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1. Introduction

Since the first half of the 20th century, care delivery models have been discussed in medical education. For a long time, the legacy of the biomedical model preached technology's sovereignty to the detriment of the health/disease and society relationship. However, currently, there is a growing awareness of the biopsychosocial perception of western white medicine. It begins to question traditional values in health practice and the emerging role of users and society in general, in order to provoke another reflection on the training and practice of health professionals[1]

The biomedical model is still hegemonic, human medicine does not adequately address the needs of the population and coexists in a contradictory way in the practices of the health teams[2;3]. Because of this, some institutions signal a concern with the reversal of this panorama when they propose pedagogical models that consider the individual in its social, economic, and cultural dimensions[2;3]. Within this context, the Amazonas' State University (UEA), a multicampus institution in all state cities, proposes to the students in Nursing, Medicine, Dentistry, and Pharmacy courses the Rural experience Internship in Public Health (ERSC). This opportunity has as a premise to allow students to live new experiences, through participation in

decision-making and actions in primary health care services and society in cities in the interior.

Thus, based on a decolonial conscience(A), this article seeks to reflect on the biomedical training model and emphasize the importance of the rural academic internship. From methodological construction, it is characterized by a particular apprehension of the reality described, based on the daily observation of academics who undertook a 43-day internship in the city of São Gabriel da Cachoeira. Therefore, the present work is part of a "report of experience" perspective.

EXPERIENCE REPORT:

The Brazilian state of Amazonas has continental dimensions, where there are regions isolated by nature. Particularly in health practice, there is great difficulty in fully serving the entire territory[4]. In Brazil, 817,900 indigenous people reside, and 342,800 of these populations live in the Northern region, who are speakers of 27 languages and represented by more than 72 organizations[5;6]. Each region has developed a specific part of our National Health System (SUS) with different particularities and distinct conceptions about the body and health[7].

The capital Manaus, where most of the medical schools in Amazonas are located, different social groups coexist, but culture and colonizing thinking predominate, making ancient indigenous knowledge invisible, as well as different ontological conceptions about the body and the process of illness[6;8]. Due to these notorious cultural differences present in urban and rural regions, which permeate the Amazon, it is necessary to move students to the interior to understand that the reality of the state is neither homogeneous nor uniform; and mask disparate and negligent social relationships[9].

Thus, during the rural internship, the student can learn more about the singularities and complexities of the people they will provide in the different regions in the future. Immersion in the countryside allows health students to get to know the Amazonians better (B). It is an essential tool for the doctor-user dialogical process, as well as for producing health[8;10]. Besides, the Rural Internship encourages the consolidation of the concept of multidisciplinary and interdisciplinary medical practice, contributing to the development of proposals aimed at assisting managers, workers, and the local community in solving health challenges in their daily lives [11]. One of the cities linked to the rural internship is São Gabriel da Cachoeira, which is located in the extreme northwest of State of Amazonas, in the Upper Rio Negro basin, within the largest tropical forest on the planet, where 23 indigenous peoples are estimated to live[12].

In São Gabriel da Cachoeira, 76.60% of the population declares they are indigenous, their lands occupy about 80% of the city, and they are distributed in 750 villages/communities[5]. Not diverging from the rest of Brazil, its official language is Portuguese. However, there are three other languages recognized by law: Nheengatu (C), Tukano (D) and Baniwa (E). The region has the highest concentration of different indigenous ethnic groups in the country, which are: Arapaço, Baniwa, Barasana, Baré, Desana, Hupda, Karapanã, Kubeo, Kuripako, Makuna, Miriti-tapuya, Nadob, Pira-tapuya, Siriano, Taiwano , Tariano, Tukano, Tuyuka, Wanana, Werekena and Yanomami[12;13].

From the idealization of a region with such characteristics, we created expectations of finding a socioeconomic infrastructure without the influence of the white man; the image of the "sign of the Indian race" was conceived linked to characters subjectively charged with media stereotypes, which simplify and generalize cultures, languages, beliefs and singular individuals of the diverse indigenous ethnicities. This sign evokes stigmas of superstitious cosmologies, of delayed cultural development, and alien to interculturality [14].

In this sense, at first, we found it strange to find so much white cultural representation in the city, such as shops with Christian names, products of foreign brands and a significant number of Catholic and Evangelical churches in a city with a predominantly indigenous population. This strangeness can be understood as a result of the social imaginary constructed about indigenous peoples - objects of discrimination and reduced to

stereotypes[15]. In addition to the media space, the invisibility of diverse knowledge developed around different ethnicities, which form the Brazilian identity, denotes a place of little democratic indigenous speech in the narrative of Brazilian history[16]. From this perspective, we began to assimilate the historical, political, and economic circumstances, which symbolically perpetuate the colonizing ideology and sustain this indigenous invisibility[17;18].

During the internship, amid so much white cultural representation, we were privileged to visit an institution of resistance, which represents the indigenous social movement in the region, known as the Federation of Indigenous Organizations of the Upper Rio Negro (FOIRN). Founded in 1987, it represents the 23 indigenous peoples of Rio Negro, in an area that covers the cities of Barcelos, Santa Isabel do Rio Negro and São Gabriel da Cachoeira, in Amazonas. It is a non-profit civil association and one of the leading organizations of the indigenous movement in Brazil, being a world reference on the defense of indigenous peoples in Latin America.[19].

During the visit, we were introduced to one of the ex-presidents of the Federation, of the Tukano ethnicity, who explained the role and importance of all departments. In the end, he explained that new challenges arise for the movement in the face of constant uncertainties and threats to the constitutional rights conquered. Besides, in the following week, we participated in the 32 years of FOIRN, where the local leaders exposed it: the history of the movement, the question of the demarcation of Indigenous Lands, in addition to discussions of the achievements, challenges, and perspectives of health in the region. As an indigenous social movement of struggle and resistance for the Land, Health, and Culture, it is an institution that suffers harsh criticisms, mainly in the current political situation that we live in this moment in the history of Brazil.

These diverse considerations served as a basis for understanding the marginalization of ancient cultures during the “progress” of the nation and the reflections of the national policy of integrating or isolating indigenous peoples[20]. We also had the opportunity to get to know the organization of indigenous health services through, first, a technical visit to the Alto Rio Negro Indigenous Special Sanitary District (DSEI - ARN).

The DSEI-ARN is organized by nuclei of primary health care, such as health promotion, prevention, control of diseases and conditions, the health of women and children, and planning, work management and continuing education[21]. During the visit, it was possible to experience the organizational structure and fundamental principles of indigenous health in the country, in addition to understanding the importance of guaranteeing indigenous rights to the preservation of their lands and natural resources, as it is recognized that their food, medicine, well-being and the joy of living come from the land(F)[22]. During the visit, we were introduced to a Tukano indigenous woman, who reported the challenge of her participation in the exchange of 50 indigenous people from the Upper Rio Negro to study medicine in Cuba in the 90s—contributing to the reflection on the flow of professionals from health of other states and countries, as well as the start of the construction project of the Amazonas State University with the mission of training professionals for the interior of Amazonas.

At a later moment, we were taken by DSEI-ARN to visit the facilities of the Indigenous' Health House (CASAI) and the staff responsible for the services. It was possible to observe how the blocks and dormitories are organized and the assistance services provided to the different ethnic groups of the Upper Rio Negro.

We were invited to follow two calls from DSEI-ARN, in the local communities called Itacoatiara Mirim and Amazonino. When we arrived in the communities, we had to ring a bell to announce our presence, and we had to organize ourselves in an open area. It is a reactive strategy contact(G). The DSEI-ARN team was already known, and we realized that their presence there was valued, as many were already looking for their younger children to receive childcare (H), or any other family members who needed assistance and/or medicines for chronic diseases. We noticed that there was significant adherence by the community to the vaccines and the therapeutic approaches proposed by the team. Some residents reported that the drugs for hypertension and/or diabetes were running out. Others had clinical complaints common to primary health care, ranging from diarrhea, common cold, scabies, superficial skin mycoses, and vaginal discharge. When someone did not speak

Portuguese, they had the help of a translator (I). However, even so, this was a limiting factor in our process of communication.

There was a particular complaint of sadness associated with a situation of lack of appetite and willingness to live. We suspected that it was a case of depression, and we did not have a psychologist on the team, and we had no experience in mental health.

The reports involved political and social issues, such as the difficulty of retiring and having to perform manual labor under the sun at an advanced age.

This community lived in vulnerable economic conditions, even though they worked with agriculture, crafts, fishing, raising chickens, among other activities. In this sense, we understand the importance of health teams moving to these communities, many of them inserted in contexts of difficult geographical and economic mobility.

In the city, we met some doctors who reported difficulties in dealing with some cultural issues, as it "limited their therapeutic approaches,"; and they intended to "save lives" and felt "frustrated". We followed up with a case of thrombocytopenic purpura (J) in an advanced stage.

Given the seriousness of the case, we had to refer to a specialized service. The team requested transportation. However, the patient had already escaped from the hospital. A few weeks later, we returned, and the situation was worst, and they reported having a treatment performed by a local Shaman, with the improvement of the condition for a few days. As she was in a severe condition, the white doctors criticized this attitude negatively, and we, as spectators, were reflective at the time

Final Considerations

From then on, we started to question and deconstruct the hierarchy of the doctor and user relationship. We understand that we were taught to "save lives" and to be "imposing" about treatment; under this biomedical perspective, we say the treatment and the user must follow it. Although in our society, imposing communication is naturalized, it prevents the establishment of dialogue itself, that is, an exchange in the deep inter-human sense, which accesses the being-in-the-world, the fundamental community values that constitute us as social beings23.

We understand that in addition to making our relationships more complicated, this type of approach could not make sense from the relationship of freedom of indigenous peoples with their bodies. At that moment, we stripped ourselves of the idea of "saving lives" traditionally incorporated into white coats, because, under this hierarchical premise, it is not possible to respect the protagonism of the person who seeks assistance24.

During the internship, a different therapeutic practice was revealed from that used by the white man's medicine *. This practice is imbued with ancient indigenous knowledge about plants with medicinal properties. It is an ethno-knowledge that spans generations and is widely respected by the residents of the city. We believe that this study gave rise to relevant information for academics and professionals, recognizing the importance of valuing and including ancient knowledge in their work practices, especially regarding indigenous health. Just as it is also a way of sharing a common therapeutic language, which allows us to get closer to the population; and encourages the transmission of knowledge about the proper use of medicinal plants to the community.

We could not fail to report that when we went to a bar in the city, we met an anthropologist, a philosopher, and a professor who were working and researching in partnership with the Instituto Sócio Ambiental (ISA). The dialogues with them, which we can affectionately call friends, helped us to understand that indigenous peoples have different ontological conceptions about the body, illness, healing, life, and time; and these are related in a more sensitive way than our conception of them. It helped us to assimilate health disparities, which must not only be respected but also understood so that responsibility for therapeutic choices can be shared. In addition to being an attempt to encourage the recognition, appreciation, emancipation, and decolonization of ancient indigenous knowledge.

Finally, we can say that the knowledge gained at this stage filled many gaps in Brazil's history that we were taught in schools. We see the dimension of the secular process of persistent colonization and in contrast, the resistance of indigenous peoples to assert their fundamental rights. Much remains to be done, but the effective implementation of their rights certainly depends on the decolonization of our thinking, on the awareness of the historical debts we have towards them, from organizations such as FOIRN, and, above all, on a true democracy that grants them a legitimate place to speak and listen. All these exchanges of knowledge and experiences have provided us with the critical appropriation of practices in health, which, above all, questions, resists, and seeks to change colonial patterns of being, knowledge, and power. As medical doctors assimilate their singularities, break with hierarchies, use non-imposing communication, consider that there are other medicines besides white modern, and be willing to relate to them, it is a way of guaranteeing dignified assistance to indigenous populations in the area of health.

Adittional information

(A)- We chose the term decolonial - decolonization instead of decolonial - decolonization as suggested by author Catherine Walsh, in order to mark a distinction with the Castilian meaning of “des” which can be understood as a simple disarm, undo the reversal of the colonial. The author shows that there is no null state of coloniality.

(B) Confluence of different social subjects (Amerindians of the floodplain and / or terra firma, blacks, Northeasterners, and Europeans of different nationalities).

(C) Known as nhengatu, ñe'engatú, nhangatu, inhangatu, it is a general Amazonian language, derived from the Tupi trunk. It belongs to the Tupi-Guarani language family.

(D) language of the Upper Rio Negro region.

(E) Arawak language spoken by the Baniwa people.

(F) Worldview built over many years by the highland peoples of the Andes, who have become invisible in the face of colonialism, patriarchy and capitalism. Thus, the term is used to relate quality of life to spirituality, nature, ways of life and consumption, politics, ethics.

(G) Strategy conceptualized by William A. Corsaro in his ethnographic studies, in which the population reacts to the presence and comes spontaneously to contact, without any other type of intervention or presentation.

(H) Set of notions and techniques aimed at medical, hygienic, nutritional, psychological care, etc., for young children, from pregnancy to four or five years of age

(I) Some relative or friend who could translate.

(J) Autoimmune disease, characterized by low levels of platelets, which are blood cells that prevent bleeding. series of rituals that the indigenous shaman performs on certain occasions with a specific goal of healing or magic.

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