

## More Doctors Project in indigenous health: reflections from an opinion survey

Maria Angélica Breda Fontão(a)

Éverton Luís Pereira(b)

(a) Departamento de Atenção à Saúde Indígena, Secretaria Especial de Saúde Indígena, Ministério da Saúde. Setor de Rádio e Televisão Norte – SRTVN, Quadra 701, Bloco D – Edifício PO 700 – 5º andar – Brasília DF. maria.fontao@saude.gov.br

(b) Departamento de Saúde Coletiva, Faculdade de Ciências da Saúde, Universidade de Brasília. Brasília, DF, Brasil. evertonpereira@unb.br

The study aims to contribute to the analysis of the implementation of the Project More Doctors for Brazil in the Indigenous Special Health Districts, with data produced by opinion research developed in communities that are served by Project's physicians. The present analysis presents a set of data produced by a questionnaire applied to indigenous communities and then compared with the general universe of the same research in municipalities. The study identifies a significant increase in the number of physicians working in indigenous health, a positive perception of satisfaction with the project pointing out a non-exclusive relationship between access to biomedical services and the use of indigenous therapeutic practices. It also demonstrates the need to expand research on the consequences of the More Doctors Program, especially on qualitative and ethnographic bases. *Keywords:* Indigenous health. Project more doctors for Brazil. Survey research.

## Introduction

The Project More Doctors for Brazil (PMM) was enacted by the Brazilian government in July 2013, within the scope of the More Doctors Program created from Provisional Measure n° 621<sup>1</sup>. According to the official documents of the Program, it is composed of three main axes and is part of a strategy to improve service to users of the Brazilian National Health System (SUS) increasing coverage of physicians in basic care in vulnerable areas. The first axis foresees investments in health equipment infrastructure, the second aims to improve and expand medical education in Brazil, by increasing the number of places in medical courses and medical residency in priority places for the SUS. The third axis, which this paper deals with, seeks to urgently solve the shortage of physicians in the countryside and the outskirts of major cities.

The selection of Brazilian and foreign professionals for the Project's vacancies is done through the classification according to different profiles. The profile of greater vulnerability is the one related to the Indigenous Special Sanitary Districts (DSEIs). DSEIs are decentralized units of the Ministry of Health (MS), linked since 2010 to the Special Secretariat of Indigenous Health (SESAI), responsible for carrying out the actions of the Subsystem of Care to Indigenous Health (SASI-SUS). SASI-SUS was created under SUS under Law 9836/1999 (Lei Arouca) to organize actions and health services aimed at serving the indigenous populations.

According to the National Policy on Health Care of Indigenous Peoples (PNASPI)<sup>2</sup>, the DSEI organization is geared towards serving a well-defined dynamic, geographic, populational and administrative ethnocultural space. It is responsible for carrying out activities in the indigenous territory, aiming at rational and qualified health care measures, promoting the reorganization of the network and sanitary practices and developing administrative and managerial activities needed to provide assistance to indigenous peoples.

Although PNASPI established that the health teams of the districts should be composed of doctors, nurses, dentists, nursing auxiliaries and indigenous health agents, the daily work of the teams was historically marked by the absence of medical doctors,

especially in the “Legal Amazon” region. This reality has been changing since the beginning of the PMM. According to data from the Special Secretariat of Indigenous Health, in two years, 339 doctors were incorporated through the PMM into the DSEIs<sup>(c)</sup>. This means a 79% growth over the number of doctors working in this body in August 2013.

The implementation of PMM in DSEIs is configured as a timely experience for research and analysis in the areas of collective health, health anthropology and related matters. This area of action is a priority for the project objectives, especially for the difficulties of placing professionals, the logistical and operational complexities and for presenting characteristics of the interethnic context. In addition, this experience is unique in the history of indigenous health, making the presence of medical professionals a reality in most of the country's indigenous communities.

After almost three years of initiating the Project's implementation, we have few publications and/or studies that portray or evaluate this experience in indigenous health. For this reason, it is identified as necessary the deepening of reflections about the benefits and challenges that the significant presence of doctors in indigenous area represents for the health situation of these populations and also for the relation between the proper practices of care of these peoples and the official and/or hegemonic health system.

In order to contribute to the reflection, this paper presents and analyzes data about the More Doctors Project in indigenous health produced by an opinion survey developed in 2014 by the Public Opinion Nucleus of the Federal University of Minas Gerais (UFMG)<sup>(d)</sup> in partnership with the Institute for Social, Political and Economic Research (IPESPE)<sup>(e)</sup>.

## Methodology

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<sup>(c)</sup> Data presented at the meeting of the Inter-Sectoral Commission on Indigenous Health (CISI) of the National Health Council held on September 1, 2015.

<sup>(d)</sup> UFMG. Faculdade de Filosofia e Ciências Humanas – FAFICH Departamento de Ciência Política. Termo de Referência para Avaliação de política pública para saúde no Brasil: Programa Mais Médicos. Belo Horizonte; 2014 (mimeo).

<sup>(e)</sup> IPESPE. Instituto de Pesquisas Sociais, Políticas e Econômicas. Pesquisa de Opinião Mais Médicos: comunidade assistida – 2º fase. Relatório. 2015 (mimeo).

A reflection was made on the basis of the quantitative data produced by the above-mentioned opinion poll. The Ministry of Health commissioned it and data are under the domain of the sponsor, being granted authorization for access to them by the Board of the Department of Planning and Regulation of Provision of Health Professionals of the Secretariat of Labor Management and Health Education. The Research Ethics Committee (CEP) of the Federal University of Minas Gerais (UFMG) with the number 796.913, dated September 19, 2014, approved the research.

The research was carried out in two phases. The first included only physicians linked to municipal services. Semi-structured questionnaires, designed for application with doctors, municipal managers and assisted community in Basic Health Units of the municipalities. The data produced by this phase will not be presented and/or analyzed in this paper.

We will focus on the second phase of the research, in which the researchers adapted the questionnaire in order to be applied with professionals from DSEIs (district and medical coordinators) and the indigenous communities. The changes were made with the aim of adapting the terminologies of SASI-SUS organizational structures, seeking to maintain comparability with the other questionnaires applied and the general parameters of the research. Specific questions were inserted for the indigenous context, such as the ethnic identity of the interviewee, information about childbirth carried out in the village and search for traditional therapeutic resources.

A total of 613 indigenous people assisted by PMM were interviewed. In order to be analyzed separately, the selection of the sample for assisted communities was done in such a way that it could be included in the general scope of the research, with a margin of error of less than 2.0% and reliability of 95.45%, representative of this profile.

The questionnaires were structured in five blocks: profile of the interviewee; evaluation of physicians; knowledge and evaluation of the More Doctors Program; public health services; team evaluation. The one used with the indigenous populations contained 67 questions. Responses were analyzed from quantitative data crossings and also in a

comparative way with the answers to the questionnaires applied in the population served in the municipalities.

The quantitative type of opinion research has limitations that do not allow the understanding of the perception of the subjective elements and of the motivations that underpin the answers. These restrictions are most noticeable in a context in which the interviewees do not share the same hegemonic cultural codes, as is the case of indigenous populations. This is even more obvious when the respondents do not speak the language of the researcher, as is the case of 12.2% of the participants.

Another possible limitation is the use of the generic category "indigenous". The use of this term homogenizes and does not explicit the diversity among the indigenous peoples who live in Brazil. According to the 2010 IBGE census, 305 ethnic groups and 274 languages are identified in the national territory. The 613 individuals interviewed were part of 43 ethnic groups. However, due to the characteristics of the research and to the limited number of individuals interviewed by ethnicity, it was not possible to adopt an ethnic breakdown for the analysis.

Bearing in mind the limitations presented, it was considered relevant to work the data of the opinion survey due to its unprecedented nature, the restriction of available information and the relevance of the subject. Thus, it is intended to contribute to the reflection and the public debate about the PMM for Brazil on indigenous health, its characteristics, potentialities and challenges for the consolidation of the differentiated attention advocated in PNASPI.

### **Theoretical reference used for research questioning**

Teixeira et al.<sup>3</sup> demonstrated that the production in the field of indigenous health has had a significant increase and consolidation in the last fifteen years, propitiated by the process of democratization in the country and implementation of SASI-SUS, together with the expansion of postgraduate programs and knowledge exchange spaces favored by scientific organizations. Utilizando o argumento das autoras, podemos pensar o

desenvolvimento do campo de acordo com três momentos históricos específicos que trazem debates teóricos pontuais: antes e depois da Constituição Federal de 1988 e a partir dos anos 2000.

Before the 1990s, health problems in ethnographic studies with indigenous populations were linked to the classic themes of anthropology such as shamanism, ritual and cosmology. This movement was influenced by the emergence of the indigenous movement and sanitary reform and its contributions to ensuring health as a universal right and duty of the State, in the recognition of the right to land and the ethnic specificities and cultures of indigenous peoples. The 1990s present the strengthening of the field<sup>4</sup> and a new calendar of research on indigenous health.

In the 1990s, reflections arose on indigenous concepts of health and disease, indigenous medicine or ethnomedicine, the "impact" of the use of medicines and other Western medical goods on the set of indigenous representations, reflections on public policies, organization of the Indigenous peoples' subsystem, indigenous health agents and other actors involved in the implementation of this policy. In addition, the field of public health has focused on the production of epidemiological studies, discussion of health indicators and operational and conceptual aspects of health surveillance<sup>3</sup>. The transformation of the political and sanitary reality of the country and the increase of the rights of the populations provoked the increase of the field: the forms as the natives give meaning to the disease–health process, as well as the interaction between the services of the State and this population appeared in the research agendas.

The expressive increase in productions on the subject starting in the 2000s. Teixeira et al.<sup>3</sup> identify two current trends in studies on indigenous health: (i) problems related to therapeutic itineraries; (ii) analysis of the interface between the State, health policies and indigenous populations, especially in the reflection on how care is organized. What we have, thus, is the expansion of studies on the permeability of the different actions and conceptions in the therapeutic choices of the natives.

The development of the field of indigenous health indicates that the movement of the structuring of the State and of the health services has caused important impacts on the

productions and theoretical references. Transformations of political and administrative order of the country contribute to the need for other looks and new ways of thinking. In the context of the PMM insertion, some analytical models should be used to understand the reality presented by the research, especially those that dialogue with the interaction between indigenous and health services<sup>5,6</sup>, as well as the proposals and challenges of "differentiated services"<sup>7</sup>. Understanding this gives us elements to think about the research presented here.

On the established interaction between indigenous and health services, Cardoso<sup>8</sup> points out that

(...)from the indigenous point of view, access to biomedical care seems to mean not only a necessary therapeutic resource, but also services (mainly medicines) are understood as 'goods', which tend to be incorporated and put into circulation according to the dynamics of social and political relations (p.102).

As access to health services is largely perceived positively by indigenous people, it is important to consider the role and hierarchical position of the physician in biomedicine in order to understand the results presented in the research. In a study on hegemonic medicine and indigenous medicine among the Yaminawa on the border between Brazil and Peru, Sáez<sup>9</sup> describes the vision of these people about the doctors of the city.

For Saéz<sup>9</sup>, The relations between these two worldviews present a mark of otherness that can be thought of as a certain prestige represented by the other (be it indigenous medicine for non-indigenous people or biomedicine for indigenous people). Following the author's reasoning, there is a symbolic prestige of "distant doctors" linked to aspects of the physician-patient relationship and this may influence the perception and expectation about the PMM, especially in the data presented here.

On the one hand, we perceive a dynamic reality in the interaction of indigenous and health services, and on the other, it is necessary to reflect on the power relations established in the doctor-patient contact. Menéndez<sup>10,11</sup> and Silva<sup>12</sup> consider that the asymmetries of power derive from the history of political struggle for the construction of medical authority, of "knowledge power" and also of the relation "hegemony-subalternity" that biomedicine establishes over other forms of non-biomedical attention.

The principle of "scientific rationality", as pointed out by Menéndez<sup>11</sup>, can be considered the milestone from which biomedicine professionally identifies itself as a science and distances itself from other forms of health care. Non-biomedical practices are treated as hierarchically inferior and identified as "unscientific" or pejoratively linked to "cultural dimensions". In this relation, other practices would tend to be excluded, ignored and stigmatized or, when accepted by biomedicine, appropriate as complementary use.

The dubious relation of the natives presented by the analyzed ethnographies shows that, on the one hand, we have a context of interaction between different conceptions of medicine – one based on hegemonic biomedicine and another one that takes into account the traditional practices. On the other hand, they help us to understand the imbricated power relations with the insertion of biomedical knowledge in indigenous communities.

These two theoretical elements are essential for the analysis of the data presented by the opinion survey on PMM in DSEIs. In addition, they demonstrate the importance of a more in-depth reflection on the idea of differentiated services, a key concept of PNASPI.

Langdon<sup>13</sup> defines differentiated services not as the incorporation of traditional practices into health services, but as a link between services and self-care practices in the communities. Although the "differentiated services" is a concept proposed since the 1st National Conference of Health of the Indigenous Peoples, the author considers it a challenge for the daily life of the DSEIs.

PNASPI reinforces the existence of other ways of understanding, living and explaining the health and illness process, thus distancing itself from the conception of biomedical hegemony. The concept of "differentiated services" and the guideline of articulation with traditional indigenous health systems are strategies present in the Policy to overcome these asymmetries. However, the implementation of the model of differentiated services in the work of biomedicine professionals with indigenous peoples remains a challenge that is also presented in the context of the PMM.

The opinion survey analyzed in this paper provides elements for reflection on the issues raised. We selected data from the interview with indigenous communities assisted by the Program, prioritizing those who comparatively stood out from the data of the research



with populations of municipalities or those that brought relevant aspects in the dialogue with other research data produced on indigenous health.

### **Profile of interviewees in indigenous communities**

The More Doctors Project interviewed a total of 613 indigenous people. These were included in 43 different ethnicities, 87.8% of whom were identified as speaking fluent Portuguese, 4.4% did not communicate in Portuguese and 7.8% spoke Portuguese, but with difficulties. Interpreter support was required for 11.4% of interviews.

Regarding gender, 66.4% of the interviewees were women and only 33.6% were men. In the universe of the research, including the municipal profiles, women were responsible for 80.5% of the responses obtained, with a tendency of greater participation of women in the research, although there is a significant difference between the percentage in the indigenous communities when compared to the general population.

The data corroborate the trend indicated in the available literature on the subject<sup>14,15</sup> stating that indigenous women are becoming important interlocutors between their groups and non-indigenous society, participating in the struggle for the rights of their people and in the dialogue with the policies developed by the Brazilian State.

We also know that the methodological design may have contributed to greater access to the female population, given the orientation of the research in which the interviews should be conducted within the health services. This issue may have been relevant in the two contexts, especially in the municipalities, considering what has been pointed out in the literature about the service and privileged access of women to health services<sup>16</sup>. However, the research data do not allow affirming that the researchers' choice in indigenous communities was exclusively in the places where the care was given, since there are own dynamics of interaction with non-indigenous in the villages.

Regarding the methodology adopted in the research, in the case of indigenous communities, the places where the teams perform the services are not configured in the same way as in the municipalities and there are no health structures in all the communities.

It was identified that the appointments performed by the health teams happened as follows: 30.5% at the base center; 47.1% in the post or basic health unit; 12.1% in community village spaces; 5.7% in schools; and 0.3% in households.

With regard to the number of children, a different profile was observed between DSEI and municipalities. In the municipalities, 52% of those interviewed reported having up to two children and 26.3% did not have children. In the DSEIs, only 15.8% had no children, 38.5% had one to two children, 34.1% from 3 to 5 and 11.5% had more than six children. The survey found responses of up to 14 children (0.3%). These data possibly indicate more than just birth elements, given the varied notions of kinship and affiliations existing in the different indigenous societies<sup>17</sup>.

Another result of the survey was that 70.3% of the people interviewed in DSEI claimed to be beneficiaries of the Bolsa Família Program, a much higher number than the population interviewed in municipalities, where only 38.6% reported receiving the benefit. In the responses of the *Quilombola* populations, also seen as vulnerable by the PMM, only 47% of the interviewees affirmed receiving Bolsa Família, significantly lower than the indigenous population interviewed. This fact in the indigenous population brings a relevant element to indicate the access to different services and social programs of the State by the indigenous communities.

When questioned, 69.8% of the natives interviewed responded to have access to some source of income. Of these, 31.8% answered that they work as a family farmer or rural worker, 14.5% retired or similar, 15% artisan, 3% indigenous health agent, 1.9% teacher, 0.7% cleaning or maid services, 33% have other occupations or other sources of income.

These questions indicated that a significant part of the interviewees establishes monetary relations, access income programs and social benefits and maintains commercial relations with the municipalities and societies in which they are inserted. Although there is no greater detail of this aspect, the data point to elements for the dialogue with other studies that have analyzed the insertion of programs and social benefits in indigenous communities and processes of change in the dynamics of social relations.

## The insertion of medical doctors in the Indigenous Special Health Districts by the More Doctors Project for Brazil

The opinion survey referred in this paper brings elements that indicate an expansion of access to health care by medical professionals in the communities interviewed. The magnitude of this phenomenon is especially significant for the DSEI profile, when we compare the results of the research with the profiles of municipalities.

47% of indigenous people stated that the health team that serves the community lacked a physician before the start of the PMM. When we look at the absolute data of the survey (all profiles of respondents), we noticed that only 31% said they had been without a doctor.

The data indicate a change in the composition of the Multidisciplinary Indigenous Health Teams (EMSI) with the incorporation of physicians. Teixeira<sup>3</sup> pointed out in a review on indigenous health research that nursing professionals were the key figure in this policy. Silva<sup>12</sup> corroborates these data in the context of research on health care in the Tapajós region as well as Souza<sup>18</sup>, when dealing with the process of supervision and changes from the More Doctors Program in the indigenous area in the context of the Amazon.

In addition, 28% of the respondents from the indigenous communities profile stated that they had stayed for more than one or two years without a doctor. The same response in the other profiles was of a maximum of 11%, including in the cut with *Quilombola* populations and municipalities with more than 20% under poverty line. These data indicate that although the medical quantification in DSEI is numerically lower than the number of PMM participants, representing only 1.8% of the total in August 2015, it was in this territory that the program seems to have reached its original objective to provide physicians in regions with a shortage or absence of this professional.

The data also include elements that relate to other attributes of primary health care, especially the continuity of care and establishing bonds. The research conducted indicated that 56.2% of the natives were treated three or more times by the same physician while only 18.1% once. A large share (73.2%) of the interviewees reported that the doctor

visited the patients' homes. Another interesting aspect is that 79.4% of the interviewees stated that they did not have difficulties in communicating with the doctor, although almost all of the physicians in DSEI at the time were foreigners, especially Cubans.

In the literature on the subject, these attributes are related to the care model advocated by the Family Health Strategy<sup>19</sup> which provides for the recognition of the living conditions and needs of the population in order to allow a broader understanding of the health and disease process<sup>20</sup>. Another important issue is regarding establishing and keeping bonds for better health care. These competences are also related to the concept of differentiated attention that must be based on cultural competence.

We cannot affirm, from the data produced by the research, that these attributes are present in the performance of the professionals of the program. However, they point out aspects that could be better developed in other studies, especially of an ethnographic nature.

In this context where coverage of medical professionals in the area appears no longer to be a significant problem for indigenous health, a number of new and not minor challenges emerge, that should be considered. Among them are the training of these professionals to work in an intercultural context (a very important debate in the literature on the subject and equally relevant for the consolidation of PNASPI<sup>21,22</sup>), the sustainability of the experience of the More Doctors Project, considering the continuity of care and the link, and the evaluation of the impacts of the program on indigenous health. It is also necessary to evaluate the changes produced and their meanings in the social dynamics from the greater presence of doctors in the indigenous communities, considering the asymmetries of power established in the doctor-patient relationship and in the relation between biomedicine and other forms of health care.

### **Perception of the indigenous people interviewed about the More Doctors Project for Brazil**

Another aspect that was addressed by the research concerns the perception of the indigenous people interviewed about the PMM. It was observed that only 54% of DSEI

respondents stated that they knew or had heard about the Program before carrying out the research. This data is smaller compared to the general universe of the research, in which it was identified that 74% of respondents stated that they knew about the program.

One element that seems to have been relevant to this prior knowledge was access to the mass media. The television was highlighted and pointed out as the main vehicle for the dissemination of information in all cases: 90.6% in municipalities and 87.6% in DSEI.

It was also stated the high level of satisfaction with the PMM physician working in the indigenous communities. The average score given to the doctors was 8.7 (on a scale of 1 to 10), and 93.1% of the respondents reported having been satisfied or very satisfied with the work of these professionals and only 4.1% would be dissatisfied.

As we have pointed out previously, these figures reflect the respondents' specific responses at a moment of questioning of the interviewer. Still, they seem to indicate a rather positive perception that should not be disregarded. Such perception may be related to the satisfaction with the expansion of the access in the villages to biomedical services, which is a demand of the indigenous movement to realize the right to health<sup>8,23</sup> and also by the way indigenous people interact with biomedicine and its agents, as previously pointed out.

When we cross the research data, we observed a relationship between the satisfaction responses with the doctor and prior knowledge of the program. The answers indicate that the more they knew him, the greater the chance of being satisfied with the professional linked to him. We can observe this relation in the table 1 below:

Table 1. Satisfaction with the doctor and prior knowledge of the Program

		Do you know or have heard of the More Doctors Program?			Total
		Know it/Have heard of it	Don't know	Don't know/Didn't answer	
With regard to the doctor working in the community you are...	Very satisfied	59,5%	39,3%	1,2%	100%
	Satisfied	52,8%	47,0%	0,3%	100%
	Unsatisfied	36,0%	64,0%	0,0%	100%

Don't know/ Didn't answer	52,9%	47,1%	0,0%	100%
Total	54,0%	45,5%	0,5%	100%

\*Source: IPESPE, 2015

The research data suggest a trend towards greater satisfaction with the professional by the individuals who knew the program previously and previously had some expectation regarding it. On the other hand, we cannot observe a numerically significant difference between those who said they were simply satisfied.

### **Elements on the relationship between biomedical and indigenous health practices in the context of the More Doctors Project**

In the questionnaire applied to assisted DSEI communities, the following question was included: "In addition to the doctor, do you seek to take care of your health with people in your community, such as the shaman, midwife, Raizeiro, healer?" Possible alternatives to this questioning were "yes", "no" and "no response".

The answers were distributed as follows: 61.5% of the interviewees stated that besides the doctor they also seek to take care of their health with indigenous specialists; 37.7% answered negatively and 8% did not respond. It is considered relevant that more than 60% of respondents recognized, in terms of the question, that in addition to biomedical attention, they also seek other indigenous therapeutic strategies.

These data, however, should be treated with caution, since it cannot be verified that 37.7% of the interviewed individuals take care of their health exclusively by accessing the biomedical services offered by the DSEI, although they answered negatively the question. Likewise, we cannot affirm that these subjects/communities lack their own therapeutic systems. It is necessary to consider that the ways in which indigenous groups understand their health systems are diverse and information on the search for other services (other than biomedical ones) is not always mentioned, considering the relations of hegemony established with the services of the State.

The manner of naming and producing meaning on indigenous specialists and/or models and practices of care may vary significantly. The data presented in the previous paragraph indicate that a significant number of respondents claimed to seek other techniques/experts, however, we do not know what they understand when asked about it.

The recognition of the effectiveness of biomedicine by indigenous peoples has been analyzed by several researchers<sup>8,9,23</sup>. These authors point out that biomedical services, when accessible, are usually part of the therapeutic itineraries of the indigenous. Biomedicine is largely presented as an alternative or "complementary coexistence"<sup>8</sup>, used by indigenous people based on their conceptions of health and disease processes. Langdon<sup>23</sup> indicates that the choice of therapies depends on the stage and type of the disease and is based on several aspects such as the perception on the prognosis, cause and individual and group experiences.

Some crosscheck of opinion data reinforces the perception that there is no exclusive relation between access to care by the medical service and the coexistence of indigenous therapeutic systems. Of the interviewees who affirmed the presence of doctors attending the community before the program, 44.6% answered positively the question about the search for health care with indigenous specialists. The same positive response occurred in 41.1% of those who said that the community would have been without medical care. We therefore identified that there was no significant difference linking the positive response to this question to whether or not there was medical care in the community prior to the program.

Thus, the data suggest that there are no single choices in health actions. That is, the presence or not of physicians with more or less frequency would not necessarily impact the search for indigenous therapeutic resources. Thus, there seems to be no exclusive relationship between indigenous therapeutic resources and time without medical care in the community, since even those individuals who had access to the biomedical service affirmed using other health care practices not restricted to this model. The data reinforce the argument that there is no antagonistic perspective among health care models that, instead of being excluded, would tend to be used by communities in an integrated way<sup>10,11</sup>.

## Final considerations

The opinion survey discussed in this paper had the merit of raising issues relevant to the debate on indigenous health in Brazil. The presented data should be analyzed under the light of possible criticisms about the subjective notions of the subjects when responding to a structured questionnaire, especially in a context of ethnic-cultural difference such as the case of the indigenous. However, the possible reflections obtained from the reading of the indigenous responses, with the aid of the theoretical discussions of the field, present a potential motivation for other analyzes. More than previous answers, the opinion survey presented here is seen as an important locus for the production of other questions that can be answered with qualitative research.

The research pointed out that the difficulty of providing access to medical care in indigenous health was met in part and in an emergent fashion with the More Doctors Project for Brazil. However, despite the significant increase in the coverage of medical professionals, the challenges of the Subsystem of Indigenous Health Care remain; the consolidation of a differentiated medical care model that considers the articulation with indigenous health knowledge and practices. In addition, it is also a challenge to assess their impacts and the sustainability of this experience, considering the temporal limitations established by the program.

The data suggest a positive perception among the indigenous about the More Doctors Project for Brazil, which is related to the satisfaction with the physician and the previous expectation of those who knew or heard about the PMM. This perception is possibly related to the positive perspective of the indigenous on access to biomedical services, understood as a right, in addition to the symbolic prestige of the medical profession, based on the dynamics of biomedical power itself.

The data showed that there is no exclusive relationship between the demands for services as offered by the biomedical system and the indigenous therapeutic practices and systems. They also point to the need to deepen the reflections on the More Doctors Project through ethnographic studies that may allow broadening the understanding of the meanings



it acquires in the indigenous context, as well as the changes in the dynamics of the teams and in the relationship between the indigenous and the biomedical services.

### **Collaborators**

Maria Angélica Breda Fontão conceived the paper, analyzed and discussed the results. Éverton Luís Pereira discussed the results and analysis of the data. The two authors participated in the final review of the paper.

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