ARTICLE ORIGINAL

DOI: 10.15343/0104-7809.202650e18802025I
ISSN: 1980-3990

# Interprofessionality in indigenous areas: enhancing and strengthening the role of health surveillance

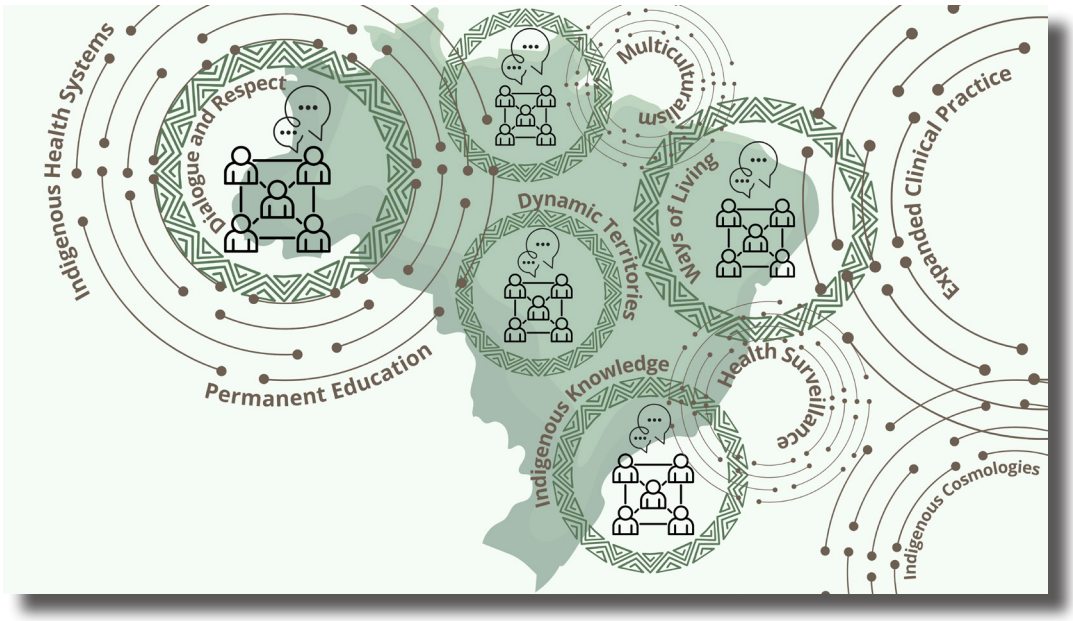
**Maurici Tadeu Ferreira Santos**[1] **Pâmela Roberta de Oliveira**[2] **Selma Aparecida Chaves Nunes**[1] **Tiago Falanque Maltez**[2] **Ana Elisa Rodrigues Alves Ribeiro**[3] **Kelly Clair de Moura da Costa**[4] **Lavínia Santos de Souza Oliveira**[1]

[1]Universidade Federal de São Paulo – UNIFESP. São Paulo/SP, Brasil.
[2]Universidade Federal de Mato Grosso – UFMT. Barra do Garças/MT, Brasil.
[3]Faculdade de Odontologia de Ribeirão Preto (FORP), Universidade de São Paulo – USP. Ribeirão Preto/SP, Brasil.
[4]Universidade Federal de Goiás – UFG. Goiânia/GO, Brasil.
E-mail: maurici.santos@unifesp.br

**Highlights**

- *Reflection on interprofessionality in the complex field of indigenous health.*
- *Obstacles that hinder better outcomes and improved health indicators.*
- *The urgent need to strengthen the efficiency of the health surveillance model linked to the concept of territory, targeting factors that enhance the problem-solving capacity of care networks.*
- *The central role of expanded clinical practice, educational processes, and the construction of dialogical spaces of complicity within the territory, as structural axes and propositions of health surveillance, with the aim of stimulating and qualifying interprofessionality.*

**Graphical Abstract**




Prepared by the authors with the assistance of artificial intelligence (illustrative image).

**Abstract**

Indigenous Health Care in Brazil encompasses 391 peoples, with broad cultural diversity and structural and educational challenges for interprofessional work. This study aims to reflect on the obstacles, potentialities, and propositions for strengthening interprofessionality within the Indigenous Health Care Subsystem (SasiSUS). This is a critical-reflexive essay, grounded in the professional experience of the authors and in the literature pertinent to indigenous health and interprofessionality. We identified barriers such as insufficient numbers of qualified professionals, uniprofessional training, high staff turnover, care gaps, and the absence of specific protocols. We propose the strengthening of the health surveillance model, which includes the expanded clinical practice approach, the valorization of ongoing intercultural educational processes, and the co-constructed collaborative spaces between biomedical and indigenous knowledge systems. The integration and consolidation of an effective health surveillance model requires technical, cultural, and communicational competencies, shared therapeutic planning, and respect for diversity. Continuous educational processes – both face-to-face and distance-based – can expand collaborative capacities and overcome fragmentation in care. Interprofessionality within SasiSUS depends on curricular changes, active methodological strategies, collaborative practices, and the urgent need to strengthen and sustain the model of territoriality and health surveillance, supported by ethics, interculturality, and co-responsibility, aiming at greater problem-solving capacity and quality of care.

**Keywords:** Indigenous Health. Interprofessionality. Health Surveillance. Permanent Educational Processes. Expanded Clinical Practice.

**Associate Editor:** Edison Barbieri
Mundo Saúde. 2026,50:e18802025
O Mundo da Saúde, São Paulo, SP, Brasil.
https://revistamundodasaude.emnuvens.com.br

**Received:** 05 november 2025.
**Accepted:** 06 may 2026.
**Published:** 27 may 2026.

©2025. This is an open-access article distributed under the Creative Commons Attribution 4.0 International License (CC-BY), which permits unrestricted use, distribution, and reproduction in any medium, provided that the original author and source are credited.

## INTRODUCTION

***The problem and its context in the brazilian indigenous scenario***

Health professionals who enter indigenous territories encounter communities that have inhabited these lands for thousands of years, displaying extensive cultural, political, and social diversity, represented by a vast material and immaterial inventory of beliefs, traditions, rituals, values, meanings, and significance.

In their totality, these areas encompass 391 Indigenous Peoples, speaking 295 languages, totaling 1,694,836 individuals – representing 0.83% of Brazil's population[1]. The Fundação Nacional dos Povos Indígenas (FUNAI) recorded approximately 23 isolated peoples in the states of Acre and Amazonas in 2020[2,3], who voluntarily maintain no proximity with non-indigenous society. Managing all of this diversity in health production represents the first major challenge, beginning with workforce composition. Data released by the Secretaria Especial de Saúde Indígena (SESAI) indicate that the service network of the 34 Special Indigenous Health Districts (DSEI) has a contingent of 22,000 health professionals[1].

As a normative instrument, Ordinance 1317 of August 3, 2017[4], in its Article 2, establishes the Multiprofessional Indigenous Health Team (EMSI) as a set of actors responsible for primary care under the management of the Indigenous Health Care Subsystem (SasiSUS), tasked with developing interprofessional work strategies in intercultural contexts capable of reducing inequities and fostering problem-solving capacity, in accordance with the principle of care integrality. In addition to traditional health teams – comprising physicians, nurses, dentists, and nursing technicians – the DSEI are composed of anthropologists, psychologists, sanitary engineers, sanitation and environmental surveillance technicians, health agents, and others. Noteworthy is the presence of indigenous professionals (approximately 65% of the total workforce), the majority (56%) of whom are Indigenous Health Agents (AIS) and Indigenous Sanitation Agents (AISAN).

With the creation of SasiSUS, systematic discussion began regarding the selection criteria for AIS and AISAN, whose consolidation occurred gradually, driven by national indigenous health conferences and recent normative advances. The enactment of Law No. 9,836/1999 – which since 2020 has constituted Chapter V of Law 8,080/90 – represented a milestone by establishing the need for professionals trained to operate in alignment with the sociocultural specificities of indigenous peoples, valuing indigenous medicine knowledge systems, and prioritizing the selection of agents from within the communities themselves[5].

In this process, noteworthy is the survey conducted in 2012 under SESAI's management, covering all 34 DSEI with the aim of mapping the profile, educational background, training, and selection criteria of AIS and AISAN. From this initiative, criteria were formalized, including: being indigenous, residing in the community, proficiency in the local language, knowledge of indigenous customs and healing systems, minimum age of 18 years, completed or ongoing primary education, specific training for the functions of AIS or AISAN, and endorsement by the community itself6. Subsequently, Bill No. 3,514/2019, combined with agreements reached with the Ministério Público do Trabalho (MPT), contributed to advancing the definitive regulation of these professions. In the more recent context (2024–2026), selection criteria were established based on the Consolidação das Leis do Trabalho (CLT) through the Agência Brasileira de Apoio à Gestão do Sistema Único de Saúde (AgSUS), securing labor rights and greater institutional stability for these professional categories[6].

Regarding the medical profession, since 2013, government programs have sought to bring physicians to underserved areas, with priority given to indigenous territories, yielding controversial results[7]. In some regions of the Legal Amazon, medical and care gaps persist – as in the Vale do Javari, southern Pará, and Alto Solimões. This scenario, in itself, justifies a more detailed investigation aimed at identifying propositions for qualifying Indigenous Health Care.

***Obstacles and interprofessional challenges in the field***

Numerous difficulties are encountered, stemming from the chronic shortage of qualified professionals, that prevent us from envisioning true interprofessionality in the scenario briefly outlined above. These obstacles have been recognized since the Serviço de Proteção ao Índio (SPI) in the 1910s through the creation of SasiSUS via Arouca Law 9,836 in 1999 – initially established as an additional provision to the Organic Health Law (LOS) 8,080/1990[8,9,10], subsequently updated and incorporated into its Chapter V. Since then, professional interactions have been guided by the National Policy for Indigenous People's Health Care (PNASPI), dated 2002, which, despite the breadth of its agenda, is not easy to operationalize and adapt[11].

Beyond these normative instruments – to which


Mundo Saúde. 2026,50:e18802025
DOI: 10.15343/0104-7809.202650e18802025I

Basic Operational Standards (NOB) must be added – the operational feasibility within SasiSUS can also be understood through an articulated set of organizational, management, and educational instruments. These establish the foundations for teamwork within the SUS and guide a differentiated care model that is necessarily multiprofessional and intercultural. At the organizational level, the DSEI and the annually developed Indigenous District Health Plans (PDSI) structure the work of teams in the territory, materializing interprofessionality in daily service routines[8,10,11]. In terms of management, planning, monitoring, and information system instruments organize care flows and promote integration among professionals and levels of care. Finally, at the educational level, the National Policy for Permanent Health Education (PNEPS) sustains in-service qualification processes, strengthening collaborative and interprofessional practices in the context of indigenous health[12].

It is useful to recall that one of the main challenges facing multiprofessional teams in Primary Health Care (PHC) relates to the need to adapt guidelines on work organization, since questions persist as to what emphasis is actually expected of these teams and how to establish their structure and modus operandi – particularly in explaining the constitution of communications, flows, and agreements within the work process.

Bispo Júnior and Almeida[13] analyzed these arguments in depth, emphasizing that "similarly to the Family Support Centers (NASF), the new multiprofessional teams [e-Multi] lack a clear identity regarding their institutional space and their attributions within PHC." Various factors compromise interprofessional communication. Among them: i) scarce collaborative interprofessional practice (CIP) since undergraduate biomedical training, recognized for its strong uniprofessional orientation; ii) cultural competencies not addressed in the vast majority of curricula; iii) high staff turnover; iv) lack of dialogical spaces for knowledge exchange; and v) care gaps in certain areas. These aspects reflect a predisposition toward barriers to interprofessional development – including resistance from biomedical professionals to adjust to intersectional actions within teams[14].

The evidence impacts the incompleteness and emptying of matrix support encounters, largely due to the absence of protocols for the applicability or operationalization of 'learning' and 'doing' indigenous health collaboratively – often carried out in a fragmented manner, impoverishing dialogue and reducing potential interactive dialogical spaces, compounded by the unfortunate factors related to logistics, management, and planning, which are frequently unavailable or inaccessible.

Such findings and evidence justify conducting a more detailed investigation, seeking signs that may help clarify which propositions could be pursued to mitigate the fragility of the realities encountered, thereby enhancing outcomes and the problem-solving capacity of care networks.

It is necessary to consider that CIP is not reducible to the mere juxtaposition of health professionals. Effective integration depends on technical skills; continuing education; specific and leadership competencies; effective communication; humanization of care; and shared decision-making[15]. CIP does not supersede the specificities of each profession; rather, it enables the valorization of other training areas and bodies of knowledge, strengthening the interdependence and complementarity among professional classes[12,16]. At the level of structures and logistics, CIP requires arrangements that favor teamwork, interprofessional communication, and integrated performance in areas of difficult access. In indigenous health, this recognition involves considering the territorial dimension, the presence of indigenous health agents, and intercultural mediation as central elements for operational feasibility and vitality.

Regarding health education and training, CIP demands the development of collaborative competencies and the transcendence of a strictly disciplinary logic. In this field, its dialogue with indigenous health occurs through the incorporation of interculturality, recognizing different care systems and broadening the scope of professional and intersectoral action. Finally, in health surveillance, CIP is expressed through the collective construction of information, integrating technical and local knowledge. This strengthens territorialized, culturally sensitive, and appropriate practices, qualifying the identification of needs with more effective outcomes and strongly impacting the improvement of health indicators.

These foundations, reviewed in our bibliographic survey, provide the theoretical grounding for this study – particularly those studies based on the theory of management, planning, and organization of services recommended by the Ministry of Health, notably in the Health Surveillance Model and the PNASPI.

Taking this entire framework as a premise, our objective was to bring forth clear and feasible propositions that allow advances in understanding the interprofessional landscape within the EMSI, since the provision and configuration of human resources substantially impact the qualification of health care for Brazil's indigenous peoples, using the methodology described below.

CC BY

## METHODOLOGY

This study was configured as a critical-reflexive essay, grounded in a qualitative approach of an applied and descriptive nature, drawing on the professional experience of the authors in the field of indigenous health. The elaboration of the manuscript was guided by a movement of theoretical reflection constructed from experiences in daily care and educational practice, analyzed in light of the theoretical frameworks of interprofessionality, health surveillance, and interculturality.

Recurring situations from practice were identified, as well as challenges and potentialities, organized around three thematic axes that enabled a critical analysis integrating experience and theoretical grounding. These are: expanded clinical practice; permanent health education; and the construction of dialogical spaces of complicity. The literature was used as support to sustain and deepen the interpretation of the phenomena discussed, without any claim to exhaustiveness or adherence to procedures characteristic of review studies.

## RESULTS

We propose, as fundamental assumptions, three pillars for strengthening the Health Surveillance Model: expanded clinical practice; permanent health education; and the construction of dialogical spaces of complicity. We shall examine in detail the results that enable us to constitute and operationalize these foundational axes.

***Expanded clinical practice as a driver of interprofessionality***

The emergence of the SUS in Brazil served as a catalyst for debates around subjectivity – understood as the fruit of the socialization of experiences, events, and multiple exchanges – and underpinned the elaboration of a collective concept of care. The country's most relevant health service models, such as the DSEI, drew from practical experiences, knowledge, and theories of health surveillance[17,18]. The authors note that the American Flexnerian model, with its biomedical emphasis, permeated the Brazilian system, consolidating a disease- and individual treatment-centered approach to the detriment of an integral perspective. Although both models have been relevant, their visions did not coexist harmoniously, generating distancing in care practice.

Gastão Campos was one of the pioneers in defending the concept of the subject-centered clinical approach, based on a reformulated and expanded form of care, developed in a work published seven years after the creation of the SUS[19]. He observed that PHC suffered a devaluation of work production, given the prevailing curative perspective – according to which lives were only saved in hospitals, where imminent dangers were concentrated. This devaluation arose from the difficulty of professionals in adopting predominantly biomedical approaches to understanding the subject, which prevented the subsumption of factors beyond objective and quantifiable manifestations. Inspired by this author, the concept of expanded clinical practice emerged as a strategy for confronting the segmentation of user health care. By strengthening interprofessionality in care – which is dynamic and complex – the horizon opened up to the viability of professional action from different areas of knowledge, enabling a valorization of the subject's dimension in clinical practice. The care model was thus expanded beyond diagnosis and treatment, incorporating the historical, sociocultural, and environmental determinants of the health-disease process.

Expanded clinical practice stands in contrast to positivist propedeutics, particularly with regard to the redefinition of its field and object of study. It is important to recognize that, amid numerous heated and controversial debates, an alternative theoretical and operational model was sought – one capable of overcoming the "limitations and biases of the paradigm of the natural history of diseases, positivist and concealing the historical-social determination of the health-disease process"[20]. According to Brazil's Ministry of Health[21,22], among the main objectives of expanded clinical practice are the responsibility of health services toward their users and the intersectoral and interprofessional involvement in therapeutic planning, so as to overcome the impediments and obstacles related to the epistemological and operational frameworks of each professional field of knowledge. Added to this is the ethical commitment to not dissociate the subject from the context in which they are embedded, contributing to the recognition of the conditions that affect them and to the development of strategies to address those conditions or find new pathways for well-being – a concept especially relevant in the context of chronic non-communicable diseases (NCDs), for example[21,22].

The adoption of the expanded clinical practice model brought significant advantages to health services, particularly by favoring and strengthening teamwork. By way of illustration, in the daily rou-

tine of a physician working at an Indigenous Basic Health Unit (UBSI), this approach can be observed in the care of a patient with Diabetes Mellitus who, beyond glycemic control, presents difficulties adhering to treatment due to sociocultural factors. In operationalizing the concept of expanded clinical practice, the physician shares the situation with the interprofessional team – collaboratively involving nurses, AIS, traditional healers (pajés), social workers, nutritionists, and psychologists, among others. In this process, strategies are constructed that seek to adapt therapeutic guidelines to the patient's and the community's food practices, as well as to plan educational actions that respect their cosmology and foster co-responsibility for care.

The discussion on expanded clinical practice in the SasiSUS context requires, however, an explicit acknowledgment of the place of indigenous medicines in health care. The publication of Ordinance GM/MS of April 2, 2026[23] by Brazil's Ministry of Health, recognizing indigenous medical specialties, reinforced the legitimacy of these knowledge systems and their insertion into the subsystem. This institutional recognition contributed to broadening the possibilities of dialogue between different medical rationalities, fostering the construction of assertive and coherent practices aligned with the differentiated care model.

In this sense, the incorporation of expanded clinical practice came to imply not only the articulation between different professional categories of biomedicine, but also the recognition and inclusion of indigenous specialists as a constitutive element of care. The practice of indigenous medicine specialists – such as pajés, midwives, and herbalists – began to be understood as a fundamental element in guiding therapeutic itineraries, requiring health professionals to engage in qualified and respectful listening to the cultural, symbolic, and collective dimensions not only of illness, but above all of self-care, prevention, health promotion, and well-being.

In this way, the principles sustaining expanded clinical practice – co-responsibility, shared therapeutic planning, and openness to dialogue between different fields of knowledge – constitute powerful strategies for overcoming disease-centered and fragmented clinical models. This is always pursued with the explicit intention of involving professionals in systematic and ongoing educational processes, as we shall examine in the following section.

***The role of permanent educational processes in interprofessional work in indigenous health***

Interprofessional training and practice signify an improvement in care quality through the exercise of individual and collective competencies by health team members. Skills in collaboration, communication, and relationship-building enable a comprehensive approach[12,16] – notably through the existence of different health perspectives and worldviews. Collaborative practices require, among health professionals, convergent actions in patient-centered care, mutually influenced by one another, resulting in an expansion of the methods for observing and interpreting phenomena. This explains the power and role of educational processes in knowledge sharing and the modification of practices – whether within the specific scope of each profession or in the construction of a common field of intervention, where actions are collectively agreed upon among professionals.

The permanent and ongoing educational process in indigenous health plays a fundamental role in interprofessional work, promoting meaningful learning and the development of competencies for practice in intercultural contexts. It aims to improve daily practices, integrate different health services, and strengthen the sharing of information, knowledge, and wisdom among professionals. It equally encourages respect for and recognition of diversity, including indigenous care practices.

In practical terms, given the territorial contexts involved, we recognize the potential of distance learning modalities – such as short courses (MOOCs), update and continuing education modules on specific topics, and more complex formats such as lato sensu specialization courses. The digital support provided by more experienced professionals from medical centers equipped with greater technological resources has enabled the development of telehealth practices[24] and the remote provision of certain specialties, as well as support for indigenous professionals through simpler and more widely accessible tools, such as messaging applications. This entire process can facilitate and create opportunities for – if not depend upon – welcoming discussion spaces, as we shall examine in the following section.

***The co-construction of spaces of complicity as interprofessional praxis***

The preceding propositions converge toward the valorization and intensification of expanded clinical practice and educational processes – conceived in their interdisciplinary and transdisciplinary scope – and lead us to reconsider the need for a systematic and continuous updating and reconstruction of knowledge and wisdom. This movement can be understood as a co-construction of new aptitudes, meaning the deconstruction of previously acquired paradigms and the incorporation of new and more adequate levels of apprehending realities.

Experiences reveal that, for many professions,

CC BY

the integration of teamwork in PHC needs to foster new relationships, transforming professionals so that they can go beyond side-by-side multiprofessional teamwork and genuinely operate from an interprofessional perspective, with collaborative exchanges[24]. In this sense, each professional contributes with their specific knowledge domain, sharing decisions, information, and responsibilities regarding the care plan – including clinical follow-up, self-care guidance, and health promotion actions. This process involves communication, recognition of each profession's competencies, and the collective construction of interventions, integration of knowledge systems, and co-responsibility for health care[25,26], strengthening dialogical spaces within interprofessional praxis.

The praxis indicated here may initially be conceived as a conceptual-operational framework through the introduction of intercultural pedagogical strategies, by collectively constructing spaces of complicity in which it is not sufficient to merely share knowledge – it must be combined. This process seeks to strengthen expanded dialogue with the holders of indigenous knowledge and sciences, such as pajés, herbalists, midwives, and all practitioners of indigenous medicines[27].

We can redefine certain spaces by continuously promoting mediation in a common territory of complicity – intertwined with the territory of indigenous health and anchored in the conception of the sociocultural determination of health and empathy. We bring to the debate the co-construction of a learning process centered on the triad of 'being', 'knowing', and 'doing' in indigenous health, based on matrix support encounters encompassing teaching, supervision, and work – revisiting inclusive communicative action through educational practices grounded in equality, equivalence, equity, and respect for diversity. The recognition of the complexity of this triad within a space of complicity must draw upon the combination of competencies in order to understand and respect all those involved within conditions of identity construction and redefinition[28], in opposition to the reification[29] of the worker-subject.

Certain situations can provide excellent opportunities for the co-creation of these spaces, fostering approximation, connectivity, and cohesion among professionals – such as: knowledge-sharing and conversation circles; participant observation; qualified and empathic listening; use of active methodologies; community learning experiences; matrix support encounters; thematic workshops; collaborative sharing immersions; inter- and multidisciplinary study groups; intercultural experiences; oral narratives and life histories; living laboratories and field experiences; social cartography and 'talking maps'; as well as qualification, specialization, and training courses. We complement this repertoire by pointing to the prominent role played by light technologies – referring to knowledge-in-practice, qualified listening, reception, and appropriate communication – aimed at meeting health needs, fostering reflection on decision-making and its consequences for the individual, family, community, and territory. Light technologies constitute the living work of health[30]. These are procedures widely used in everyday practice that typically involve actions such as: field visits; home visits; school visits for health education and promotion conversations; community dialogues for health education and promotion, as well as the survey and diagnosis of problems and community demands[31]. It is recommended to bear in mind the premise of establishing a bottom-up approach, giving voice to the activism and engagement of participants as they become protagonists involved in planning actions and collective problem-solving strategies.

Technical competence, commitment, ethics, valorization of interculturality, diversity, and the collaborative spirit become guiding principles in favor of constructing spaces of complicity and solidary work – as they represent a mode of exercising interprofessionality through collaborative practices within the team or through networked work with users and community[32].

## DISCUSSION

Throughout our research journey, we extended the epistemic frontiers as far as possible, always with the aim of appreciating and fostering new ways of thinking about professional interrelationships as a foundation for the care continuum within the EMSI. The committed positioning within context and territory places expanded clinical practice as an extremely valuable emerging tool. Much has already been advanced within the SUS in this regard; however, there is an urgent need to review the current state of practices, reinforcing, re-energizing, and strengthening the standards advocated and consolidated within the Health Surveillance Model, including indigenous health.

It is necessary to consider that the expanded clinical positioning provides both professionals and service users with support and receptive care in the face of the complexity of the health-disease process, stimulating and enhancing the commitment of services and management to promoting structur-

al and contextual changes that enable its valorization, consolidation, and promotion – thereby contributing to the improvement of care quality and the expansion of PHC in Brazil. The trend toward dedicating efforts to strengthening interprofessional work and enabling the integration of different areas of knowledge will make it possible to reformulate the mode of therapeutic conduct, fostering more adequate outcomes and greater problem-solving capacity.

We have likewise seen that educational processes contribute to the qualification of professionals, rendering them more capable of working in diverse sociocultural settings and implementing health actions that respect the rights and specificities of the indigenous populations served.

Finally, though no less fundamental, we reinforce the need to promote the interaction of professionals with these communities, involving them in the political-pedagogical discussion for the implementation of health education projects, creating spaces for dialogue and co-construction of complicity. Translated into values and principles, these attributes can be qualified in the measure of the praxis of permanent education. In other words, it is precisely in the act of exercising such competencies that they evolve in the continuity of encounters. Such protocols tend to further valorize altruistic attitudes, through openness to the diversity of ideas, making of inclusion, bonding, reception, the use of receptive non-verbal communication, qualified listening, and empathy the co-creation of a receptive, generous, and mutually respectful atmosphere.

## CONCLUSION

We conclude that the work of EMSI and collaborative practice in PHC need to be addressed contingently, according to the characteristics of each assigned territory. We note that collaboration involves professionals who wish to work together to provide better health care, and that this can occur through participation in the team and through cooperation within an intersectoral network involving the community. Perhaps this is the moment to reconstruct and reframe much of our praxis.

There are various concrete strategies and possible follow-up indicators for improving and sustaining CIP in the territories. Examples include the construction of communication protocols and team flows regarding cases under care, deepening matrix support through team meetings and the joint construction of Singular Therapeutic Plans (PTS). Additional application examples include incentivizing actions such as shared consultation records, the development of educational processes that dialogue with local demands, and the use of technology to maintain teamwork – especially in remote work settings. These activities and strategies can be measured – for example, by evaluating the proportion of interprofessional actions in comparison with uniprofessional care, or the quantity of teleconsultations or tele-interconsultations received in the territories.

Curricular changes and more active teaching methodological strategies will have a positive impact on interprofessional education. These are being recognized in the readaptation of professional training and practice models, originating in the development of collaborative competencies for teamwork – thereby enhancing the problem-solving capacity of care. The propositions need to be guided by the Health Surveillance Model, so that they effectively become powerful from the perspective of the collective construction of knowledge – constituting a dialogical space conducive to critical reflection and the improvement of interprofessional health practices, as well as serving as an updated epistemological radar and observatory of our daily praxis.

We have seen how health surveillance implies educational processes that can favor the alignment and conformation necessary for the constitution and permanence of the expanded clinical practice model, together with the emergence of the spaces of complicity that are necessary and desired in intercultural contexts.

The proposed suggestions point toward interactive, civic, and inclusive coexistence as potentials for the development of synergistic competencies – guided by ethics, humanized care, and constant communication among team members. In this way, it is possible to broaden the level of intra- and interprofessional respect, fostering complementarity, quality, and safety in health care networks – dependent upon the praxis of complicity, continuous and systematic; and on the time and maturation of each professional in their formative journey, aligned with the recognition of the territory in which they operate. Ethics, values, and professional roles must develop jointly with communication and collaborative work.

CC BY

### CRediT author statement

Conceptualization: Santos, MTF; Oliveira, PR. Methodology: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Validation: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Statistical analysis: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Formal analysis: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Investigation: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Resources: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Writing-original draft preparation: Santos, MTF. Writing-review and editing: Santos, MTF; Oliveira, LSS; Nunes, SAC; Oliveira, PR; Maltez, TF; Ribeiro, AERA; Costa, KCM. Visualization: Santos, MTF; Oliveira, LSS. Supervision: Oliveira, LSS. Project administration: Santos, MTF; Oliveira, PR.

All authors have read and agreed to the published version of the manuscript.

### Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

## REFERENCES


1. Brasil. Ministério da Saúde do Brasil. Secretaria de Saúde Indígena (SESAI) [Internet]. Brasília: Ministério da Saúde; [acesso em 16 abr 2026]. Disponível em: https://www.gov.br/saude/pt-br/composicao/sesai
2. Oliveira L. Caminhos equitativos e na diferença para a saúde indígena. In: Barbosa DA, organizador. Boas práticas e desafios na atenção à saúde com grupos vivendo em situação de vulnerabilidade. Brasília, DF: ABEn; 2023. p. 1–4. doi:10.51234/aben.23.e21. Disponível em: https://publicacoes.abennacional.org.br/ebooks/boas-praticas-e-desafios-na-atencao-a-saude-com-grupos-vivendo-em-situacao-de-vulnerabilidade. Acesso em: 20 mai. 2025.
3. Brasil. Conselho Nacional dos Direitos Humanos (CNDH). Resolução nº 44, de 10 de dezembro de 2020: dispõe sobre princípios, diretrizes e recomendações para a garantia dos direitos humanos dos povos indígenas isolados e de recente contato [Internet]. Brasília, DF: Diário Oficial da União; 2020 dez 11 [acesso em 1 out 2025]. Disponível em: https://www.gov.br/participamaisbrasil/resolucao-n-44-de-10-de-dezembro-de-2020-2.
4. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Portaria nº 1.317, de 3 de agosto de 2017: adequar o registro das informações relativas a estabelecimentos que realizam ações de atenção à saúde para populações indígenas no Cadastro Nacional de Estabelecimentos de Saúde (CNES) [Internet]. Diário Oficial da União. 8 ago 2017; Seção 1:49 [acesso em 1 out 2025]. Disponível em: https://pesquisa.in.gov.br/imprensa/servlet/INPDFViewer?jornal=1&página=49&data=08/08/2017.
5. Torres, R. O SUS nas aldeias. Revista Poli - saúde, educação e trabalho nº 10, de março/abril de 2010. p.22-23. Disponível em: https://www.epsjv.fiocruz.br/publicacoes/revista-poli. Acesso em 16/04/2026.
6. BRASIL. MINISTÉRIO DOS POVOS INDÍGENAS. Regulamentação das profissões de Agente Indígena de Saúde e Agente Indígena de Saneamento é aprovada pela Comissão de Saúde. Disponível em: https://www.gov.br/povosindigenas/pt-br/assuntos/noticias/2024/10/regulamentacao-das-profissoes-de-agente-indigena-de-saude-e-agente-indigena-de-saneamento-e-aprovada-pela-comissao-de-saude. Acesso em 16/04/26.
7. Brasil. Lei nº 12.871, de 22 de outubro de 2013: institui o Programa Mais Médicos, altera as Leis nos 8.142, de 28 de dezembro de 1990, e 12.871, de 22 de outubro de 2013, e dá outras providências [Internet]. Brasília, DF: Diário Oficial da União; 2013 out 23 [acesso em 1 out 2025]. Disponível em: http://www.planalto.gov.br/ccivil_03/_ato2011-2014/2013/lei/l12871.htm.
8. Brasil. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde [...]. Diário Oficial da União. Brasília, DF; 1990. Disponível em: https://www.planalto.gov.br/ccivil_03/leis/l8080.htm. Acesso em: 19 mai. 2025.
9. Brasil. Decreto nº 8.072, de 20 de junho de 1910. Cria o Serviço de Proteção aos Índios [...]. Brasília, DF; 1910. Disponível em: https://www2.camara.leg.br/legin/fed/decret/1910-1919/decreto-8072-20-junho-1910-504520-republicacao-109749-pe.html. Acesso em: 11 mai. 2025.
10. Brasil. Fundação Nacional de Saúde. Lei Arouca: a Funasa nos 10 anos de saúde indígena. Brasília, DF: Funasa; 2009. Disponível em: https://www.funasa.gov.br/site/wp-content/files_mf/livro-lei-arouca-10anos.pdf. Acesso em: 19 mai. 2025.
11. Brasil. Ministério da Saúde. Portaria nº 254, de 31 de janeiro de 2002: aprova a Política Nacional de Atenção à Saúde dos Povos Indígenas [Internet]. Brasília, DF; 2002 [acesso em 1 out 2025]. Disponível em: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2002/prt0254_31_01_2002.html.
12. Brasil. Ministério da Saúde. Portaria nº 198/GM, de 13 de fevereiro de 2004. Institui a Política Nacional de Educação Permanente em Saúde. Diário Oficial da União. 16 fev 2004.
13. Bispo Júnior JP, Almeida ER. Equipes multiprofissionais (e-Multi): potencialidades e desafios para a ampliação da atenção primária à saúde no Brasil. Cad Saúde Pública. 2023;39(10):e00120123. Disponível em: https://www.scielo.br/j/csp/a/Vc9wbm9xLKqTKRScJwBym5d. Acesso em: 20 mai. 2025.
14. Mestriner Junior W, Ribeiro AER, Mestriner SF, Fumagalli IHT, Lago LPM. Formação interprofissional na saúde indígena: a experiência do projeto "Huka Katu"– a FORP-USP no Xingu. Rev ABENO. 2021;21(1):1670. doi:10.30979/revabeno.v21i1.1670. Disponível em: https://revabeno.emnuvens.com.br/revabeno/article/view/1670. Acesso em: 20 mai. 2025.
15. Lima AWS, Alves FAP, Linhares FMP, et al. Perception and manifestation of collaborative competencies among undergraduate health students. Rev Lat Am Enfermagem. 2020;28:e3240. Disponível em: https://www.scielo.br/j/rlae/a/tdmjYfY5DLsgnBg3WJm3GGM/abstract/?lang=en. Acesso em: 20 mai. 2025.
16. Batista REA, Peduzzi M. Interprofessional practice in the emergency service: specific and shared assignments of nurses. Rev Bras Enferm. 2019 Jan;72:213–20. Disponível em: https://www.scielo.br/j/reben/a/M9B97N5JWfVyjHK3QkrKHgM/?lang=en. Acesso em: 20 mai. 2025.
17. Conselho Nacional de Saúde (BR). Resolução nº 588, de 12 de julho de 2018. Fica instituída a Política Nacional de Vigilância em Saúde (PNVS). Diário Oficial da União. Brasília, DF; 12 jul 2018; Seção 1:87.
18. Merhy EE, Franco TB. O reconhecimento de uma produção subjetiva do cuidado. In: Merhy EE, Franco TB. Trabalho, produção do cuidado e subjetividade em saúde: textos reunidos. São Paulo: Hucitec; 2013. Disponível em: https://www.professores.uff.br/tuliofranco/wp-content/uploads/sites/151/2017/10/10reconhecimento-producao-subjetiva-cuidado.pdf. Acesso em: 20 mai. 2025.
19. Campos GWS. A clínica do sujeito: por uma clínica reformulada e ampliada. In: Campos GWS. Saúde Paidéia. São Paulo: Hucitec; 2002. Disponível em: https://www.pucsp.br/prosaude/downloads/bibliografia/CLINICAampliada.pdf. Acesso em: 11 mai. 2025.
20. Castiel LD. Inefetividade e ineficiência: reflexões sobre a epidemiologia e os serviços de saúde de um estado de mal-estar social. Cad Saúde Pública. 1990 Jan–Mar;6(1):27–39. Disponível em: https://www.scielo.br/j/csp/a/9fkxytN6XBkcRyqyS4bw6DB/. Acesso em: 11 mai. 2025.
21. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Núcleo Técnico da Política Nacional de Humanização. Clínica ampliada, equipe de referência e projeto terapêutico singular. Brasília, DF: Ministério da Saúde; 2007. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/clinica_ampliada_2ed.pdf. Acesso em: 19 mai. 2025.
22. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Política Nacional de Humanização da Atenção e Gestão do SUS: clínica ampliada e compartilhada. Brasília, DF: Ministério da Saúde; 2009. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/clinica_ampliada_compartilhada.pdf. Acesso em: 19 mai. 2025.
23. Brasil. Ministério da Saúde. Portaria GM/MS nº 10.676, de 2 de abril de 2026. Dispõe sobre o reconhecimento do valor das medicinas indígenas no âmbito da PNASPI e do SasiSUS [Internet]. Diário Oficial da União. 6 abr 2026 [acesso em 16 abr 2026]. Disponível em: https://www.gov.br/saude/pt-br/

assuntos/noticias/2026/abril/atuacao-de-especialistas-de-medicinas-indigenas-e-reconhecida-pelo-ms
24. Organização Mundial da Saúde (OMS). (2010). Telemedicine: opportunities and developments in Member States: report on the second global survey on eHealth (Global Observatory for eHealth series, 2).
25. Peduzzi M. Equipe multiprofissional de saúde: conceito e tipologia. Rev Saude Publica. 2001;35(1):103-9. doi:10.1590/S0034-89102001000100016.
26. Peduzzi M, Norman IJ, Germani ACCG, Silva JAM, Souza GC. Educação interprofissional: formação de profissionais de saúde para o trabalho em equipe com foco nos usuários. Rev Esc Enferm USP. 2013;47(4):977-83. doi:10.1590/S0080-623420130000400029.
27. Barreto JPL. O mundo em mim: uma filosofia do corpo e do cuidado no Alto Rio Negro. Brasília: Mil Folhas; 2022. 260 p.
28. Oliveira L. O agente indígena de saúde do Parque Indígena do Xingu: perspectivas de formação e trabalho. In: Junqueira C, Baruzzi R, organizadores. Parque indígena do Xingu: saúde, cultura e história. São Paulo: Terra Virgem; 2005. p. 247–57.
29. Lukács G. Reificação e consciência do proletariado. In: Lukács G. História e consciência de classe: estudos sobre a dialética marxista. São Paulo: Martins Fontes; 2003.
30. Merhy EE. A perda da dimensão cuidadora na produção da saúde: uma discussão do modelo assistencial e da intervenção no seu modo de trabalhar a assistência. In: Sistema Único de saúde em Belo Horizonte - Reescrevendo o público. Editora Xamã: São Paulo; 1998. p: 1-13.
31. Rodrigues, D. Vigilância em Saúde Indígena. Caminhos para a organização e qualificação do processo de trabalho em Distritos Sanitários Especiais Indígenas. Curso de Especialização em Saúde Indígena. Unifesp-Unasus Edição 7. Mimeo. p. 6. 2026
32. Peduzzi M, Agreli HLF, Silva JAM, Souza HS. Trabalho em equipe: uma revisita ao conceito e a seus desdobramentos no trabalho interprofissional. Trab Educ Saúde. 2020;18(Suppl 1). doi:10.1590/1981-7746-sol00246. Disponível em: https://www.scielo.br/j/tes/a/RLtz36Ng9sNLHknn6hLBQvr/?format=pdf&lang=pt. Acesso em: 21 mai. 2025.

**How to cite this article:** Santos, M.T.F., Oliveira, P.R., Nunes, S.A.C., Maltez, T.F., Ribeiro, A.E.R.A., Costa, K.C.M., Oliveira, L.S.S. Interprofissionalidade em área indígena: aprimorar e fortalecer o papel da vigilância em saúde. O Mundo Da Saúde, 50. https://doi.org/10.15343/0104-7809.202650e18802025I. Mundo Saúde. 2026,50:e18802025.