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Articles

Experiences of Brazilian doctors in their first months of Primary Health Care in the Yanomami Indigenous Land

Experiências de médicos brasileiros em seus primeiros meses na Atenção Primária à Saúde na Terra Indígena Yanomami (resumo: p. 18)

Experiencias de médicos brasileños en sus primeros meses en la Atención Primaria de la Salud en la Tierra Indígena Yanomami (resumen: p. 18)

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The More Doctors Program expanded access to medical care in the Brazilian indigenous contexts, as in the Yanomami Land (TY). This qualitative research sought to understand the experience of the Brazilian doctors in the TY in their first months of work since November 2018. The research conducted a thematic analysis of the contents from semi-structured interviews, having as its common thread the principles of Primary Health Care (PHC) and as theoretical frameworks, experiential knowledge and indigenous health policies. Three categories related to indigenous health care emerged: work process; encounter between cultures; medical training. The experience proved to be complex and heterogeneous, demonstrating satisfaction and learning. The study concludes that indigenous health care demands a singular and differentiated outlook at the principles of PHC, and that competencies for medical practice in this context must be built.

Keywords: Health of indigenous populations. Primary Health Care. Physicians. More Doctors Program.

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Introduction

The 1978 Alma-Ata Conference championed the key role of Primary Health Care (PHC) in guaranteeing rights and reducing inequalities, declaring the responsibility of all governments to formulate policies and strategies to launch and sustain primary health care in coordination with other sectors[1]. However, Brazil's public health has historically experienced a shortage of doctors in PHC, leading to the creation of the More Doctors Program (PMM) in 2013[2] as a response to medical supply.

In the "Legal Amazon", a legally defined region, often cared for by campaign and emergency models[3], the PMM has enabled a significant increase in the number of doctors and consequent improvement in access to medical care in the Special Indigenous Health Districts (DSEI)[4]. These physicians were to receive periodic visits from academic supervisors from local supervisory institutions, but the difficulty of accessing part of the territories, such as several indigenous areas, resulted in the absence of supervision in the first year of the PMM[5]. Therefore, in 2015, the Ministry of Education created the Special Group of Supervision (GES) for the pedagogical monitoring of these doctors[6]. In Roraima, the authors of this article were part of the GES as supervisors and/or tutors, with a focus on ongoing education related to the work process and skills for action in indigenous health in the DSEI East and DSEI Yanomami and Ye'kuana (DSEIY)[5]. One of the authors was also a physician linked to PMM at DSEIY.

Starfield[7] classically described the principles of PHC in four essential attributes (first contact access, completeness, longitudinality and coordination), plus three derivatives (family, community, and cultural competence). In Brazil, public policies on PHC have been gradually developed from the Alma-Ata Conference up to the current Family Health Strategy, deploying several devices.

In the case of public policies for indigenous peoples, progress was also slow and gradual, culminating with the creation of the Indigenous Health Care Subsystem (SASI-SUS) in 1999, through the Arouca Law (nº 9.836/99)[8]. Through these initiatives, the DSEI was proposed to provide PHC care, with multidisciplinary indigenous health teams (EMSI) linked to the base poles and with the support of professionals from the Indigenous Health Support Center. The states and municipalities must guarantee the levels of secondary and tertiary care.

In indigenous contexts, PHC has guidelines described in the National Health Policy for Indigenous Peoples (PNSPI)[9], focused on interculturality and the concept of differentiated attention, through the adaptation of technologies and professionals to local specificities[10]. It also contemplates diversity and the overcoming of factors that make this population more vulnerable to health hazards, recognizing the efficacy of their medicine and the right to their culture[4], although in practice it still presents several challenges and contradictory aspects to be understood and overcome[11].

However, the DSEIY had already been created in 1991, coinciding with the demarcation of the Yanomami Indigenous Territory (TY) and the overwhelming epidemic of malaria in the region, largely as a result of the massive entry of miners into the territory in the late 1980s[12]. By 2017, the population served by the DSEIY was over 25,000 people in the TY, Yanomami and Ye'kuana ethnic groups, in some 320

communities in the states of Roraima and Amazonas (Figure 1). In that year, there were 67 EMSI responsible for PHC in the villages, encompassing 460 professionals hired by a non-profit organization and 14 doctors linked to PMM[e].

[e] Data provided by the DSEIY Epidemiology team

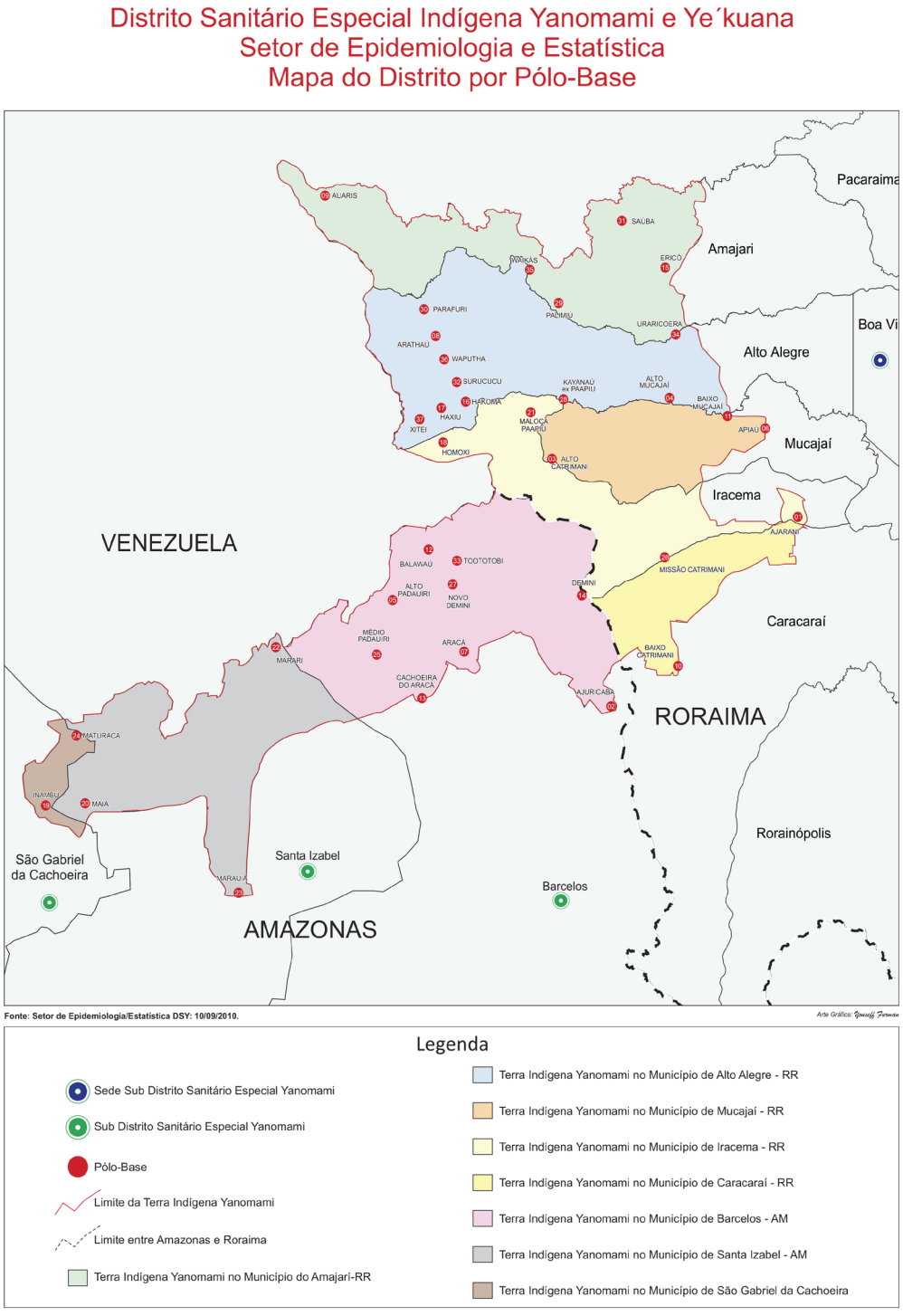

Figure 1. DSEI Yanomami and Ye'kuana map.

Source: Operational Epidemiological Report from November 2009 to March 2010 - Yanomami and Ye'kuana Special Indigenous Health District. Boa Vista, Roraima; 2010

Until November 2018, all the PMM doctors who worked at DSEIY were Cuban. With the end of the international cooperation Brazil-Pan American Health Organization - Cuba, all vacancies were occupied by Brazilians, bringing to the debate new relationships and challenges. This research aimed to understand the experiences of Brazilian doctors in their first months of work in PHC within the DSEIY, analyzing challenges and potential in this context.

Methods

An exploratory research was carried out, with a qualitative approach, seeking to work with an understanding of reality focused on meanings and subjectivities, in the sense of the discovery of its social codes from the speech, in a field marked by specificity and differentiation[13]. Such choice aimed to exercise the attentive look and the deconstruction of the idea of neutrality, since all researchers involved in the process had some function in the indigenous health related to the DSEIY.

In order to build the data, individual interviews were conducted with 18 of the 20 doctors linked to the PMM who worked in the DSEIY in 2019. We opted for the use of semi-structured interviews to allow the interviewees to discuss the subject, without being restricted to the inquiry formulated[13]. The questions were about the experience of acting in indigenous health, using the concept of experience as "what crosses us by, what happens to us, what touches us"[14] (p. 21). It is not what happens, but what generates transformation in the subject who lives it, according to Larrosa Bondía[14].

The subjects were 7 women and 11 men; they were between 25 and 53 years of age; 9 declared themselves white, 7 brown, and 2 black; 9 graduated in medicine in Brazil and 9 abroad, with completion of the course between 2014 and 2018; and worked at DSEIY for 2 to 9 months.

The materials from the interviews were submitted to exhaustive reading, with the construction of conceptual maps[15] to visualize the contents brought by the subjects, with the emergence of pre-categories of analysis.

A thematic analysis of content was carried out using Gomes's perspective as its basis[16]. The documents were ordered, the materials decomposed identifying those nuclei of meaning crosscutting the scenarios of indigenous health care experienced by doctors. It was concluded with the elaboration of an interpretative synthesis, allowing the dialogue of the axes identified with the experiences of the doctors, the objectives and the initial questions of the research. All through this process, procedures were fundamental to give value, understand, interpret the empirical data and articulate them with the theory, to allow the emergence of more consistent reflections on the reality in question[13].

The thematic categories were constructed and discussed using the Principles of PHC[9] as a guide and, complementarily, theoretical references on the knowledge of the experience[14] and indigenous health policies.

The Research Ethics Committee of the Federal University of São Carlos under CAAE 17995819.9.0000.5504 approved this research. In this text, all the original names were replaced to ensure the confidentiality of the information.

Results and discussion

Three thematic categories related to health care emerged from the analysis: Work process; Meeting between different cultures; Educational process for and in indigenous health.

Category 1 - Work process

This first category brings the experiences of doctors in the midst of the work process in the care of indigenous people. The nuclei of meaning developed were: relations between PHC and Emergency and Urgency (EU); logistics and infrastructure issues; and interpersonal relations.

In the process of physicians' work, conflicts arose regarding the identity of the care practices developed, raising questions about the role of PHC:

> All drugs and materials they send to the area are for prevention, for primary care. But there are always some serious cases, such as an offidical accident. A trauma they suffer because they fell from the tree or cut themselves with the arrow. And then you end up having to have a material to be able to give assistance. (Carlos)

According to the SASI-SUS guidelines, the DSEI develop actions within the scope of PHC, and should be dedicated to essential health care, especially in the most frequent problems presented by people, especially in its initial phases, and in the prevention and promotion of health[7,9]. For Carlos, there is some confusion about the role of the teams in indigenous health, since emergency actions are separated from PHC, which would require care at other levels of attention. However, in indigenous communities, the demands often include EU care, something that creates confusions as professionals transpose urban models of health care to that scenario:

> Where I work is not a basic health unit, but it is a immediate care place. I do things that in no other post in any city are done. There they have how to direct, there are things that we don't have, from a simple communication with any other colleague or internet. (Jorge)

According to the principles of APS and the PNSPI, EMSI should ensure first contact access, i.e., to be identified as the first resource to be sought, also called the gateway to the health system[7], which includes the EU for EMSI. However, relations with other levels of attention have been weak in Yanomami TI, and it is difficult to guarantee referral to another level of attention due to difficulties in radio communication, distance from reference centers, and transportation. For this reason, the limitations encountered for the realization of care in this territory generated insecurity and fear:

> The indigenous area is very distant and, because of this, I think that it is poorly assisted. There are a few things missing, because we don't only do basic care. We provide emergency and emergency care. (Gustavo)

This complexity of situations brought the need to reorganize the health environment as highlighted by Vânia, bringing an example of hospitalization in the PHC environment:

> The strategy to overcome this follow-up difficulty is the hospitalization of the patients there in the sector and follow them closely to take medication at the right time. It was an adaptation. (Vânia)

Some doctors argued that the materials provided should be compatible with the EU admissions and services they performed, which was often not the case:

> I delivered a baby and didn't have a pair of tweezers, no scissors [...] and no first aid materials, like an AMBU bag. Sometimes there was even a lack of oxygen. (Daniela)

Daniela and other interviewees also mentioned difficulties for universal assistance due to limitations in the availability of medications and inputs:

> They have very few medications. You think about a medication and you don't have it [...], we don't have anything in hand. You don't have an antibiotic. (Daniela)

Some conditions were decisive in the supply chain, highlighting the restriction of items in the List of Basic Care Medications for Indigenous Health; the logistics of distribution and insufficient supply; and an abusive and unrestricted use of some medications, especially antibiotics and anti-inflammatories:

> It is very important to talk about the issue of dispensing antibiotics in a totally irrational way in an indigenous area. It is one thing in an amoebiasis epidemic to let go a little on the use of secnidazole, metronidazole, because it really has some theoretical substrate in what you are thinking. Another thing is an open bar of ceftriaxone, amoxicillin, without indication, for an already vulnerable population. This is a crime to me! (Sandro)

This use, besides depleting the stock, could generate risks to the indigenous people, such as induction of bacterial resistance and undesirable adverse effects, as questioned by Barbara:

> I feel that sometimes, with this excess of medication, we do more harm than good, you know? I don't think it always does our presence good. (Bárbara)

Sometimes the professionals justified this irrational use by the difficulty of continuity of care, which they related to the diffuse location of communities, the high turnover of professionals and the scales of teams, alternating periods of work and time off. This fact, combined with the focus on emergency actions, hinders the improvement of indicators in indigenous health[17]. Thus, considering the longitudinality as an attribute of PHC, which implies the existence of a regular source of attention and its use over time, regardless of the presence of specific health-related problems, establishing a bond and trust[7], it is perceived that it needs other contours in indigenous health, as Gustavo brought out:

> We stay many days in the area, even so, it is complicated because we doctors do not stay in one sole region. Maybe it will take me six months to return to that region. (Gustavo)

In this dynamic, the professionals lived in the area for several days, which made the interpersonal relations intense. Some interviewees contested the excessive autonomy of the nurses in making decisions in an indigenous area, justified by the fact that, historically, they were used to working in teams without a doctor. This expectation of being team leader is called by Starfield the "delegated model", when the legal responsibility is clearly the doctor[7]. In indigenous health, this model is not necessarily the most common, nor the most effective. Other professionals tend to have more experience than doctors in the cared for territories, less rotation between the base poles, greater workload, and generally more experience in indigenous areas.

Indigenous health professionals should receive adequate training for interdisciplinary work according to local reality[9]. However, non-indigenous professionals are usually non-qualified to work in very heterogeneous inter-ethnic contexts[18], as Sandro pointed out:

> It was frightening to see that the people who work there defend the extinction of the indigenous people and their environment. (Sandro)

Working conditions, food, housing, sanitation and maintenance of boats and airplanes were structural problems related to health care, which were pointed out as capable of causing risks to the workers' health:

> The missions are all done using boats and often without any safety. The lives of our professionals are at risk. This month a plane stopped right in middle of the air. And suddenly it continued. My God!. (Alice)

The isolation generated by scarce access to the Internet and to other doctors for case discussions were described as generators of insecurity. The only external means of communication in most of the base poles was radio, which presented communication and privacy flaws.

One of the precipitators of interpersonal conflicts were the "Medevac removals", characterized by the air transport of patients to a reference service in the city, whenever there are no adequate conditions of care in the base poles. In these cases, a negotiation between health professional, management, community, and patient happened, in a situation where health care and available resources were in shock because the costs of removal were high, as Flávia put it:

> The attempt to avoid removing patients because they did not want to spend much is a concern. The DSEI exerts pressure because it is expensive. They practically say: try to solve these cases in site. And then how to solve them in site? (Flávia)

Interpersonal relationships in the work process were also pointed out as favoring the care processes, such as: interdisciplinary integration, realization of conversation wheels with the community and "love" in the care relationship. According to Mário, the organization of shifts among professionals for the division of tasks related to work and domestic responsibilities was a very positive aspect:

> what improved the relationship was to take turns regarding kitchen, attendance, of those who start and stop the engine. [...] Even about loud music we have to talk about to avoid problems". (Mário)

The good receptivity of the teams and the indigenous people was also highlighted in several reports, which favored the commitment of the doctors who were arriving at these places of work.

Category 2 - Meeting between different cultures

This category presents the care experiences of doctors with a focus on relations with indigenous culture. Three nuclei of meaning were highlighted: approximation with the different; hierarchy in professional-indigenous relations; and respect for diversity.

In the meeting between cultures, the experience of what is different was highlighted, as described by Daniela, demonstrating enchantment:

> They have their culture. It is another way of living. I look at them and talk to them a lot. It's a world apart, I like it! (Daniela)

TY is home to five languages from the Yanomami and Ye'kuana peoples, Karib linguistic trunk, being characteristically scarcely fluent in Portuguese. Therefore, the difficulty with the unknown language was recurrent, demanding that the relationship be frequently mediated by the translation of an Indigenous Health Agent and demanding an effort to observe non-verbal language. Therefore, doctor-patient interaction and proper identification of people's health problems was difficult, making the quest for comprehensiveness challenging. According to

Starfield, comprehensiveness requires that PHC adequately recognize the full range of needs related to the patient's health and provide the resources to address them[7]. In this context, the different languages and languages made comprehensive care more challenging, as reported by Alice:

> It is a little difficult because of the language, it is a barrier. (Alice)

The differences in language and culture also influenced the way people observed time and space, as Leandro pointed out:

> They don't count the years, which makes it very difficult to have a temporal notion. They work with time in a different way, in weeks, on moons. You can't have a time dimension when telling a story of the disease. (Leandro)

In this universe of the different, some local words were being incorporated by doctors, who used them when talking about their experiences, like: *Hoximi* (being bad, ugly), *Totihi* (being good, beautiful) *Tuxaua* (leadership, chieftain) and *Nabè* (non-Yanomami, outsider).

Differences were identified in the way the indigenous people perceived their own bodies and experienced the disease; and the objectivity of biomedicine was not enough in that context, being necessary to relativize the knowledge:

> Here I learned that two plus two does not equal four. There is a patient who doesn't want to take that medication and we think he is going to die. But he survives. There is a mother with a child with diarrhea who doesn't even take the serum home, but the child comes back healthy. They are very tough! (Daniela)

In Flávia's account, this other form of experience of illness and pain also arose when reporting the care of a child:

> I did not have an accurate diagnosis. Since he was very resistant to pain, he moved and made the movements as if he had not fractured. I only found out he had a fracture later. (Flávia)

These differences favored personal reflections from doctors who recognized the health/illness process from other points of view. In this sense, there seemed to overcome the disease-based model, reaching an understanding of the experience of illness, emphasizing that the productions of meaning about illness refer to worldviews that, expressed by the individuals, are conformed by the culture of which they are part[19].

In this change of viewpoint, it was possible to recognize a new understanding about the local and family culture and how that community experienced health practices and the processes of illness, or even the family and community orientation - an attribute derived from PHC. Therefore, for an adequate analysis of people's health needs, knowledge about the social and family context where they occur is required[7].

Recognizing the different ways of seeing health and illness favors an adequate positioning in the face of the tensions produced by the encounter between doctors and patients[19]. Hélio said:

> With a different culture, some things change, some concepts have to be tested a bit to see if they fit with that reality. And they themselves will say what doesn't fit or the team will see in practice that some things just don't fit. (Hélio)

This reflection relativized the hierarchy of knowledge, biomedical power, and Eurocentrism, placing the knowledge of indigenous people in equal importance, reflecting the development of another attribute derived from PHC, cultural competence, which involves the recognition of the special needs of subpopulations that may not be in evidence due to ethnic, racial or other special cultural characteristics[7].

However, the relationship between doctors and indigenous people did not always happen this way. Some questioned the way the indigenous people demanded their rights, interpreting it as excessive, which again brought non-horizontality to the relationship:

> Some want to profit from the white and say: I am an Indian and everything was mine and you have to give it to me. They cross a little the limit [...]. They take advantage of this condition to try to be as white as possible, but without ceasing to be Indigenous.
> Because being an Indian brings many benefits. (Jorge)

The questioning between identity and rights brings with it a static view of culture, as well as the remnants of guardianship, faced by the indigenous until the 1988 Constitution. In other words, in Jorge's understanding, the indigenous peoples would have more rights the closer they are to the primitive, in an evolutionist vision of culture, disregarding its dynamism[20]. The history of contact with the "white" (non-indigenous), the situation of isolation or settlement, the fact of frequenting the city and the use of non-indigenous products and goods interfere with this identity, generating cultural prejudice[21]. According to the doctors' report, some contacts with the health teams also affected this relationship with the indigenous, as they reproduced relations of domination:

> I am learning these two paths: that of the team which is a place of domination, but also of a position that is "superior", so to speak, in quotation marks, because it has the possibility of giving assistance, but also because it has different products and goods that the community does not have. (Hélio)

In this report, it is noted that the products taken from the city to the village would be tools that maintain the relationship of domination and perpetuation of the tutelage perspective within the indigenous people, centralizing the inputs and decision making in the non-indigenous, which made difficult the horizontal relationship between health professionals and the population.

In the attempt to achieve respect for different cultures, empathy seems to be one of the paths to dialogue between cultures, as Bárbara expressed:

> I try to do my best to treat them in the best way and understand the complexity that exists in cultural differences. I try to be available and put myself in their place. Be respectful and introduce myself to the Tuxaua, because I will live in that place. (Bárbara)

Thus, after the initial strangeness, attempts to respect and tolerate diversity can be a first step in the shared construction of care in these territories, being a challenge pointed out in various realities[22]:

> It is complicated for you to know how far to go. Regarding the xabori that they speak, the pajelança (curing rituals). They will take away the spirit that causes the disease. How to act together with them? The shamans arrive and they start to do the ritual. Maybe it's my ignorance, but I don't know what to do in front of that. (Jorge)

Interculturality is a possible path for this non-colonizing construction, with recognition of practices and representations of subjects and groups, including the intentional use of therapeutic itineraries different from biomedicine[23].

Category 3 - Training for and in Indigenous Health

The first experiences of doctors, and the challenges encountered questioned their own training, by putting into practice the knowledge learned. In this Category Three nucleus of meaning emerged: relationships with biomedical formation; outstanding previous experiences; and permanent education in indigenous health.

The graduation in Medicine has a strong biomedical character and, at the same time that this training seems to have generated safety conditions for clinical decision-making in EU situations, it was perceived the need to review precepts that seemed unique to them before.

> [...] what has helped me in medicine is what we have learned from my student times, is pharmacology, of making efforts, of looking at what I can substitute one thing for another. (Daniela)

For her, the biomedical knowledge seemed to contribute to decision-making but, for Gustavo, it would help more "to know better the way of taking more empirical behaviors,

which is something that we end up doing, but without training for it", evidencing that training focused on protocols was not enough for the work in the face of specificities or lack of resources. Besides not being enough, it would need to be reviewed, recreated, as Flavia says: "I had to act several times the way I was told not to do in medical school".

Although the indigenous peoples themselves recognize resolutiveness in biomedicine, they identify boundaries as to its effectiveness in certain contexts[24]. In this context, the study of Social Sciences, especially Anthropology, was reported as important for action in the context of indigenous health.

The National Curricular Guidelines of Medicine courses (DCN) point to critical and reflective humanistic education, increasingly earlier insertion in the most diverse public health scenarios, especially in PHC, and to the importance of considering human and cultural diversity in its several contexts from the dialogue with other disciplines[25].

This process seems to have positively influenced the educational process of interviewees who graduated in Brazil from previous contact with public health in several scenarios, as stated by Bárbara: "I think that the institution helped a lot in understanding public health, it was something that helped me a lot in making this decision".

In this sense, learning in the PHC services can favor the performance of these professionals because they recognize themselves as the coordination of care, described as an adequate and efficient exchange of information so that people can receive the care in health, including in cases of reference and counter-reference[7].

The DCN recognized the need for discussions involving the universe of ethnic-racial differences during graduation[25], but they do not exactly address the indigenous issue. Therefore, they have not yet been able to reflect changes in the courses, generating fragility or often lack of specific training for indigenous health, as Tatiana reported:

> I came from a federal university and there is no basis within the curriculum that help me in this regard. Even though we had a territory with several indigenous lands. (Tatiana)

Experiences in graduate courses, with approaches to the indigenous universe through immersion in local culture, can favor students in the area of health to overcome the romantic imaginary, comprising historical processes of exclusion from public policies, in addition to the development of respect and appreciation of traditional knowledge[26]. However, this training hardly happens, as pointed out by the speakers, even for those trained outside Brazil, including countries with a strong presence of the indigenous population, such as Bolivia. It is also important to consider the great diversity of indigenous peoples and their territories. Alice said that she graduated in Paraguay and, even with little contact with the indigenous people in that place whose majority of the population was Guarani, what was lacking was clinical preparation for the endemic:

> [...] in Paraguay there is no malaria. So I studied this subject very superficially and here it is full of it. (Tatiana)

The previous contact with traditional populations, even if not indigenous[27], as well as out-of-town experiences and lack of resources were favorable to the work of doctors in the indigenous context:

> In my training I felt the lack of emergencies in these rural settings, in these isolated contexts. [...]. I had a rural internship and was able to develop a little these skills of cultural competence, that's when I opened my eye to it. (Hélio)

Others pondered that the experience in rural areas was not enough, since they are different realities, despite some approaches reported by Leandro:

> We had a rural health post, which I consider to be the most similar thing we had with indigenous health. I had to work with few inputs and with greater distances. But it is not the same thing. You can't say it's just rural health, because it's not. (Leandro)

The Fourth National Conference on Indigenous Health recommended the inclusion of the contents on Indigenous Health in the curricula for technical and higher education in health, but this was not carried out in the great majority of the courses, which generates invisibility about the health of this people[28]. Thus, the training of professionals working in indigenous health is really completed only after they enter the service, and it is important to create forms of continuing education that address this scenario, which was also recommended by the Conference[18].

An introductory course on Anthropology, promoted by local management to all professionals, as provided in the PNSPI, brought a contact with the culture of the people of TY, as reported by Daniela: "The only thing I did was the course on Anthropology. It helped me a lot".

However, the training was seen as pinpointed and insufficient, especially given the complexity of the work and the absence of previous contact with these topics during graduation, as Jorge said:

> That course should be much deeper [...]. I think it was twenty hours. And it was not enough, because we didn't expect much there. (Jorge)

> I had never had any discussion about it, nothing from anthropology, from other areas, from the social sciences of health. (Hélio)

In the encounter with the different and the limits of biomedicine, dialogue with other sciences becomes necessary. However, training for indigenous health professionals has been discontinued and guided by the programs of the Ministry of Health, and not by the local reality[18].

The learning experience over time has been brought up by doctors, developing their safety in the daily health practices in the villages, which demonstrates the construction of the knowledge of the experience, in the relationship between knowledge and human life[14]. In this way, daily and specific learning in continuing education should fill the gaps left during graduation. That is, since specificities are very unique, they become unpredictable and the process of action-reflection-action must arise for the problems encountered in practical life[29], building new tools for differentiated attention and according to the principles of PHC.

Final considerations

The experience of Brazilian doctors in the first months of work at DSEIY proved to be complex and heterogeneous, despite the demonstration of satisfaction and learning.

The professionals faced a diversity of challenges related to the work process, highlighting the high turnover of doctors, identity conflicts between PHC and the EU, infrastructure and logistics weaknesses, and strengthening professional performance from interpersonal relations.

The encounter between these professionals and the indigenous people brought enchantment and learning to the performance in the local health context. It also touched on different understandings about the health process and illness. The participation of the indigenous people in health decision-making was presented as important, questioning the power relations between health professional and patient.

They highlighted the absence of content regarding indigenous health in the medical undergraduate program, the importance of personal construction of learning from experience and permanent education processes.

It was concluded that health care in indigenous areas requires an attentive look at the principles of PHC and to this end, it is important to consider the guidelines of differentiated care processes, since it is not just a matter of transposing the work carried out in urban areas, or in the usual rural areas, to the indigenous context. Nor is it a question of simply applying what is taught in medical degrees, since indigenous health is not part of the curriculum. It is a question of building competencies for action in the indigenous context from the practice and to achieve the right to health of these populations.

Authors' contributions

All authors actively participated in all stages of research and manuscript preparation.

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Conflict of interest

The authors have no conflict of interest to declare.

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O Programa Mais Médicos ampliou o acesso à assistência médica nos contextos indígenas brasileiros, como na Terra Yanomami (TY). Até novembro de 2018, na TY havia exclusivamente médicos cubanos, quando foram substituídos por brasileiros. Esta pesquisa qualitativa buscou compreender as experiências desses médicos brasileiros em seus primeiros meses de trabalho. Realizou-se análise temática dos conteúdos provenientes de entrevistas semiestruturadas, tendo como fio condutor os princípios da Atenção Primária à Saúde (APS) e como referenciais teóricos o saber da experiência e as políticas de saúde indígena. Emergiram três categorias relacionadas ao cuidado em saúde indígena: processo de trabalho, encontro entre culturas e formação médica. As experiências mostraram-se complexas e heterogêneas, com demonstração de satisfação e aprendizados. Conclui-se que o cuidado em saúde indígena demanda um olhar singular e diferenciado para os princípios da APS, devendo-se construir competências para atuação médica nesse contexto.

Palavras-chave: Saúde de populações indígenas. Atenção Primária à Saúde. Médicos. Programa Mais Médicos.

El Programa Más Médicos amplió el acceso a la asistencia médica en los contextos indígenas brasileños, como en la Tierra Yanomami (TY). Hasta noviembre de 2018, en la TY había exclusivamente médicos cubanos, cuando fueron substituidos por brasileños. La investigación cualitativa buscó comprender la experiencia de esos médicos brasileños en sus primeros meses de trabajo. Se realizó un análisis temático de los contenidos provenientes de entrevistas semiestructuradas, teniendo como hilo conductor los principios de la Atención Primaria de la Salud (APS) y como referenciales teóricos el saber de la experiencia y las políticas de salud indígena. Surgieron tres categorías relacionadas al cuidado en salud indígena: proceso de trabajo, encuentro entre culturas y formación médica. La experiencia se mostró compleja y heterogénea, con demostración de satisfacción y aprendizaje. Se concluyó que el cuidado en salud indígena demanda una mirada singular y diferenciada para los principios de la APS, siendo necesario construir competencias para la actuación médica en ese contexto.

Palabras clave: Salud de poblaciones indígenas. Atención Primaria de la Salud. Médicos. Programa Más Médicos.