a consequence of the very commitment made by NCPIP. The policy emphasizes the role of Indigenous Health Agents (AIS) as the main agent responsible for conducting and creating intercultural dialogue. According to NCPIP, the training of these agents "is a strategy that aims to favor the appropriation, by Indigenous peoples, of knowledge and technical resources of Western medicine"[1] (p.15). One can see that interculturality begins to serve as a desire for

greater acceptance of medical care by Indigenous communities[7].

NCPIP's perspective of interculturality could be understood as a functional interculturality, whose objective is not a true exchange of knowledge, but an attempt at a hierarchical translation of biomedicine into culturally acceptable terms. The subversion of the term interculturality culminates in several practical consequences that reproduce the subordination of the knowledge of traditional peoples to biomedical knowledge:

All these difficulties point to the need to rework the systems and meanings culturally constructed in educational and health policies, as these were often imposed based on hegemonic references, excluding the cultural references of belonging of the various social groups. In this sense, it makes the Indigenous people "included" in a hegemonic perspective, but maintains the exclusion of their cultural references and belonging and their participation as protagonists of public policies[9] (p.211).

The emphasis on AIS as those intended to carry out intercultural dialogue between the biomedical system and traditional medicine has resulted in the remaining members of the Multidisciplinary Indigenous Health Care Teams (*Equipes Multidisciplinares de Atenção à Saúde Indígena* - EMSI) being unprepared to work in intercultural contexts. This situation has reinforced the struggle of Indigenous movements to train their own professionals[10,11]. In this context, ethnic-racial quotas have allowed progress in this impasse. The expectation was that, over time, EMSI could be comprised entirely of Indigenous people[5]. This struggle by the Indigenous movement seeks to consolidate professionals committed to the Indigenous cause[12] and more attentive to the cultural and epistemological aspects involved in health care for these communities.

Monoepistemic universities, ethnic-racial quotas, and the challenge of intercultural education

The ethnic-racial quota policy opened space for the training of young Indigenous people in higher education courses. This ethnic-racial diversification in the group of students in health courses enabled a movement towards a training capable of providing professionals for Indigenous communities. However, allowing Indigenous students to enter did not mean, in most cases, any form of openness to their knowledge.

Universities began to train Indigenous professionals, but in an entirely biomedical logic, as one of the still hegemonic legacies of Western epistemic colonialism. The health education model continued to be fundamentally Eurocentric, disciplinary, and monoepistemic. Master Makota Kidoiale, a member of the Manzo Ngunzo Kaiango *quilombo* (MG) and invited to the MK at UFMG, reflects on the impasse of quota students when entering this monoepistemic space and its consequences in a shocking text about the suicide of a student at UFMG in 2018 and the mental illness of quota students[13]:

I don't know if this young man was black, but I worry about our (except the fake) blacks in there, when they enter this place that instead of forming people, forms machines, to challenge nature itself, and destroy all the tradition of ours that before I thought it was a source of pride to be in this place, today I am afraid, knowing that when our children enter this academy, only their bodies enter, their entire identity is left out, and that in traditional peoples, we have to be at the doors of this place to ensure that when our children leave, they can rediscover their Self[13] (p.141).

The lack of preparation of the university space to receive other epistemologies creates an arid environment for quota students. In this space – dominated by a colonized and scientific-instrumental vision – philosophical and cultural differences manifest themselves with the silencing and indifference to the different ways of living and thinking about the world.

Indigenous, black, and *quilombola* quota students reported, in higher education courses, the lack of content and disciplines that address the traditional knowledge of their peoples. In the particular case of health, they point out how a monoepistemic education is insufficient for the training of professionals to care for Indigenous populations[5,10]. We can understand that opening the university space to students belonging to these communities represents a first step, since little by little the agendas of quota students begin to transform universities.

While the challenges for intercultural care are significant even within the context of Indigenous health teams, they increase when it is necessary to divert Indigenous people to other levels of care within SUS. Reports of institutional racism and mistreatment by professionals in hospitals and other services are recurrent[14-16]. These contexts show that mastery of intercultural relational skills is not required exclusively by professionals in the Indigenous Health Care Subsystem, which is probably a common challenge for all of SUS.

It is important to note that, among the various people and populations that will be served by SUS, it is not only Indigenous populations that

require intercultural care. Brazil is inhabited by several traditional groups. These issues must be expanded to include the various *quilombola*, riverside, gypsy, *terreiro*, and other communities. The dilemma of interculturality must be understood as part of the health system as a whole.

The Meeting of Knowledge (MK): epistemic quotas

The MK is a pedagogical innovation project initiated in 2010 by the National Institute of Science and Technology for Inclusion in Higher Education and Research (*Instituto Nacional de Ciência e Tecnologia de Inclusão* - INCTI), coordinated by José Jorge de Carvalho, with the aim of advancing the construction of a democratic and decolonized university space. This project formalized a methodology for the incorporation of masters of traditional knowledge from Indigenous, *quilombola*, agroextractivist, and other traditional knowledge traditions as university professors. Each teacher is welcomed by a partner professor who welcomes him/her as a host in the university space.

MK can be understood as a second phase of the process of democratization of higher education, which was initiated by ethnic-racial quotas. If quotas have brought about ethnic-racial inclusion in the student body, the encounter of knowledge becomes an "epistemic quota", as defined by Carvalho[17], promoting the inclusion of traditional knowledge from Indigenous peoples, black people, and other traditional groups that have historically been silenced in the university space. The history of Brazilian universities, fundamentally, is marked by theoretical, institutional, and organizational subordination to European universities, as well as their elitist and racist character.

In a survey conducted over the ten (10) years of the MK[18] project, we have observed an expansion of the initiative in several universities in various regions of the country and in two (02) international academic institutions. In total, the MK has reached sixteen (16) universities and has seen the participation of 161 Master's students of traditional knowledge in the different areas of academic knowledge. The majority of the professors partnering with the MK are from the field of Human Sciences (62.2%), while the health field ranks fifth, with only 4.7% of the total. The presence of MK in higher education courses in the health field is scarce, a fact that draws attention, since a major part of the Master´s students invited to the project work in the healing-care interface.

Intercultural Experiences and the UFSB model of health education

Even though the participation of masters of traditional knowledge from health centers in Espírito Santo is still low, there has been a growing number of participants in recent years. In 2010, in its first edition at UnB, Espírito Santo had the participation of Professor Lucely Pio, who taught the Medicinal Plants course and was welcomed by her partner professor Silvéria Santos, from the School of Nursing. In 2014, the Federal University of Minas Gerais (UFMG) offered the first edition of the MK. Due to the success of the proposal, in 2016, the Cross-Cutting Training in Traditional Knowledge was founded as an extension project linked to the Cross-Cutting Training, recently created at UFMG. In 2015, the discipline, "Traditional Knowledge: Cures and Care" was offered, which had the participation of teachers from the School of Nursing[19].

In addition to UFMG, in 2014, the State University of Ceará offered the subject entitled "Traditional Healing Knowledge" in the Academic Master's Degree in Public Policy[20], which had the participation of five Masters. At UFRJ, in 2018, a subject entitled "Traditional Occupations: Meeting of Knowledge" was started at the School of Medicine[21]. In 2019, UFVJM held the first subject of the MK Project in the "Master's Degree in Health, Society, and Environment" program, entitled "Healing Arts"[22]. It can be seen that the MK project, initially promoted by INCTI, has been incorporated by several educational institutions. In this process, the proposal has been adapted with local rearrangements, gaining life and its own particularities.

Another context in which the MK found fertile ground was at the Federal University of Southern Bahia (UFSB), which until recently adopted "...what we can call the UFSB model of health education"[23] (p.547). The UFSB presented, as a founding and structuring document, the proposal for a University Guidance Plan, in which it proposed the possibility of overcoming the limitations of models based on disciplinarity, with the development of curricular structures in a cyclical system.

Although we do not see in the Guidance Plan the inclusion of Indigenous Master's as instructors at UFSB, according to Tugny[24] (p.444): "its text proposes the actions of: 'creating spaces

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that facilitate the penetration of the ecology of knowledge', with the practice of a 'reverse extension', the 'valuation' and 'creation of broader epistemic communities' and the 'promotion of dialogues' with 'knowledge that circulates in society and also composes it'". With this perspective of seeking dialogue with traditional knowledge, since the first four months of the UFSB's opening in September 2014, the MK Module has been offered in a Curricular Component, entitled the "Field of Education: Knowledge and Practices". In this first experience of the MK at UFSB, a total of fourteen (14) Indigenous Masters participated as instructors.

In 2015, UFSB held its first Social Forum, inviting twelve (12) segments of organized society to come and outline priorities for the construction of its institutional pedagogical policy. In the Forum report, we found demands from black and Indigenous communities, calling for the inclusion of traditional knowledge on a continuous basis, equating it to scientific/academic knowledge[24]. The commitment to the knowledge of black Indigenous communities in the southern Bahia region enabled several instances of joint collaboration with the Master's student instructors of traditional knowledge.

In the case of health, in 2016, students of the Interdisciplinary Bachelor's Degree in Health (BIS) developed, within the activities of the Curricular Component (CC): Integrated Practices of Health Promotion and Surveillance and Coexistence Space, a partnership with teachers from the Pataxó Indigenous School of Coroa Vermelha and Pataxó Indigenous Masters This partnership gave rise to the Pataxó Medicinal Network: Education and Comprehensive Indigenous Health, a project that developed pedagogical workshops with Pataxó Masters for eighth-grade elementary school students. It was a health intervention action, within the BIS training process, which was constructed as an intersectoral and intercultural action that aimed to promote traditional health knowledge to young Pataxó people.

In the context of this project, Master Japira Pataxó, who had participated in the first edition of the MK at UFSB, invited two students to assist her in writing a book about their medicinal, poetic, mythological, and ecological knowledge. This partnership culminated in the publication of the book Knowledges of the Pataxó Wilderness (*Saberes dos Matos Pataxó*)[25], and was also of fundamental importance for Master Japira's nomination for the title of Doctor of Education for Notorious Knowledge at UFMG in 2022. Recently, Master Japira was selected to work as a visiting professor at the School of Philosophy and Human Sciences at UFBA.

The UFSB model of health education encountered strong institutional resistance and was formally terminated in 2021, in an administrative measure by the university's management. Transforming education and health therefore means dealing with political disputes, with contradictory and conflicting movements and processes, of advances and setbacks, with the possibility of crises in the direction of this transformation.

Teaching-learning in health and Meeting of Knowledges (MK)

The implementation of interculturality within teaching and learning in health is part of the contemporary challenges for transforming the curricular bases of health courses. Thus, it is understood that there is a need to implement models to train individuals capable of implementing public health policies, operating problem-solving care practices, using technologies appropriately and producing knowledge relevant to the health of the population, with equity, justice, and quality[26]. To this end, in the context of the health of Indigenous peoples, it is also necessary to develop communicational and relational skills, as well as linguistic-cultural skills, for work in an intercultural context. Thus, following Almeida Filho's[23] reflections on the challenges for health training, it is necessary to overcome the fragmentation produced by the reductionist disciplinary approach, since many projects commit to inter-transdisciplinarity models in the academic field but are unable to translate this epistemological option into the practical field.

The MK is a theoretical and practical proposal for intercultural training in higher education from a critical perspective. By inviting masters of traditional knowledge to teach classes at the university, the experience of the encounter is promoted as a way of teaching skills that are essential for working in intercultural contexts. In this movement, the training of health professionals occurs through a process in which Indigenous knowledge finds a space of legitimacy, equality, and symmetry, distancing itself from a perspective that objectifies it. From this approach, it promotes attention to Indigenous health from a critical intercultural perspective that distances itself from a tutelary, paternalistic, or functionalist intercultural approach. Furthermore, due to the nature of the knowledge of the masters of tradi-

tional knowledge, it presents itself as a necessarily transdisciplinary proposal, integrating health with history, art, politics, philosophy, and other fields of knowledge.

The great advance that Higher Education presents in terms of interculturality lies in its role reversal. The qualification of health professionals ceases to be a training *about* the other and becomes a training *with* him. Here, the exercise of interculturality in health is not a mere set of anthropological, sociological, historical, and epidemiological theories, often unrelated to complex realities, but rather a commitment to a true practice of encounter. It is in dialogue with masters of traditional knowledge, who are in the place of the subject of supposed knowledge, that students begin to relate to other perspectives of health, care, and attention. Interculturality is not a set of theories, but rather a theoretical-practical skill in itself.

Many of the universities that expanded to regions in the countryside of Brazil have never engaged in dialogue with their territory, reproducing the same curricula, unrelated to the local context. One of the key roles of Higher Education is to root our higher education institutions. The possibility of inviting masters of traditional knowledge from the territories where they are located can present a great opportunity for the university space to be affected by local knowledge and to be rooted in its territory.

Intercultural education in the encounter with masters of traditional knowledge takes place in the context of teaching other traditions of care. In our higher education institutions, the teaching of traditional medical rationalities is insufficient, so much so that most graduates are unaware of their logic and procedures. The approach to these healing traditions takes place in a contextualized manner, not as mere objects of study or translations that end up essentializing them, treating them only as "culture" or "customs". Following Costa and Carvalho[27]:

The care they [the teachers] demonstrate is in the contextualization of the culture in which that knowledge was produced. They do not suggest revering the knowledge presented there, nor reducing it to an object. What they propose is an understanding of culture in an embodied, living, and contextualized sense through experience[27] (p.46).

Meeting the Masters also allows students to learn about their biographies, which is essential to valuing their knowledge and practices. Knowing their biographies means understanding the Masters' formative processes, as well as the history of their communities. The lack of knowledge about the trajectories of the Masters of healing and care is demonstrated in Barreto's account of the events that preceded the construction of Bahserikowi – the Center for Indigenous Medicine of the Amazon. Faced with a disjuncture between care practices, one of the doctors delegitimized the Tukano wise men, stating: "I studied for eight years to have the authority to decide what is best for a patient, while you (with great respect), have not even attended a single medical school"[16] (p.600). The dialogue could certainly have been different if the professional had at least been aware of the complex and long history of the shamans' training.

The pedagogy of masters of traditional knowledge and Public Health

The Indigenous Masters are responsible for bringing academic students a new perspective on being an apprentice, in which the urgency to understand everything, to think about everything, and to occupy without existing, is replaced by a pedagogy that identifies silence, time, the development of curiosity, and the construction of (and in) the apprentice's path as a true learning process. Perhaps it is this dynamic of circularity[27], a concept coined by Master Antônio Bispo dos Santos, that will allow us to establish an intercultural interaction that truly understands knowledge as a complex space. To do so, we can come a little closer to the "wisdom", conceptualized by Master Seu Miguel, Guarani Mbyá chief of the Paratimirim Village (Parati, RJ), and summarized by Carvalho as:

The strategy used by the Masters is to strengthen their own identity and culture, and to bring them into encounter and dialogue with others, encouraging "wisdom" to learn from others, but not to let oneself die or be subjugated. Or, as Master Seu Miguel, a Mbya chief, says, not to let oneself be "eaten"[27] (p.53).

Returning to the concept of interculturality as the search for a space in between, the conception of knowledge as obtainable must be modified. It is necessary to see the world with eyes that allow us to accept the multiplicity of knowledge, to exercise the capacity to recognize the unknown as potential. In this sense, to carry out a "movement [that] does not distance or reject what is outside; on the contrary, it seeks similarities, identifies complementarities, welcomes, and skillfully adds differences"[27] (p.52).

Still contemplating the dialogue between knowledges, Arriscado Nunes[28] draws attention to the fact that the process of recognizing traditional knowledge does not imply the rejection

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of modern/Western medicine. As Carvalho and Florez[29] also reflect, two characteristics of knowledge in this encounter must be recognized: its axiological and ideological incommensurability (impossibility of measuring and learning the totalities of the logics that govern this knowledge) and its irreducibility (traditional and modern knowledges will not always be able to find a disciplinary equivalence). This avoids the misunderstanding that what is proposed is a "replacement of modern knowledge with ancestral knowledge or a mere translation of ancestral knowledge into terms of modern Western knowledge"[29] (p.142).

In addition to serving as training for intercultural work, the MK is also responsible for bringing students other perspectives concerning care and attention. Following Almeida Filho's reflections[23] (p.547) on the challenges of teaching health: "How to train subjects who are truly competent to care for the health of other subjects? In other words, how to train subjects through teaching-learning processes that are directly engaged in the concrete practice of producing acts in health in the real world?".

Part of the challenge pointed out by Almeida Filho may be related to the "structuring tension" of health training. Because biomedicine is the reference basis for this field of knowledge, health students are exposed throughout their training to a conflict between "knowledge" and "feeling"[30]. The demands of the biomedical model to classify, describe, and understand protocols clash with the experience and feelings of those who provide care. The biomedical model of care prioritizes knowledge over feelings. The silencing of feelings in the learning process ends up causing suffering in students. Within this tension, being able to form subjects who are competent with health and not just with illness, who care for subjects, do not objectify bodies and are able to overcome the dichotomy between knowing and feeling, becomes a real challenge for teaching and learning in health.

Although in the field of health the dichotomy between knowing/feeling, established by the biomedical knowledge model, is particularly relevant because it directly addresses a crisis of care, this structuring tension described by Bonet[30] seems to be a constituent of all Western science. In this sense, Costa and Carvalho reflect on the teaching in our universities that "excessively privileges the ability of rational thinking, to the point that thinking becomes, more often than not, hypertrophied, while feeling becomes atrophied"[27] (p.41).

For a teaching-learning process that overcomes this dichotomy, a direct relationship between teacher and student is necessary; one can only teach feeling by being close to the other. The Masters of MK are excellent Masters of thinking, feeling, and doing. Based on a teaching in which affection regains centrality, the teachers transmit to the students a way of constructing knowledge through love. In this way, Costa and Carvalho propose thinking about the pedagogy of the Masters as a verb "to think-feel-do"[27]. From this perspective, MK can also serve to bring other forms of knowledge transmission into the university space, anchored in affection and love, capable of overcoming the duality of knowing/feeling.

It is also worth considering the impacts that the critical intercultural perspective can have on health technologies in Indigenous care. The incorporation of Indigenous Masters into the academic context of critical reflection, care processes and health services can contribute to the development of new technologies for the care of these communities. In this sense, in the MK space, we have begun to include the perspectives of Indigenous thinkers in the academic and theoretical field.

An interesting example brought by Master Mapulu[31], Kamayurá shaman, is what she refers to as the "Takumã model of healing". Takumã, remembered as the greatest shaman in the history of Xingu, was Mapulu's father and transmitted his spiritual line to her. In a description of the father's teachings to the teacher, the practice of the Takumã Model of healing is observed:

[...] when an Indigenous person comes to Mapulu with a health complaint, she first tries to identify whether it is a spiritual problem, and if so, she may recommend a cure only through shamanism. If she identifies a physical illness that seems curable through Indigenous medicine, Mapulu will recommend treatment with herbs and transfer the patient to her husband Raul, a healer respected throughout the Upper Xingu, who will identify the plants and prepare the specific medicine to cure that person. However, if she identifies the presence of an illness outside the knowledge of the shaman or healer, she will refer the patient to the Leonardo do Alto Xingu Health Center or to the hospital in the nearest city, to see a doctor[31] (p.9).

In the Takumã model of healing, we find a technology for assisting Indigenous communities: a stratification of levels of care, adapted to the Kamayurá context, in addition to a model of integration between traditional and Western medicines. In this proposal, Takumã was able to

anchor the Indigenous Health Care Subsystem in a local health care network, also achieving the articulation between Indigenous and biomedical knowledge. This example shows us that the participation of masters of traditional knowledge is important for the development of new health technologies and for advancing local and national challenges in the care of Indigenous communities.

The inclusion of Indigenous teachers in higher education health courses also has an impact on the field of Public Health. This movement contributes to taking a further step in critical and Latin American thinking in Public Health, deepening it in an emancipatory, rooted, and decolonized perspective. Let us remember that, in Latin America, we find one of the largest areas of biodiversity in the world, as well as one of the greatest cultural diversities, both accompanied by a diversity of healing traditions belonging to the different peoples of Latin America.

Unlike other countries in the Global South that are also home to great biodiversity and cultural diversity and healing-care systems, such as China and India, in Latin America we find almost no dialogue between biomedical and traditional care systems. Opening up the participation of experts in discussions on Public Health can provide an environment conducive to the emergence of new theories on health, care, and intercultural care systems. We understand this movement as a broad transformation of health theories, including related perspectives that have always been absent within this field.

Conclusions

Understanding the challenges faced by NCPIP in training professionals to work in intercultural contexts, we seek to present the MK as an innovative teaching-learning proposal capable of promoting critical intercultural training in undergraduate and graduate health courses. The demand for the transformation of higher education courses in the health field with the inclusion of traditional knowledge is increasingly strong, whether by students who enter higher education through ethnic-racial quotas, or by social movements in these communities. We recognize that the MK proposal is expanding rapidly and should be increasingly embraced by the health field. We believe that MK presents a theoretical-practical proposal for the construction of a democratic, pluriepistemic, differentiated, rooted, and decolonized Indigenous health.

In addition, we seek to show how the inclusion of Masters of traditional knowledge provides a great opportunity for the field of Public Health, which is now nourished by new vitality. Public Health, a Latin American field of knowledge, is beginning to incorporate other epistemologies and is becoming a space for interepistemic dialogue. Promoting joint reflections on the notions of care, attention, health, illness, and affection can bring new perspectives to the field of research and extension in this area.

We understand that MK can play a major role in training professionals for communication and relational competence in intercultural contexts, skills that are essential for implementing Indigenous Health policies. Furthermore, MK can have other effects on health training courses, since the presence of masters of traditional knowledge is responsible for transforming modes of knowledge transmission, temporalities, and spaces for knowledge construction; that is, it has the capacity to transform the health training environment, bringing new perspectives that rescue the sensitive aspect of care.

Collaborations

VAM Miranda was responsible for the conception, curation, organization, final draft, and critical review in its various stages. ABQ Belizário was responsible for the conception, final draft, and critical review in its various stages. MF Pereira was responsible for the conception, final draft, and critical review in its various stages.

References

1. Brasil. Ministério da Saúde (MS). Fundação Nacional de Saúde. *Política Nacional de Atenção à Saúde dos Povos Indígenas*. 2ª ed. Brasília: MS; 2002.
2. Garnelo L. O SUS e a Saúde Indígena: matrizes políticas e institucionais do Subsistema de Saúde Indígena. In: Teixeira CC, Garnelo L. organizadores. *Saúde Indígena em perspectiva: explorando suas matrizes históricas e ideológicas*. Rio de Janeiro: Editora FIOCRUZ; 2014. p. 107-142.
3. Santos P, Menicucci TMG. Mapeando o surgimento da Política Nacional de Atenção à Saúde dos Povos Indígenas no Brasil. *Resistances J Philosophy History* 2021; 2(3):e21042.
4. Walsh C. Interculturalidad crítica y educación intercultural. In Viaña J, Tapia L, Walsh C. *Construyendo Interculturalidad Crítica*. Bolívia: Instituto Internacional de Integración del Convenio Andrés Bello; 2010. p. 75-96.
5. Ferreira LO, Pereira MF. Interculturalidad y Formación Superior en Salud Indígena: aportes para un proyecto político-pedagógico emancipatorio. *Rev ISEES* 2013; 13:109-128.
6. Diehl EE, Pellegrini MA. Saúde e povos indígenas no Brasil: o desafio da formação e educação permanente de trabalhadores para atuação em contextos interculturais. *Cad Saude Publica* 2014; 30(4):867-874.
7. Pedrana L, Trad LAB, Pereira MLG, Torrenté MON, Mota SEC. Análise crítica da interculturalidade na Política Nacional de Atenção às Populações Indígenas no Brasil. *Rev Panam Salud Publica* 2018; 42:e178.
8. Tubino F. *La interculturalidad crítica como proyecto ético-político. Encuentro continental de educadores agustinos* [Internet]. Lima; 2005 jan 24-28 [citado 2024 abr]. Disponible en: https://www.oalagustinos.org/edudoc/LAINTERCULTURALIDADCR%C3%8DTICACOMOPROYECTO%C3%89TICO.pdf.
9. Alves AO, Pontes ALM, Souza ICF. Interculturalidade e formação profissional de agentes indígenas de saúde na região do alto rio Purus, Brasil. *Abatira* 2020; 1(2):205-232.
10. Hoefel MGL, Severo DO, Hamann EM, Santos SMD, Selau MGG. O Projeto Vidas Paralelas Indígena e a construção da interculturalidade na formação em saúde: um estudo de caso. *Tempus* 2012; 6(1):23-35.
11. Nascimento VF, Hattori TY, Terças-Trettel ACP. Desafios na formação de enfermeiros indígenas em Mato Grosso, Brasil. *Cien Saude Colet* 2019; 25(1):47-56.
12. Brasil. Ministério da Saúde (MS). Conselho Nacional de Saúde (CNS). *5ª Conferência Nacional de Saúde Indígena: Relatório Final* [Internet]. Brasília; 2-6 dez 2013. 2015 [citado 2024 abr]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/5_conferencia_nacional_saude_indigena_relatorio_final.pdf.
13. Carvalho JJ, Kidoiale M, Carvalho EN, Costa SL. Sofrimento psíquico na universidade, psicossociologia e Encontro de saberes. *Soc Estado* 2020; 35(1):135-162.
14. Pellon LHC, Vargas LA. Cultura, interculturalidade e processo saúde-doença: (des)caminhos na atenção à saúde dos Guarani Mbyá de Aracruz, Espírito Santo. *Physis* 2010; 20(4):1377-1397.
15. Pereira DR, Coelho EMB. O Descompasso entre os Saberes Canelas e as Práticas Biomédicas. *Rev Politicas Publicas* 2013; 16(1):223-231.

16. Barreto JPL. Bahserikowi - Centro de Medicina Indígena da Amazônia: concepções e práticas de saúde. *Amazonica Rev Antropol* 2018; 9(2):594-612.
17. Carvalho JJ. Cotas étnico-raciais e cotas epistêmicas: bases para uma antropologia antirracista e descolonizadora. *Mana* 2022; 28(3):e2830402.
18. Carvalho JJ, Vianna LCR. Vista do O Encontro de Saberes nas Universidades, uma síntese dos dez primeiros anos. *Rev Mundau* 2020; 9(1):23-49.
19. Guimarães C, Oliveira L, Brasil AG, Tugny RP, Takahashi R, Tugny A, Moura MA, Oliveira F, Altivo BR, Furiati T. Por uma universidade pluriepistêmica. A inclusão de disciplinas ministradas por mestres dos saberes tradicionais e populares na UFMG. *Tessituras Rev Antropol Arqueol* 2016; 4(2):179-201.
20. Andrade JT. Encontro de saberes: experiencia intercultural na pós-graduação da Universidade Federal do Ceará. *Conhecer* 2021; 11(27):193-205.
21. Costa SL, Gabriel E, Camargo DR, Aragão KJL, Benites S. Vista do Encontro de Saberes na Universidade Federal do Rio de Janeiro: uma Experiência com Mestres e Mestras Guarani Mbya. *Rev Mundau* 2024; 9:190-208.
22. Figueiredo AFA, Nobre JCL, Allain LR, Paes SR. Vista do O Encontro de Saberes como expansão epistêmica: percursos na Universidade Federal dos Vales do Jequitinhonha e Mucuri. *Rev Mundau* 2024; 9(1):50-67.
23. Almeida-Filho N. Ensaio de referência teórica e política para o modelo UFSB de formação em saúde. In: Tugny RP, Gonçalves G, organizadores. *Universidade Popular e Encontro de Saberes*. Brasília, Salvador: INCT de Inclusão, EDUFBA; 2020. p. 545-558.
24. Tugny RP. Conhecimentos tradicionais e território na formação universitária. In: Tugny RP, Gonçalves G, organizadores. *Universidade Popular e Encontro de Saberes*. Brasília, Salvador: INCT de Inclusão, EDUFBA; 2020. p. 439-462.
25. Pataxó J. *Saberes dos Matos Pataxó*. Belo Horizonte: Editora Teia dos Povos, Editora Piseagrama; 2022.
26. Souza LEPF. Saúde, desenvolvimento e inovação: Uma contribuição da teoria crítica da tecnologia para o debate. Cad Saude Publica 2016; 32(2):e00029615.
27. Costa SL, Carvalho JJ. Processos de transmissão: o ensino universitário e o encontro com mestras e mestres dos saberes tradicionais. In: Monteiro ACL, editor. *Processos Psicológicos. Perspectivas situadas*. Niterói: Eduff; 2020. p. 26-55.
28. Nunes JA. *Epistemologias do Sul e descolonização da saúde*. Ciudad Autónoma de Buenos Aires: CLACSO; 2023.
29. Carvalho JJ, Flórez J. Encuentro de Saberes: Proyecto para decolonizar el conocimiento universitario eurocéntrico. Nomadas 2014; 41:131-147.
30. Bonet O. *Saber e Sentir: uma etnografia da aprendizagem da biomedicina*. Rio de Janeiro: Editora Fiocruz; 2004.
31. Carvalho JJ. A Escolhida dos Espíritos: Mapulu Kamayurá, Pajé e Visionária do Alto Xingu. *Ayé Rev Antropol* 2023; 5(1):110-148.

Article submitted 15/09/2023
Approved 29/02/2024
Final version submitted 19/06/2024

Chief editors: Maria Cecília de Souza Minayo, Romeu Gomes, Antônio Augusto Moura da Silva

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