




Identity, Care and Rights: the Experience of Talking Circles about the Health of Indigenous People


Identidade, Cuidado e Direitos: a Experiência das Rodas de Conversa sobre a Saúde dos Povos Indígenas

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KEYWORDS

- Indigenous Peoples Health.
- Health Education.
- Problem-Based Learning.
- Indigenous People Health Professionals Training.
- Indigenous Population.
- Community-Institutional Relations.
- Talking Circles.

ABSTRACT

Introduction: There is a historical fragility regarding the training of health care professionals working with the Indigenous Health System in Brazil and the awakening of the growing sensitivity for the promotion of intercultural dialogue is recognized as essential in this context. Thus, the project “Talking Circles about the Indigenous People’s Health” in the university emerged in 2016, developed in a partnership between medical school professors and indigenous students from the Indigenous Tutorial Education Program - PET Indígena – Health Actions, UFSCar. **Method:** This report is based on the qualitative documental analyses, aiming to present and discuss the experiences, perspectives and dialogues carried out during those meetings, the construction of diversity, the description of the activities performed and the exposure of their potentialities and limits. **Results:** Based on both Paulo Freire’s Culture Circles and active teaching-learning methodology tools, those meetings dealt with topics related to Indigenous People’s Health, the results of which were here grouped into three categories: Identity; Care; and Indigenous Rights. The Talking Circles format fostered the construction of new knowledge in indigenous health’s field related to different cultures, specific health policies, concepts of health-disease process, providing an initial approach on the indigenous health context in Brazil. Additionally, they provided a space with indigenous leadership that dared to indicate innovative perspectives on identity issues and health understandings, disease and healing processes, as well as raising the epistemology inherent to these populations. **Conclusions:** Based on the dialogue between different actors, it was possible to arouse interest of the health professionals regarding ethnic and cultural issues and give visibility to the indigenous people at the University. Moreover, it can be a first step towards the construction of optional interdisciplinary disciplines and the insertion of the topic in undergraduate school curricula in the health area.

PALAVRAS-CHAVE

- Saúde Indígena.
- Educação em Saúde.
- Aprendizagem Ativa.
- Ensino.
- Estudantes Indígenas.
- Extensão Comunitária.
- Roda de Conversa.

RESUMO

Introdução: Há uma fragilidade histórica na formação dos profissionais da atenção à saúde indígena no Brasil e reconhece-se o despertar da sensibilidade para situações de diálogo entre diferentes culturas como essencial nesse contexto. Assim, surge em 2016 o projeto de extensão “Rodas de Conversa sobre a Saúde dos Povos Indígenas”, criado numa parceria entre professores de Medicina e estudantes indígenas do Programa de Educação Tutorial Indígena – Ações em Saúde, da Universidade Federal de São Carlos. **Método:** Este é um relato sobre os três anos dessa experiência, tendo sido construído a partir de uma análise documental de abordagem qualitativa. Os objetivos foram resgatar os temas e conteúdos desenvolvidos e discutir as vivências, as perspectivas e os diálogos desse espaço de encontro. Ao longo do texto há descrição das atividades realizadas e reconhecimento de suas potencialidades e seus limites. **Resultados:** Com base nos círculos de cultura e instrumentos de metodologias ativas de ensino-aprendizagem, os encontros trataram de temas relacionados à saúde indígena, aqui agrupados em três categorias: identidade, cuidado e direitos indígenas. O formato em rodas de conversa possibilitou a construção de saberes no campo da saúde indígena relacionados às diferentes culturas, às políticas de saúde específicas e às concepções do processo saúde-doença, propiciando aproximação inicial com o contexto de saúde indígena no Brasil. Adicionalmente, proporcionou um espaço com protagonismo indígena que ousou apontar para olhares inovadores sobre questões identitárias e compreensões de saúde, doença e processos de cura, levantando inclusive epistemologias intrínsecas a essas populações. **Conclusões:** A partir do diálogo entre diferentes atores, foi possível despertar o interesse dos participantes para especificidades étnico-culturais e dar visibilidade à presença dos indígenas na universidade. Além disso, pode ser um primeiro passo para a construção de disciplinas interdisciplinares optativas e a inserção da temática nos currículos de graduação na área da saúde.

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INTRODUCTION

Health care offered to indigenous populations in Brazil has a trajectory characterized by sporadic actions and irregular coverage in Brazilian territory. It started with the work of missionaries, followed by the creation of the Indian Protection Service in 1910, and from 1967 onwards by the National Indian Foundation (FUNAI, *Fundação Nacional do Índio*), it had mostly an activist and integrationist profile^{1,2}. Since the First National Conference on the Protection of Indian Health, held in Brasília in 1986, the need to create a specific indigenous health subsystem with its own agency for this purpose has been identified, guaranteeing indigenous peoples the universal right to health, as it was being sought for the entire Brazilian population^{3,4}. However, it was only in 1999 that guidelines for health care for indigenous peoples were established, as defined in Law 9.836/99 – known as the Arouca Law. This law established the Indigenous Health Care Subsystem, with the creation of the Special Indigenous Health Districts (DSEIs, *Distritos Sanitários Especiais Indígenas*)^{4,5}, being integrated into the Unified Health System (SUS, *Sistema Único de Saúde*) in 2010.

Currently, the activities developed within the scope of indigenous health are guided by the National Policy of Health Care for Indigenous Peoples (PNASPI, *Política Nacional de Atenção à Saúde dos Povos Indígenas*), launched in 2002, recognizing the ethnic and cultural specificities of these peoples, as well as the right to their territory¹. The health care model of indigenous peoples is based on the DSEIs, which constitute a specialized model of service organization, focused on the protection, promotion and recovery of health, characterized as a looregional organization of the health system. The DSEIs have a network of primary care services installed inside indigenous lands, which must be integrated, hierarchized and articulated with the SUS network^{2,5,6}. In indigenous lands, primary care is provided through multidisciplinary teams consisting of doctors,

nurses, dentists, nursing assistants and indigenous health and sanitation agents, in addition to other professionals who provide matrix support^{2,5}.

There are few studies and investigations on the profile of these professionals, but this model is characterized by high turnover of professionals and discontinuity of actions. There are difficulties in adapting to daily work, training needs and precarious employment relationships; it can be said that most professionals are recently graduated ones and seek new challenges and professional inclusion, with a scarce profile to deal with complexities in intercultural relations^{7,8}. In addition to the low qualification of professionals to work with the communities, they generally ignore the systems of representations, values and practices related to the disease and are unaware of traditional healing systems performed by indigenous specialists, such as *pajés*, shamans and healers, often generalizing the “indigenous individual” or even acting in a prejudiced manner, leading to a deficient assistance^{1,3,9,10}. In order to achieve PNASPI purpose of guaranteeing indigenous peoples access to comprehensive health care, one of the established guidelines was the training of professionals to act in the context among different cultures, recognizing the right of these peoples to their culture, as well as the effectiveness of their medicinal practices, contributing to overcome the factors that make this population more vulnerable to health problems^{1,8}. However, the frequent turnover of team members, added to the lack of adequate training, either in a previous training or the process of continuing education, results in flaws on the part of professionals to work in specific ethnic contexts¹¹.

In the health area, the undergraduate formation contributes little to the work performed in interethnic contexts, with the experiences where the early placement of students in indigenous lands occurs being rare, or even a theoretical space that addresses the health of native peoples and intercultural contexts⁷. Approaches to the indigenous universe through

immersion in the local culture, as in experiences of continuing education, could favor students in the health area to overcome the romantic imaginary, including historical processes of exclusion from public health policies, in addition to the development of respect and appreciation of traditional knowledge¹². In this context, the construction of competences for indigenous health care could be initially developed; however, few students have this opportunity to experience it in the field¹³.

In addition to the students' training, educational extension experiences in indigenous health can undertake other commitments that have an impact on the development of the communities, such as scientific production and the development of health actions, while approximating the fields of health, education and the humanities and social sciences¹⁴. Likewise, activities at the universities that allow approaching traditional populations and communities, even if not specifically indigenous, can favor the development of skills to act in different cultures, as well as raise awareness regarding the needs of other socio-cultural realities^{10,15}. However, these experiences are diffuse and infrequent in educational institutions, keeping students away from these contexts.

The current National Curricular Guidelines for medical courses, published in 2014, showed small advances in this direction. Although they do not explicitly mention the need to develop skills in indigenous health, they indicate that the courses should provide learning opportunities relating to the pluralism of health-disease concepts and cultural diversity, in addition to recognizing the universe of ethnic-racial differences¹⁶. The consolidation of SUS, of the Indigenous Health Subsystem and, consequently, health training aimed at public health in the country, can lead to a society project that expands the boundaries of the exercise of citizenship, reinforcing the role of the State in guaranteeing health as a right of all individuals, including indigenous populations, which currently amount to more than 800,000 Brazilians¹⁷. However, the challenges of achieving the universality of access, equity and integrality of actions have to face, in part, the deficient training profile of health professionals, with excessive specialization and distancing from the needs of the population, with emphasis on traditional peoples.

The need for the inclusion of disciplines or discussions on Indigenous Health in the curricula of health area courses was already identified at the 4th National Conference on Indigenous Health in 2006⁵, as well as the creation of medical and multiprofessional residency programs, postgraduate courses in indigenous health, and the provision of distance learning, but little progress has yet been made in these constructions. In addition to professionals working directly with Indigenous Health, it was identified the need for training in anthropological and cultural knowledge for health professionals working in public hospitals, aiming to qualify the interaction between teams and indigenous people, in mutual understanding and respect for traditional practices and cultural differences⁷. Thus, there are still many paths to be followed when seeking the training of health professionals who are more competent to work with the needs of indigenous peoples and who value more subjective aspects of health in all of its complexity.

The indigenous College admission exam at Universidade Federal de São Carlos and the Indigenous Tutorial Education Program (PET, *Programa de Educação Tutorial*) – Actions in Health

In this context of a meeting between different cultures, historically there is little access for indigenous people to enter higher education

institutions as university students, which does not allow the training of health professionals from these communities. In recent years, some strategies have been created locally and others nationally so that the right of access to higher education is guaranteed to indigenous people, such as inclusion programs and affirmative actions. The conception of Affirmative Actions as a policy implies working for the deconstruction of historical asymmetries in the public university, mainly regarding the access by low-income individuals, blacks and indigenous people¹⁸.

In Brazil, considering the 2010 IBGE Census, whites represent 48% of the population and, based on the analysis of data from the Socioeconomic Questionnaire of the National Student Performance Exam (ENADE) carried out by Ristoff¹⁹, it was observed that the Brazilian campus was still approximately 20% whiter than the Brazilian society, even after a series of public policies that aimed to change this scenario. Based on the Affirmative Action Policies implemented at Universidade Federal de São Carlos (UFSCar) in 2008, one slot has been reserved in each undergraduate course for indigenous students. Currently, a specific admission exam takes place in a decentralized manner in different Brazilian cities with slots offered in the 64 undergraduate courses at UFSCar, including all health courses¹⁸, totaling 242 indigenous individuals from 42 different peoples in 2019.

During the process of including indigenous people into the universities, in 2010 the Tutorial Education Program (PET) was created through an Ordinance from the Ministry of Education, and new PET groups were linked to priority areas and public and development policies²⁰. In this context, the creation of proposals aimed at the indigenous population was considered a priority, given that at that time UFSCar already offered 57 slots in undergraduate courses for indigenous students.

This entire process culminated in the creation of a PET Group aimed at indigenous university students, with a focus on activities in the health area, named “Indigenous PET - Health Actions (PET *Indígena* – *Ações em Saúde*)”, which has been developed since then. This group seeks to train agents capable of collaborating for the improvement of indigenous health conditions, in popular communities, while taking into account the traditional indigenous health practices. In that year, 12 indigenous individuals were regularly enrolled in health courses at UFSCar. Newly arrived from their villages and bringing with them strong cultural traits, they had been facing challenges in this new sociocultural reality, economic difficulties and, above all, adapting to the pedagogical model of teaching²⁰. Over time, several constructions were carried out by this group, one of them, in partnership with the medical course professors, the Extension Project “Talking Circles about the Health of Indigenous Peoples”, which is the focus of this experience report. The aim of this article is to report and discuss the activities and methodologies used in the Talking Circles, acknowledging their limits and potential, while serving as an inspiration for other constructions in different institutions.

METHODOLOGICAL STRATEGY

This experience report was created based on a documental analysis with a qualitative approach. It was created based on materials produced within the scope of the “Talking Circles about the Health of Indigenous Peoples” Extension Project, from March 2016 to July 2019. The qualitative approach was chosen because it is the most adequate to discuss experiences, perspectives and dialogues experienced in this meeting space aimed at the construction of diversities^{21,22}.

The creation of this manuscript was carried out by the two teachers and three extension students involved in the coordination of the Talking Circles. The creation was carried out based on 1) Retrieval of reports of all activities in the extension project; 2) Reading of materials and organization of topics into three categories. For the category construction, the organization of the material was carried out, which allowed the grouping of topics with common characteristics, or related to the same idea²³, favoring the visualization of what was worked with the participants; 3) Analysis of the evaluations made by the participants during the Talking Circles; 4) Synthesis of the findings, with the creation of the experience description and discussion.

The investigations of this research were approved by the UFSCar Research Ethics Committee under number CAAE 20177619.9.0000.5504.

EXPERIENCE REPORT

During the study period, the Talking Circles were coordinated by two teachers, family and community physicians with experience in indigenous areas, and three indigenous students, one from the Psychology and two from Medical areas, respectively from the *Tariano*, *Pankararu* and *Atikum-Umã* Peoples. One of the activities had the collaboration of an anthropologist. Seventeen meetings were held in the physical space of the Department of Medicine, lasting four hours each.

This Extension Project arose from the identification of a gap in the development of competences related to the health of indigenous populations in the training of health professionals, recognizing as essential the awakening of the sensitivity to accept diversity and deal with situations of dialogue between cultures.

The Talking Circles were built based on the principle of Paulo Freire's 'Culture Circles'²⁴, seeking to promote a horizontal relationship in the meeting between educators and students, as opposed to an elitist view of education, respecting oral tradition and legitimizing cultural and knowledge diversity. Such conception is based on three methodological principles: respect, autonomy and dialogicity²⁴. Each one of the meetings was created using an artisanal approach, recognizing the importance of the (re)invention of educational practices, building new meanings for the experience itself of creating a teaching activity. It became a space for collective learning, and it was necessary to rethink the language, the resources, the methods being used, by having a glimpse of the actual founding dialogue of/in the relationships between equals in their differences²⁵. Each of the Talking Circles had a central provocation in the form of a question that identified the meeting and stimulated the participants to problematize around that topic.

Strategies and instruments from several active teaching-learning methodologies were used, inspired by Problem-solving²⁶, the Constructivist Spiral²⁷ and Problem-Based Learning²⁸, as detailed throughout this article. The meetings had the following standard structure. In a large group: welcoming the participants with an initial welcome speech; central provocation disclosure; individual presentations by each participant, explaining their expectations; topic-triggering activity. In small groups: analysis of the topic connecting personal experiences and available materials. In a large group: presentation of small-group discussions and collective synthesis.

Among the different topic-triggers, films, documentaries, testimonies and interviews were used. The use of testimonies recorded by hand was

presented as an interesting trigger when they brought opinions about the central provocation of the Talking Circle. These short videos were sent by indigenous students from several Brazilian universities, health professionals who worked or had worked in Indigenous Health and, indigenous, political and spiritual leaders. The display of these testimonies allowed the debate to be extended to people in different realities of indigenous health in Brazil, bringing participants closer to a greater variety of experiences.

The small-group work was an important pedagogical strategy used during the meetings. It consisted in dividing them into groups of around eight people, seeking to maintain the diversity among them, aiming to improve interaction and mutual trust. The trigger question was analyzed in each small group, allowing each person to bring their experiences and thoughts based on the reading of small excerpts of scientific texts or Problem Situations, related to the central topic. Problem Situations are the main triggers used in Problem-Based Learning²⁸ and consisted of simulated cases or stories extracted from the real experience of the activity coordinators, aiming to motivate the participants' discussion. Small-group meetings made it possible to break with the traditional way of teaching and learning, encouraging the participatory management of the protagonists of the experience and reorganizing the relationship between theory and personal experiences²⁶. The synthesis of the small-group discussion was recorded on cardboards, A4 sheets or on cards.

At the second moment of the large-group meetings, all participants returned to the plenary meeting and shared their analyses, allowing new considerations and reflections through this new collective synthesis, through the Constructivist Spiral movement²⁷.

A recurring instrument, especially in the large group, were cards – paper cards smaller than an A4 sheet. Known as the Mobile Visualization Technique, the cards were distributed among the participants to record their ideas using magic markers and then they were fixed on a panel, being visible throughout the debate and being able to be collectively reorganized into nuclei of ideas²⁹. The Mobile Visualization allowed the organization of the participants' individual ideas, while taking into account the singularities, expanding the comprehension and collective negotiations, without losing the focus of the central issues. Still in the large group, a strategy used was the construction of a 'Clothesline of Ideas', which also uses cards, but which are arranged on a clothesline, instead of a panel, building a set of ideas, or common interests on a given question³⁰. While a coordinator led the discussion, the other mediators wrote, on the cards, demands and motivations of the participants to be developed in the next meetings. The cards were placed on a clothesline and later organized by groups of affinities. Based this collection of ideas, the planning of a series of topics and discussions for the next Talking Circle was carried out.

The Talking Circles included the participation of health professionals, social scientists, educators, teachers, elementary and high school students from the municipality, undergraduate students from health courses and other areas, indigenous and non-indigenous, who were interested in learning about the health of these peoples.

In addition to the face-to-face meetings, a blog³¹ was created, in which complementary content was made available at each meeting, consisting of books, articles, films and interviews, which provided the participants with greater depth and discussion about the Talking Circle topic. The blog included a field called "Activity Diary", where the participants could post

a reflective individual synthesis seeking to answer the central provocation, recording what was learned during the face-to-face activity. In relation to these distance activities, participation was less than the expected by the organizers. When this fragility was identified, we aimed to encourage participants to reflect immediately after the face-to-face meeting, offering the possibility of filling out printed paper forms at subsequent face-to-face meetings, in addition to sending electronic messages to the participants, encouraging the completion of activities. Nevertheless, it is possible that other strategies should still be considered, since the reflection after the meeting, performed individually and supported by reading the recommended bibliography, would have an impact on the expanding of learning. For the participants who attended 75% of the meetings in the year and who carried out the distance activities, a certificate of participation was issued as an introductory course.

What was discussed in the Talking Circles?

During the developed activities, the universe of different indigenous communities in Brazil was considered, with different historical processes and cultural constructions. To facilitate the visualization in the writing of this article, the topics discussed in the meetings were grouped into thematic categories, with examples of the educational strategies used. The three categories were: Identity Issues; Indigenous Health Care; and Indigenous Rights. The set of provocations, topics and contents is described in the Table 1.

In the first category of developed topics, aspects related to the identity constitution of the indigenous individual were discussed, gathering people who did not have any experience with native populations, health professionals working in healthcare in the villages, and indigenous people who lived in urban and community contexts. Establishing a dialogue about diversity, differences and equality disclosed the challenges of sharing perspectives and incongruities, and the very process of recognizing oneself and the other.

In this context, it was possible to discuss the historical processes in the encounter of indigenous and non-indigenous people in Brazil; approach the list of prejudices against indigenous people; advancing into thinking about the indigenous people at the present time, taking into account the contemporary situation of the indigenous people living in the villages or in the city, overcoming the comprehension of the indigenous people shown in textbooks in most cases³². The differences between the terms indigenous, aboriginal, native inhabitant, was discussed, seeking to deconstruct the concept of generic indigenous³³, allowing participants to question the usual judgments of the non-indigenous society that consider indigenous knowledge as backward, primitive or less developed.

In this context, one of the central provocations was: "Indigenous peoples in the city: what prejudices do I have?". On this day, a powerful strategy was used, which was to request testimonies recorded on video from indigenous people from different regions of Brazil so they could tell about the prejudices they suffered when in the city. These several videos were presented to the group of participants, who were also able to exchange their understandings about the indigenous experiences in villages and cities, with emphasis on the university environment, in different geographical regions of Brazil, allowing the participants to broaden their views on diversities.

The second category of provocations was centered on indigenous health care, which required guiding the discussions toward several

directions, with a significant focus on the relationship between health and culture. We reflected on the concepts of health, illness and healing processes, as well as the presence (or absence) of traditional care. Thus, the meeting between biomedicine and indigenous healing systems was also problematized, raising the challenges of developing a care process that shared different worldviews. In this context, the debate on the relativization of values and the differences between the experience of health and illness for each person was considered³⁴.

Moreover, we sought to understand the sociocultural construction of the illness, associating it to the community, their histories and beliefs and overcoming the biomedical only and often ethnocentric view that is considered during the training and performance of health professionals¹¹. Therefore, we insisted on the understanding of culture as a dynamic and not as a static thing³⁵ amid dialogical relationships between people with different types of knowledge²⁴.

Another central aspect in this set of meetings was the concept of cultural competence, understood as a set of skills that health professionals must have to work with population groups that have customs and traditions that are different from their own, contributing to a health performance with better and more qualified communication with respect to differences³⁶, or even a set of policies, values, behaviors and attitudes within a system, or among professionals that allows an effectively cross-cultural work¹⁰.

To develop the provocation "*What are the relationships between cosmology and indigenous health?*", the small groups used clippings from excerpts of articles about the worldview of some indigenous peoples (Yanomami, Baniwa, Kamaiurá, Wari and Tukano). Each group read and discussed the text about one people, also discussing the views of the indigenous people present at the meeting. Subsequently, in a large group, all these stories were presented, seeking similarities and differences between them. Therefore, the discussion about the indigenous health care in the Talking Circles aimed to work with transversal and non-technical topics, recognizing the specificities of health in this context.

In the last category of topics, provocations related to indigenous rights were highlighted, both those specific to health and related areas. For indigenous peoples, health is understood in a broader sense, not being restricted to the health of the body, but integrated into the planet. Thus, the right to land, education and the maintenance of its cultural diversity are closely related to health promotion. Focusing on the discussion of the rights of indigenous peoples in Brazil, we started with the creation of indigenous health policies, before and after the 1988 Constitution, in order to understand the meanings of differentiated care based on the subsystem¹. Moreover, it was possible to broaden the discussion about other Native American peoples, especially with regard to overcoming the tutelage and the strengthening of the indigenous individual as a citizen³⁷.

An interesting dynamic was carried out to discuss the provocation: "Tutored indigenous individual or citizen?". Based the film "*Índio Cidadão?*" (Indigenous Citizen?), each participant was invited to write on the cards about the aspects they considered relevant to the trajectory and continuity of the struggle to attain indigenous rights. After the film, the group gathered around a large table where the cards were arranged and organized into nuclei of meanings in the middle of the collective discussion. At the end, a reading was carried out listing all the cards and summarizing the construction of the group regarding the indigenous struggle for the rights to land, health and education, recognizing the achievements and the setbacks.

Table 1

Set of central provocations, topics and contents developed in the Talking Circles, 2016 - 2019.

Thematic groups	Central Provocations	Main concepts and contents worked upon
Identity Issues	What does it mean to be indigenous? (*)	Indigenous identity; Brazilian identity; Historical process of Brazilian colonization; Indigenous in contemporary times.
	What are the differences between indigenous peoples?	Concept of ethnicity and people; Linguistic diversity; Amerindian peoples.
	Indigenous people in the city: what prejudices do I have?	Prejudice and intolerance; Deconstruction of the idea of “acculturation”; Affirmative Action Policies.
Indigenous Health Care	What are the connections between health and culture?	Concept of Health; Concept of Culture; Sociocultural construction of the disease.
	Health education with indigenous people: can we do it?	Popular Education in Health; Community approach; Ethnocentrism.
	Teaching or learning in the context of indigenous health?	Cultural conflict; Learning from the differences; Intercultural dialogue.
	What are the specificities of indigenous women’s health?	Self-care of indigenous women; Indigenous women and community; Gender and generation.
	What is the meeting between biomedicine and indigenous people like?	The experience of illness; Respect for traditional practices; Cultural specificities.
	What should be taught for the work in indigenous health?	Respect and tolerance; Differentiated health care; Cultural competence.
	What are the relationships between cosmology and indigenous health?	Cosmology and complex planetary vision; Amerindian perspective; Relations between cosmology and health.
Indigenous Rights	Tutored indigenous individual or citizen?	Citizenship; Historical process of acquiring rights; 1988 Constitution.
	Are indigenous rights the same as non-indigenous rights?	Equities and inequalities; Historical colonization process; Activism and preservation of rights over land, education and health.
	Why is there a health subsystem for indigenous people?	Indigenous Health Subsystem (SASI-SUS); Principles of the National Indigenous Health Policy.
	Indigenous health as a right: is it necessary? ”	Differentiated health care; Basic structure of the indigenous health network; Special Indigenous Health Districts (DSEI).
	Municipalization of health: a premature death?”	Historical process of SASI-SUS creation; List of SASI-SUS and municipal networks; Challenges of SASI-SUS.
	Why should indigenous people be at the university?	Affirmative Actions and Diversities; Ethnic-racial relations in higher education; Affirmative Action local policy guidelines.

(*)Provocation developed in two meetings;

Source: Prepared by the authors.

Evaluation of participants and coordinating students

During the three years of the Project, evaluations of the process were carried out with the participants at different times; however, their content was not recorded. Aiming to rescue these materials, we located the assessments for the year 2017, carried out at the last meeting of that year. An unidentified printed questionnaire was used, with open questions, which was distributed to the participants. We sought to assess the main lessons learned in that space, their positive aspects and their flaws. As learnings highlighted by the group, the sharing of ideas and new perspectives between indigenous and non-indigenous people were mentioned; the rescue of identity narratives and the reaffirmation of traditional knowledge; the identification of the contemporary situation of indigenous peoples from different regions of Brazil; the construction of knowledge amidst the diversities; the breach of stereotypes about the generic indigenous individuals; developing tolerance, respect and a broader view of people; and favoring indigenous activism and resistance.

The positive aspects evaluated by the participants were the identification of the Circles environment as an opportunity to listen, speak and exchange knowledge, information and opinions, in a meeting between indigenous and non-indigenous people, students and professionals from different courses and areas of knowledge, with a rich interaction among all. It reinforced the idea that the environment was always protected, and people could talk without being afraid of different opinions. Moreover, it was identified as an welcoming environment that awakened individuals to different ways of understanding science and health, both for students in the health area, as well as for students from other areas, such as education and engineering.

The identified flaws comprised the low participation of professors and people outside the University; precarious disclosure; and ending of meetings extended beyond the scheduled time. There were also suggestions for continuing the Extension Project and maintaining methodological strategies that favored the participation of all those present.

From the point of view of the three indigenous students who were coordinators of the activity, some other aspects were highlighted, such as the recognition of the Project environment as a possibility of authorship by the indigenous students themselves, both for having a format that portrayed the exchange of knowledge, and for the fact they are also coordinators of the activity. Another highlighted learning point was the understanding of the pedagogical strategies, the ability to register, plan and evaluate activities, which also made it possible to write scientific manuscripts and participate in events.

DISCUSSIONS

The Talking Circles about the Health of Indigenous Peoples comprised spaces for reflection, discussion and dialogue between different actors, with an exchange of knowledge and personal experiences. The meetings allowed the construction of knowledge, as proposed by the Culture Circles²⁴, which reinforces that the talking circle is more than the circular arrangement of chairs, but there must be a critical commitment to think about society and give voice to the divergent individuals²⁶.

The use of strategies and instruments inspired by active methodologies^{26,27,28} sought integration among the participants, favoring a construction based on previous experiences and individual gaps, in addition to encouraging the collaboration of those who participated less.

The improvement of activities was progressively carried out over

the years, with ongoing assessments and planning, trying to advance according to the needs of the group. This shared construction strategy, similar to that described in other experiences, allowed the participants to recognize that space as their own, a generator of connection and one that valued subjectivities^{25,30}.

Moreover, learnings that were similar to those constructed in this experience were reported by other extension projects on indigenous health, with emphasis on overcoming stereotypes about indigenous people, recognizing the knowledge of others as complex, respecting different cosmologies and social commitment to overcoming inequities^{10,12,13}. A different characteristic when compared to other projects is that the 'Talking Circles' were developed at the University in an environment open to anyone interested, which enhances the multiplier effects of this experience. However, there was no experience of immersion into the realities of these communities, which limits some learnings when compared to those described in other studies.

Another singularity of this experience is the fact that the construction takes place with the indigenous protagonists, pointing to innovative perspectives on the understanding of health, illness and healing processes, even raising the possibility of rethinking the role of environments for the construction of knowledge and the University. In this sense, there was an approach on indigenous perspectives about the world, seeking to overcome prejudiced and Eurocentric views, as often developed in teaching spaces^{10,33}.

From this viewpoint, one can envision possibilities of building more appropriate strategies for indigenous health care with indigenous people who are students or professionals in the health area. However, for that to occur, it is necessary to have an environment for their traditional knowledge to emerge, as health graduation courses scarcely provide knowledge beyond conventional biomedical knowledge, with difficulties in including other issues related to the recovery of individual and collective health⁷.

In Talking Circles, the topics initially more restricted to health were expanded and took on a broader and more comprehensive frame, based on the group's own perception that, to discuss health and care, it was necessary to broaden the understanding in relation to issues such as identity, cosmology and cultural sensitivity. Access to land, the right to a differentiated health system, and Affirmative Action programs for the inclusion of indigenous people in the university, also emerged from the group as essential elements for achieving the health of this population.

FINAL CONSIDERATIONS

This was an opportunity to carry out an interdisciplinary Extension Project within the University and with the participation of the external community, which reinforces the commitment to social issues by constructing shared channels. During the activities of the Talking Circles, we sought to build a space to learn and reflect about the health complexity of indigenous communities, dialoguing with different cultures, specific health policies, conceptions of the health-illness process, providing an initial approach to the context of indigenous health in Brazil.

The discussion about the topic of indigenous health contributes to the qualification of future and current health professionals and may awaken the sensitivity regarding the ethnic-cultural specificities, or even working in indigenous health teams. This dialogue also points to possibilities for the creation of optional interdisciplinary disciplines and inclusion of the indigenous health topic in the curricular matrices of

different undergraduate courses in the health area, which may favor the development of cultural competence for the future health professional, regardless of their working scenario.

In addition to the construction of new interdisciplinary knowledge, these activities gave visibility to the presence of indigenous individuals at the University, aiming to make it plural and more representative of the Brazilian population diversity.

After this period of development of the Talking Circles, one might ask what still needs to progress in the constructions and understandings about the Health of Indigenous Peoples. Being in this meeting place among so many diversities affects everyone at every movement, making participants increasingly more sensitive regarding the importance of providing training both for working in the indigenous context and for the training the indigenous themselves so that they can use other epistemologies, intrinsic to indigenous peoples, which can meet the legitimate needs about the illness, the body and health in its complexity. But these are questions for the next Talking Circle.

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AUTHORS' CONTRIBUTION

Authors Willian Fernandes Luna and Cecília Malvezzi were in charge of the methodological planning of the research. All other steps were carried out by all authors.

CONFLICTS OF INTEREST

The authors declare there are no conflicts of interest regarding the writing of this manuscript.

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