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Dossier

Race, Ethnicity, Gender: experiences in Health Education

Expanded education during health multiprofessional residency: the experience report of a dentist in the Xukuru do Ororubá indigenous people (Pernambuco/Brazil)

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Formación ampliada durante residencia multiprofesional en salud: relato de experiencia de un cirujano dentista con el pueblo Xukuru del Ororubá (Pernambuco/Brasil) (resumen: p. 17)

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This is an experience report, based on the recommendations that call to close the gap between health education and the reality of populations in vulnerable situations, from the perspective of a residence worker, about the internship experience in the Xukuru do Ororubá Indigenous Territory (Pernambuco/Brazil). The observations emerged regarding the living and health conditions of the indigenous people, the internship pedagogical process and its repercussions on professional training and practice, as well as the weaknesses related to the coverage and longitudinality of oral health care. It was possible to improve the socio-political glance at the indigenous issue through interventions from the perspective of subject autonomy. The potentiality of the proposal is evident, stimulating the confrontation between established professional knowledge and the objective reality of the communities, seeking to overcome the colonial model of care, expanding the perspective of professional training for the Brazilian National Health System (SUS).

Keywords: Primary health care. Health of indigenous populations. Oral health. Access to health services. Post-graduate health programs.

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Introduction

The Multiprofessional Integrated Residency in Family Health (RMISF), offered by the Faculty of Medical Sciences of the University of Pernambuco (UPE) in partnership with the Health Secretariat of Recife, trains professionals from different health courses, in an integrated manner at a *lato sensu* postgraduate level. This is implemented through in-service training under supervision, lasting 24 months, with a workload of 60 hours per week, to work in Primary Health Care (PHC) under the Family Health care model[1], in the context of the Brazilian National Health System (SUS).

The RMISF proposes through its pedagogical project the development of a countryside internship (EI) with experiences with populations in situations of vulnerability and social inequality included in the Health Equity policies[2], for example, indigenous peoples, quilombola communities, populations settled by the Agrarian Reform movements, riverine communities, among others, during thirty days, seeking the learning of other ways of doing health, far from large centers, with fewer resources and more focused on popular knowledge.

Some experiences in Brazil have sought to bring health education processes closer to indigenous health care. Among them: the experience with the Potyguara people (in Ceará), in postgraduate research in Collective Health[3]; the RMS program internship experience, in the Pankararu lands (in Pernambuco)[4]; the undergraduate dental internship (Huka-Katu Project) in the Xingu[5]; the undergraduate medical school experience with the Potiguara indigenous community (Iandé Guatá Project, in Paraíba)[6]; and the undergraduate experience in Rio Grande do Sul through the implementation of the Education through Work for Health Program (PET-Health)/Indigenous Health Care Networks[7].

The institution of the Indigenous Health Care Subsystem (SASI-SUS) in 1999, together with the National Policy for Indigenous Peoples' Health Care (PNASPI) in 2002, proposed a specific health care model aimed at improving the indigenous population's access to services, taking into account the socio-political-cultural diversity of the peoples and the need to prepare human resources to work in the intercultural context[8,9]. Oral health care for indigenous peoples follows guidelines published in 2011[10], being managed by the Ministry of Health through the Special Secretariat for Indigenous Health (SESAI), established in 2010[11,12]. Among the 34 Special Indigenous Health Districts (DSEI) distributed throughout the country, the DSEI Pernambuco has under its jurisdiction the Indigenous Territory of the Xukuru do Ororubá people. This is the largest ethnic indigenous population in the state with about 7,900 indigenous people living in a territory that includes the municipality of Pesqueira, 200 kilometers far from the capital[13].

Based on these guidelines, we report the experience of a dental surgeon resident in the RMISF Program, a non-indigenous person, during an internship developed in the Xukuru do Ororubá Indigenous Territory. This report is a product emerging from the perspective of outlining critical reflections on the conditions of access to oral health of the indigenous people, analyzing how this internship experience in a traditional community may have repercussions on the objective reality of the community as well as on the professional training of the health resident.

Material and methods

This is an experience report guided by methodologies of critical and dialectical reflection on the objective reality, seeking to capture the historical-social reality of the context experienced, interpreting it and acting to transform it from practical experiences, and finally reinterpret it from theoretical analysis.

The systematization of the experience was conducted based on two methods. The Theory of Practical Intervention in Collective Health Nursing (Tipesc)[14], based on the historical and dialectical materialist worldview, which operates in the stages of capturing objective reality and its interpretation; proposal of intervention and practical realization; and the reinterpretation of reality, evaluating the product/process of the experience. Together, Holliday's method of systematization[15], of dialectical methodological conception, defined by: participation and registration of the experience; definition of the objective, object, and central aspects to be systematized; reconstruction of the experience and classification of information for analysis; background reflection (synthesis, analysis, and critical interpretation); conclusions and acquired learning.

The following sections of this report were built based upon these methods, organized into three thematic categories of approach: the conditions and characteristics of the territory, oral health care, and the influence of the internship on professional training.

Description of the experience

The Xukuru do Ororubá indigenous people live in a territory that is part of the municipality of Pesqueira, located in the Agreste region of the state of Pernambuco, a semiarid region surrounded by rocks. Their Indigenous Territory is bordered to the north by the municipality of Poção and the state of Paraíba; to the south and east by the municipality of Pesqueira and to the west by the municipality of Arcoverde, being inserted in a region of variable soil and climate[13,16,17]. The Indigenous Territory, approved in 2001, covers 27,555 hectares[18], located in the Serra do Ororubá and divided into three Socio-Environmental Regions - namely, Serra, Ribeira, and Agreste - encompassing 24 official villages. These regions are spatial categories established by the indigenous people themselves, based on the geo-climatic and socioeconomic characteristics of the territory[19] (Figure 1). Even though the Indigenous Territory is located in the rural area of the municipality, the proximity of some villages to the urban area, about six kilometers, facilitates the acquisition of products and services available in the city, as well as the circulation of individuals on this route, stimulated also by the fact that many indigenous people live in the urban area.

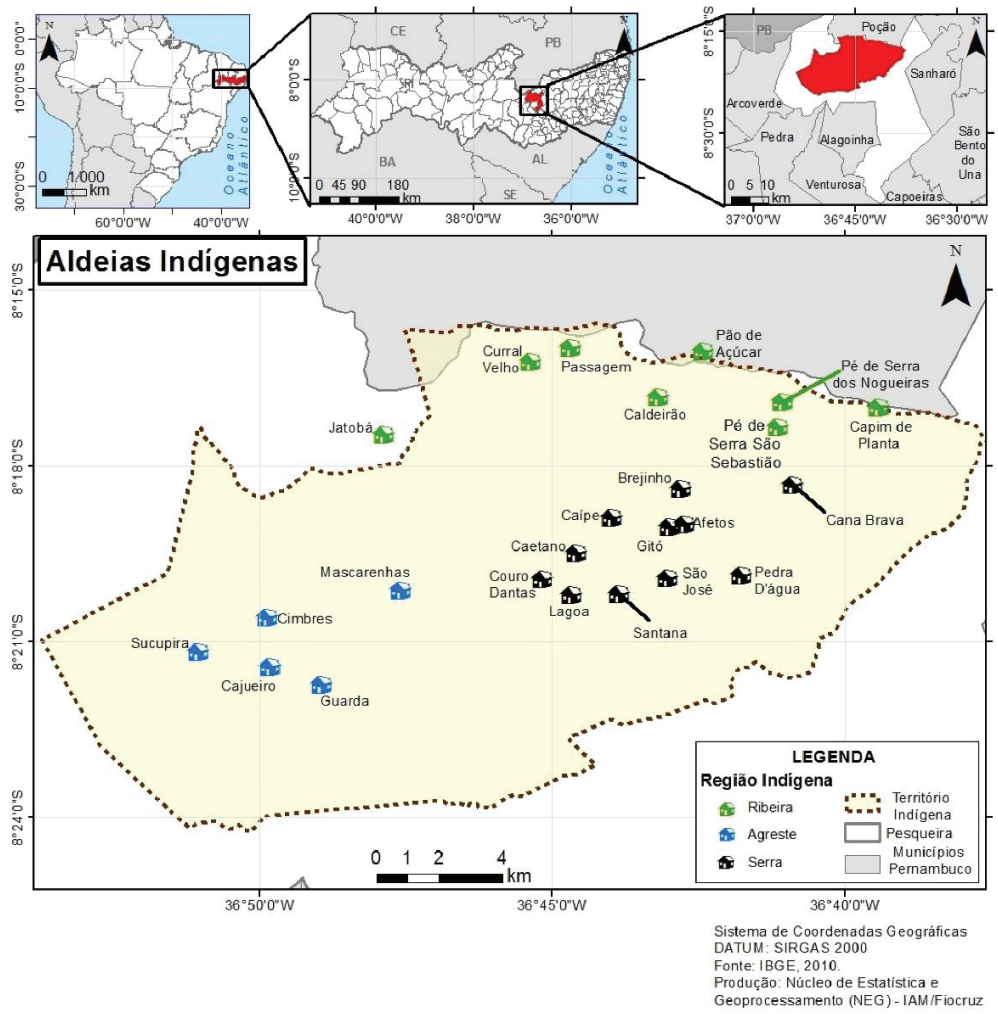

Figure 1. Geographic location of the Xukuru do Ororubá Indigenous Territory and its division according to socio-environmental regions and villages. Pesqueira, 2018.
Source: Maurício HR[19].

As for the organization of the PHC health services located in the Xukuru do Ororubá Indigenous Territory, among the 24 villages, seven have a Health Unit, all with a dental office (Cimbres village, in the Agreste region; Pão de Açúcar, Passagem, and Pé de Serra dos Nogueira villages, in the Ribeira region; and Brejinho, Cana Brava, and São José villages, in the Serra region). Regarding the oral health network, considering Secondary Care, procedures not performed in PHC have as referral reference the Center for Dental Specialties (CEO) of Pesqueira-PE and the CEO of Caruaru-PE, a municipality about 84 kilometers from Pesqueira – Regional CEO, at the Tabosa de Almeida University Center Asces (Unita).

An important strategy of organization and education became necessary, after a historical process characterized by political persecution, acts of violence, removal, and criminalization of community members, sponsored by forces of various levels, some of them responsible for the near extinction of the indigenous people. In the last three decades, forms of political organization have materialized, the recovery of their ancestral territory from the hands of squatters. This movement, known as "retomadas," promoted the establishment of ways of survival, in addition to the gathering of villages and

leaderships acting in the educational and political formation of young people - citing the Poyá Limolaygo network, a socio-political instance of the Xukuru do Ororubá youth, and Ororubá Filmes, a group created for audiovisual production. Through the Xukuru Assembly of Ororubá, an annual event in which the cacique Xicão Xukuru, the historic leader murdered in May 1998 under circumstances of conflict over land, is honored. This reaffirms the commitment to defend the Serra do Ororubá, discussing issues of the national socio-political scenario and planning for the future, focusing mainly on education and health projects for the Indigenous Territory[18,20-22].

The strategic internship experience of the dental surgeon resident of the RMISF Program took place from November to December 2018 linked to the fieldwork of an inter-institutional research team composed of the resident, researchers from UPE, the Federal University of Alagoas (UFAL) and the Aggeu Magalhães Institute (FIOCRUZ-PE) and undergraduate dental students from University of Pernambuco and the Federal University of Pernambuco (UFPE). The research team has been working with the Xukuru do Ororubá people since 2008, having issued publications regarding historical approaches produced from oral memories of this people and research on written records[20]; the process of using pesticides in agricultural cultivation and its relationship with the environment and indigenous health[23]; health information policy in a case study with indigenous health information systems[24]; with practices of popular education in health, analyzing the educational actions carried out by indigenous health and sanitation agents[25]; and related to the oral health conditions of these people[26].

Based on the experience of observation and capture of the elements that emerge from the Indigenous Territory, the proposed systematization axes are presented and discussed.

The processes and contacts with the Xukuru do Ororubá Indigenous Territory

During the period of the experience, the team traveled from Recife to Pesqueira, and then continued to the Indigenous Territory, exploring it during the morning and afternoon shifts. Twenty-three villages of the territory were visited, and one village could not be visited owing to logistical difficulties. There are water springs, wells, dams, and reservoirs in the Indigenous Territory. At the time of the visit, the impact of the drought and scarcity of potable water on the routine of these people was noticeable. Alternative sources of potable water did not prove sufficient to meet the needs of such an extensive and diverse territory. The impacts of scarcity had an impact on the survival of families and their relationship with work in the fields (loss of animals and crops); on household cleaning tasks; on eating conditions, cleaning and food preparation; and on the body and oral hygiene practices of individuals.

It is important to note the relationship of these people with the territory they occupy and protect, considering the meanings of having such possession and guarantee. It was possible to notice an intense connection between the indigenous people and their work in the fields, with the land, cultivating a variety of crops that are used both for their own consumption and for exchange/sale. Besides the connection to housing, food, and survival, land issues are also linked to family and ancestral relationships; to spirituality; to identity and a relationship of belonging, not owning; to education and people's health; that is, to life and the ways of experiencing it[3,27].

Some moments are noteworthy, among the activities/interventions scheduled for the internship period. Initially, theoretical and practical training was carried out for the team, which took place in one of the Indigenous Territory's main Health Unit, located in the Cimbres village. At this time, there was an opportunity for contact with the health professionals working in the public network and residents of the territory, discussing issues regarding the reality, history, and local culture, and providing guidance on the situation and specificities of the families that live in the villages. The next step was to visit the homes and the Health Unit, aiming to: collect spatial/geographical coordinates and make observations about living conditions in general, access to health services, self-perception of oral health, oral hygiene practices, food consumption pattern of the families, and identification of nutritional status.

During the home visits, oral health interventions were performed: clinical oral examinations (Figure 2) and guidance to participants/families regarding oral health care and healthy eating, taking into account the socioeconomic, cultural, and geographic reality of that people. At the end of each visit, oral hygiene kits with a toothbrush, fluoride toothpaste, and dental floss were given to specific cases.

Figure 2. Performing clinical oral examination during home visit in a village of the Xukuru Territory of Ororubá. Pesqueira, 2018.
Source: Prepared by the authors

Oral health care in the Indigenous Territory and the repercussions of the intervention

The PNASPI points to the need for a network of services in Indigenous Territories, in order to overcome the deficiencies in coverage, access, and acceptability of the health actions and projects implemented by SUS for these populations[9]. The logic of PHC was applied to the current indigenous health care model, which is composed, among other instances of care, of base poles, Health Units and Multiprofessional Indigenous Health Teams (EMSI)[3,9]. The EMSI encompass Oral Health Teams (ESB) with a dentist, an oral health technician and/or oral health assistant[10].

Among the attributions of the professionals who make up the three ESBs working in the Xukuru do Ororubá Indigenous Territory are the collective actions (supervised tooth brushing, topical application of fluoride, distribution of toothpaste, toothbrush and dental floss, oral health education and promotion activities) and individual (basic clinical dental care) oral health care, considering the epidemiological, cultural, social, political and economic aspects of the indigenous populations, and considering that they should be carried out in the villages, even in situations of poor infrastructure or places of difficult access[10,28].

Regarding the work process of the ESBs hired to work in the Indigenous Territory, considering its extension and the fact that only seven villages have Health Unit, the professionals are required to rotate among them. In each of the three regions of the Indigenous Territory, there is a designated team and the main Health Unit, with the others working as support.

The rotation system is reinforced by the weakness of the employment bonds established by contract with the third-party private operators that manage the indigenous health care. These operators work under a capitalist productivist logic with the fulfillment of quantitative goals, disregarding the qualitative focus of the work directed to the indigenous context, ending up removing the health worker from the spaces of care and contact, contributing to difficulties in scheduling appointments, impediments in building the bond between professional and user, and continuity of treatment, compromising the quality of care offered in the Indigenous Territory[29].

Regarding the actions/interventions in oral health carried out during the experience, it is deemed essential to prioritize the preventive dimension in the context of the DSEI, especially by providing access to fluoridated toothpaste and fluoride therapy (topical use of fluoride). This preventive dimension must be closely coupled with educational actions[30], of valuing the autonomy of the subjects, the reflection on their reality and their experiences. This should be done trying not to blame nor to centralize in the individual the contextual problems, which are beyond their competence.

The interventions started by questioning the participants about their hygiene and dietary practices. The importance of care concerning these aspects was strengthened through the answers obtained, and necessary adaptations to improve these conditions were proposed so that the family/household/territorial contextual characteristics were respected. Among the advantages found in the proposed actions, there was a good receptivity from the participants, as well as demonstrations of interest and involvement, with appreciation

and satisfaction for the simple presence of the team and the hygiene material received. The difficulties of action were related to the careful use of sensitive and appropriate language and interventions that did not hurt the local characteristics.

The work in health has a pedagogical dimension that can collaborate with the construction of the possibilities of the social being or, in the same way and through the same action, promote the reproduction and maintenance of relations of domination. Professional action and intervention, based on the pedagogical dimension, is not neutral. It imprints a social direction that has the potential to build the subjects' autonomy in care and understanding of the social determination of health, with a view to bio-psychosocial integrality - including the assimilation of the indigenous worldview, as ways of perceiving and interacting with the world and society -, or to reproduce a hegemonic domination, stimulating dependence and subalternity for care - with practices centered on a daily, individual and positivist dimension -, and the fragmentation of health and the subjects' socio-political awareness[29].

Countryside internship and its influence on professional training

By intending to reorient the services according to health needs, especially in the PHC context, the RMS is designed to contribute to the training and qualification of health professionals, committing to comprehensive care, deepening theoretical and practical debates, and allowing for the construction of new knowledge among health professional categories, based on a pedagogical structure founded on the problematization of the reality of health services. Using as a basis the immersion in the health reality of the communities, the teaching-learning process becomes capable of producing, besides scientific knowledge, transformations of self and reality[31,32].

In order to transform the training process, the health actions, and the pedagogical practices, it is necessary to stimulate the problematizing practice, incorporating a training that awakens critical consciousness, reflexive action, and the need to transform reality. However, the expansion and transformation will emerge in the intermediation between the established scientific knowledge and the knowledge coming from the real experiences[31,32]. The professional training practices in residency must be connected to the social context of the populations, in sensitive listening to users, in political action to face the challenges of the system[33], shifting the emphasis from logics based on the therapeutic perspective and the health-illness issue to the social determination of health processes and practices[29,34].

Torres *et al*.[35] suggest that the "residency programs present, as their main challenge, the overcoming of limitations arising from the original training of professionals, contributing to a contextualized and committed performance with the SUS" (p. 4). In addition to organizational and technical knowledge, the residency training process must involve social and human aspects, such as values, feelings and different views of the SUS and the world.

Throughout Brazil, internship opportunities outside the standard service linked to the RMS programs have become common practice, based on the finding of personal enrichment and changes in the professional training of residents to work in the SUS[4,36,37] as is done through the optional internship experience of resident (nutritionists and dentist) of the Family Health program of the state of Bahia[4]. The report was produced

from experiences in the Pankararu lands (state of Pernambuco), and highlights the need for expansion of the EMSI, including other health professions, in order to meet the demands of the community. In addition, it points to the need for continuing education strategies for doctors, nurses and dentists to work in the indigenous area.

In the context of the undergraduate courses, there is an experience related to the preparatory activities of an optional internship for a dentistry undergraduate, called "Project Huka-Katu - the FORP-USP in Xingu"[5]. The authors discuss the reconfiguration of the teaching-learning process in the formation of dental surgeons, bringing the problematization as a promoter of the understanding of the intercultural context in the multiprofessional work and the proposal of comprehensiveness of oral health care, with recommendations for the development of competencies that focus on the symbolic dimension of the health-disease processes and healing strategies in different communities.

Another published experience is that of undergraduate medical students with the Potiguara indigenous community (State of Paraiba), from the extension project Iandé Guatá, discussing the potential of the learning process during an immersive experience in the local culture[6]. The report points out as expressions of the experience an approximation of the students to the indigenous universe; the overcoming of the romantic imaginary, through immersion in the local culture; the recognition of a commitment to social transformation; the development of skills for community work; and the appreciation of traditional indigenous knowledge.

In order to provide more substance to this debate around higher education, Forsyth *et al*.[38] indicate the need to reorient the training of health professionals, including the promotion of training students from indigenous communities. The author also remarks on the inclusion of indigenous people in the teaching staff, in order to meet the health needs of these populations, allowing the transformation and breaking of stereotypes. An important tool is the integration of cultural competence in the curriculum, promoting contact with the epidemiological, sociopolitical and historical reality of indigenous peoples, through the disciplinary curriculum, research, and engagement, immersion and interaction with the communities[5,6,38,39].

Regarding the international landscape, Australian higher education institutions are required to demonstrate how their strategic plans incorporate cultural competence, and it is recommended that Indigenous knowledge and culture be included in the curriculum so that future health professionals can act on the health inequities that these people are subject to. In the sphere of oral health, the Australian Dental Council requires curricular evidence of the integration of Indigenous cultural competence[38]. Such proficiency prepares trainee professionals to interact and communicate effectively with indigenous individuals and their cultural particularities, being aware of the worldviews of each people and developing positive attitudes when dealing with cultural differences.

In Brazil, Diehl and Pellegrini[40] underscore resolutions present in the final report of the 4th National Conference on Indigenous Health, held in 2006, which are relevant to the issue of training health workers. They are: the inclusion of the discipline Indigenous Health in the curricula of technical and higher education levels in health; the creation of postgraduate courses in indigenous health for workers in the area and residency programs in service and at a distance; and continuing education for the indigenous population.

In this regard, recently, dealing with the teaching of indigenous health in the context of medical undergraduate and residency programs, considering even the pandemic period in 2020 and being evidenced the intense social and health inequalities, the Brazilian Association of Medical Education has prepared recommendations[39] advocating that there should be visibility to the indigenous topics during professional training, development of competencies related to the health of the peoples, approach to care in an intercultural context, in addition to encouraging the presence of students from indigenous communities in higher education health courses.

The Brazilian internship experiences mentioned here, together with the intentions and the national and international strategic training models, corroborating the experience of the strategic internship in Residency reported here, illustrate how contact with this topic, and with indigenous peoples, can be seen as an experience that drives expanded professional training aimed at a more adequate care, as it acts as a stimulating factor to problematizing reflection about the origins and the means to overcome the weaknesses in the professional performance in such contexts, beyond the consensual pointing to the weakness in the "traditional" health formation and its normative and biologicist concepts as the only or main justifications for the problems.

The normative education is indeed a relevant issue, but it is necessary to consider a performance that goes beyond the professional act as an end in itself, beyond an exclusive conception of approaching the individual, the family, and the community[3,29]. The educational processes in health, in order to perform a role in indigenous contexts, require elaborations beyond the classical disciplines. They must provide training that is sensitive to diversity and difference that is prepared for symmetrical dialogue, giving priority to the communities and their perspectives on health and services[40].

Training and professional practice in socio-historical relations

Considering the need to extrapolate the consensual justification around the objective weaknesses in traditional higher education in health, which are limited if applied to a critique of the sociopolitical structure, it is necessary to direct the debate also to the roots of professional practice. In that way it may be recognized the essence of the social direction of work and, therefore professional practices in health services are actions that have a social purpose. These actions present alternatives, from a vision of the individual and of the world, and are materialized under the direction of different forms of apprehension of the societal movement. Therefore, it is fundamental to consider the repercussions of the capitalist mode of production in the scope of social and historical relations[29].

Based on this, it is considered necessary to reflect on the impacts of colonialism and racism, as forces that have effects on social and individual behavior, on professional performance and conduct, and consequently on the health care offered to Brazilian indigenous peoples

Colonialism as a form of power emerges during the colonial period, the cradle of present racial classification, establishing the strategy of domination of peoples and the idea of racial superiority. The original indigenous peoples, the black people trafficked from the African continent, subjected to the European colonizers, were part of the development of

colonial capitalism at the expense of their labor exploitation, extortion of land and natural wealth[27,41]. Regarding the Xukuru do Ororubá People, in the 17th-century colonizers invaded the ancestral peoples' territory, founding a Catholic church, using the land for cattle ranching and exploiting the labor force for little or no payment[27].

The colonization process brought problems to the continuity of the cultures of the exploited peoples, forcibly re-signifying and marginalizing concepts, social roles, beliefs, and representation of bodies. Colonized people are placed in a condition of underdeveloped and subordinated, disseminating the Eurocentric thought as instituted truth and reflecting in the racist assimilation of extermination. The end of the colonial process in Brazil did not imply the end of colonialism, giving birth to the model of society perpetuated until today that, even with the advances, is still based on racism, Eurocentrism and sexism[3,27,41].

Countering the discourse of scientific racism, Mariátegui[42] asserts that the problem of the indigenous race in the Latin American context is fundamentally a socioeconomic problem, which has its roots in the land tenure regime. These are issues of landlessness, serfdom, concentration of property, and political domination by landowners. But beyond this, the indigenous populations are the objects of a double oppression, on the one hand, class exploitation, and on the other national oppression, as centuries-old racial, educational, legal, political, and cultural discrimination is enforced against them[42-44].

Perceiving colonialism as a form of domination and imposition of authority of one culture over another, and as a process belonging to the capitalist structure, a driver of oppression of race and class in the social reality, it establishes the unleashing of insufficient conceptions of health that are possible to be built with and for indigenous peoples and their cosmology, an issue that promotes fragilities in the institutional configuration of the SUS, in the process of service management, in health training, and especially in the individuals themselves, health agents, who produce indigenous health care[3,27].

Concluding remarks

The experience of the internship contributed to the acquisition of a sociopolitical and historical look at the indigenous issue, enhancing the fact that public policies evolve from cultural, historical and social processes. There are evidence elicited from the life and health conditions and needs of the community reported, given the place that indigenous people occupy in today's society, the political conflicts, the land issue, the dismantling of assistance and protection policies, the impact of oppression, discrimination, and violence on the health of these people. We seek to give visibility to their resistance, and at the same time, the enormous organizational capacity has strengthened the community in the sense of reconquering its own identity as a traditional people, its ancestral rituals and ways of life.

The EI pedagogical proposal of the RMISF program allows the resident to visualize other health needs. The contact with the condition and the knowledge about the oral health of the indigenous people made explicit the need for treatments for maintenance and recovery of teeth and oral functions, with pictures of suffering and pain resulting from these problems, which require greater contact with protection through fluoride,

considering the absence of fluoridated water in the Indigenous Territory; improved surveillance of food safety in agreement with the cultural issue; consolidation of oral hygiene practices through culturally contextualized and dialogued actions; reinforcement of human and structural resources at the service of oral health care, understanding the extent and the access barriers produced in Indigenous Territory.

There is a reflection emerging from this encounter, regarding how to deal with a reality that is adverse to urban standards, and how to sensitively apply to it the knowledge acquired in "traditional" health training, which generally does not incorporate the topic of traditional peoples and the countryside into its curricula, and, therefore, does not take into account the diversity of health care practices, the historical and structural issues, the political confrontations, the ways of survival, and the understandings about health-disease-death.

Experiencing the realities of other territories confronts the established professional knowledge with the objective reality of people in situations of vulnerability and inequality, oppressed as a result of political choices, the lack of guaranteed rights, and discourses of racial inferiority. Such confrontation demands contextualized and expanded solutions, going beyond the modern colonial model of life. The debate regarding health for indigenous people means to take care of the community and its wellbeing, as well as to fight for their ancestral lands and their recovered lands. The solutions go in the direction of breaking down the logic of the colonial, capitalist, and racist relationship inside and outside the health care domain, and strengthening the fight in defense of life and of the indigenous worldview as a basis for dialogue, nurturing the development of cultural competence and of a differentiated care that contemplates diversity and does not homogenize the health care of the peoples.

A limitation of this report, which may be further analyzed in future studies, is the lack of a view of the health conceptions of the professionals working in the indigenous territory, their relations with the academic training and the concrete repercussions in the professional practice in the context of the Xukuru do Ororubá Indigenous Territory.

In summary, being a health care agent creates the necessity to understand that the professional training of the health residency, which is technical, theoretical-practical, but also political, should not belong exclusively to the subject, as something acquired and of restricted use for personal benefit, but rather, as a choice of individual responsibility that was collectively financed by the people and therefore there is a social debt that has been established.

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Authors' contributions

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

The authors have no conflict of interest to declare.

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A partir das recomendações sobre experiências que aproximam a formação em saúde da realidade de populações em situação de vulnerabilidade, apresenta-se um relato de experiência, na perspectiva de um trabalhador residente em saúde, sobre a vivência de estágio no Território Indígena Xukuru do Ororubá (Pernambuco/Brasil). Emergiram reflexões sobre as condições de vida e saúde do povo indígena, o processo pedagógico de estágio e repercussões na formação e no fazer profissional, além das fragilidades relacionadas à cobertura e longitudinalidade do cuidado em saúde bucal. Por meio de intervenções com a perspectiva de autonomia dos sujeitos, foi possível aprimorar o olhar sociopolítico à questão indígena. Aponta-se a potencialidade da proposta, que estimula o confronto entre saberes profissionais instituídos e a realidade objetiva das comunidades, buscando superar o modelo colonial de cuidado, ampliando a perspectiva de atuação do profissional em formação para o Sistema Único de Saúde (SUS).

Palavras-chave: Atenção Primária à Saúde. Saúde de populações indígenas. Saúde bucal. Acesso aos serviços de saúde. Programas de pós-graduação em saúde.

A partir de las recomendaciones sobre experiencias que aproximan la formación en salud de la realidad de poblaciones en situación de vulnerabilidad, se presenta un relato de experiencia, desde la perspectiva de un trabajador residente de salud, sobre la experiencia de pasantía en el Territorio Indígena Xukuru del Ororubá (Pernambuco/Brasil). Surgieron reflexiones sobre las condiciones de vida y salud del pueblo indígena, el proceso pedagógico de la pasantía y las repercusiones en la formación y el quehacer profesional, además de las fragilidades relacionadas con la cobertura y longitudinalidad del cuidado de salud bucal. Por medio de intervenciones con la perspectiva de autonomía de los sujetos, fue posible perfeccionar la mirada sociopolítica sobre la cuestión indígena. Se señala la potencialidad de la propuesta que incentiva el enfrentamiento entre saberes profesionales instituidos y la realidad objetiva de las comunidades, buscando la superación del modelo colonial de cuidado, ampliando la perspectiva de actuación del profesional en formación para el Sistema Brasileño de Salud (SUS).

Palabras clave: Atención primaria de la salud. Salud de poblaciones indígenas. Salud bucal. Acceso a los servicios de salud. Programas de postgrado en salud.