

Experience Report: Situational Health Diagnosis Of The Guariba Indigenous Community, Roraima

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Abstract:

Our objective was to report on the experience of conducting a Situational Health Diagnosis during Stage I - community time of the Indigenous Collective Health Management Course, carried out in the Guariba Indigenous Community from November 6 to December 8, 2017. The main health problems identified by the community are the increase in chronic non-communicable diseases. We proposed an action on healthy dietary education. The results achieved by the developed action included the encouragement of healthier dietary practices rich in natural and traditional foods and a life with more regular physical exercise, along with the acquisition of knowledge about type 2 diabetes mellitus, its prevention methods, treatment, and control. As future managers in indigenous collective health, we can support, plan, and execute health promotion activities such as health education practices in advocating for differentiated and quality health care.

Keyword: Indigenous Health. Health Planning. Health Management. Health Promotion.

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I. Introduction

This paper is organized into five respective sections: the introduction, the experience report, the intervention proposal, the final considerations, and the references. It represents a segment of the Thesis defended in 2022, as an experience report on the Supervised Curricular Internship I - community time, which involves 120 hours of work and is one of four mandatory curricular internships of the Bachelor's Degree in Indigenous Collective Health Management (CGSCI) at the Insikiran Institute for Higher Indigenous Education

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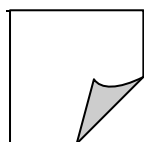
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of the Federal University of Roraima (UFRR) (UFRR, 2012). Accordingly, a Situational Health Diagnosis of the community was carried out, currently referred to in the field of collective health as a Health Situation Analysis (Brazil, 2015).

The situational strategic planning (SSP) was developed by Carlos Matus in the 1980s as a theoretical-methodological proposal for planning and governing (Kleba; Krauser; Vendruscolo, 2011). When SSP is used as a management tool in collective health, it facilitates the organization of work based on the principles of the Unified Health System (SUS), as it requires community participation, allows for the publication of information on the capacity of health services and their utilization by users, and mandates the use of epidemiology to establish priorities, allocate resources, and provide programmatic guidance (Paim, 2012; Brazil, 1990).

The SSP consists of four stages of a systematic process that seeks to organize interventions and generate results concerning a specific reality. These stages are: the explanatory moment; the normative moment; the strategic moment; the tactical-operational moment. Briefly, in the explanatory moment, we describe the current situation, identify and explain problems and needs. In the normative moment, we present the objectives and outcomes to be achieved. It is at this stage that solutions are formulated to address the problems prioritized and analyzed in the explanatory moment. In the strategic moment, we aim to examine and build feasibility for the proposed solutions, formulating strategies to achieve the outlined objectives. And in the tactical-operational moment, the plan is implemented. Here, the management model and the instruments for monitoring and evaluation of the plan must be deliberated and executed (Kleba; Krauser; Vendruscolo, 2011; Teixeira, 2010).

The explanatory moment consists of the Situational Health Diagnosis, which is one of the phases of the health planning function. The development of a situational health diagnosis is one of the responsibilities of health managers and collaborators. Upon its completion, it will allow for the formulation of their work proposal for the service they manage, both at the micro and macro levels within the health organization (Cecílio, 1997). The diagnosis can be conducted in institutions, programs, services, basic units, or territories, such as in indigenous communities.

Thus, the present work was carried out in the Guariba indigenous community with the purpose of characterizing the territory; identifying the main health needs and problems. Similarly, its structure was based on the information obtained through Stage I - community time. Secondary information was researched and provided by the Special Indigenous Sanitary District East Roraima (DSEI-EAST - Roraima), and primary information was provided by the community residents, taking into account their understanding, worldview, and cultural perspectives.

This is a descriptive study with a qualitative approach, in the form of an experience report. Descriptive research aims to observe and present more accurately the reality being studied (Polit; Beck, 2018). Experience reports are works that detail the specificities arising from particular experiences, which provoke reflections on the studied phenomenon (Pereira et al., 2020).

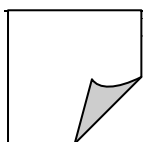
The relevance of this study lies in its aim to describe how the community understands its most prevalent health needs and problems, and how they think about and negotiate solutions within their territory. Consequently, the general objective of this study was to report the experience of conducting Stage I – Community Time - Situational Health Diagnosis carried out in the territory of the Guariba indigenous community, Araçá Indigenous Land, in the municipality of Amajari-RR, from November 6 to December 8, 2017.

II. Experience Report

This report recounts the experiences of a graduate from the Bachelor's Degree in Indigenous Collective Health Management at the Insikiran Institute for Higher Indigenous Education of the Federal University of Roraima, in the municipality of Boa Vista-RR, during the period from November 6 to December 8, 2017. Stage I was conducted through a prior connection with the community stemming from my belonging to the Wapichana people and being a resident of the Guariba indigenous community.

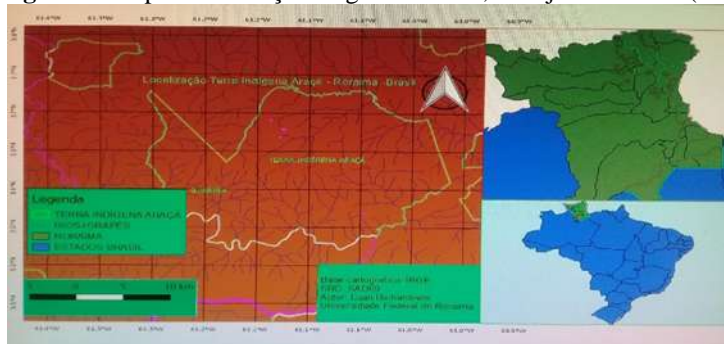
All information presented in this report was previously authorized and collected through semi-structured interviews with residents, community leaders, and some health professionals working at the Araçá Base Health Pole, located in the Araçá community, Araçá Indigenous Land, municipality of Amajari-RR. Our main objectives were to characterize the territory of the community (demographic, social, political, economic, environmental, structural characteristics, among others); identify institutions present in the community, such as schools and churches; identify the needs and main health problems. Data collection was conducted; the study of the gathered data; priority setting. Thus, upon understanding the situation, we chose a problem together with the community, over which we have governability, and proposed an intervention action.

The activities conducted corresponded to the Situational Health Diagnosis, a curricular activity of the Bachelor's Degree in Indigenous Collective Health Management, carried out in the Guariba Indigenous Community, located in the Amajari Ethnoregion, Amajari municipality, part of the Araçá Indigenous Land, as shown on the map in figure 1. During this period, through observations of the territory's characteristics and the



population, it was possible to better understand the community's socio-economic and cultural structure, as well as to reflect on its dimensions, potentialities, limitations, and needs. The Guariba community is located in the Araçá Indigenous Land, Amajari municipality, in Roraima, accessible via the highway, BR 174, followed by RR 203. The Araçá Indigenous Land, established in the 1960s, comprises six indigenous communities: Araçá, Guariba, Mangueira, Mutamba, Novo Paraiso, and Três Corações. In 2021, it had a population of about two thousand people, including children, youth, adults, and the elderly.

Figure 1: Map of the Araçá Indigenous Land, Amajari Roraima (RR)



Source: Luan Richardson Tavares da Silva/QGIS Program (2018)

The total population of the Guariba community is divided into 96 families residing in the community, totaling 330 people, with some family members living in neighboring communities and villages near the Araçá Indigenous Land. The population includes 54 children aged 0 to 4 years, 59 children aged 5 to 11 years, 54 adolescents aged 12 to 17 years, 20 youths aged 18 to 19 years, 88 adult and elderly men, and 58 adult and elderly women (Community Census, 2022). The Araçá Indigenous Land covers an area of 52,700 hectares, consisting of marked farmland islands; in the Guariba community, there is a vast expanse of farmland, highlighted in **figure 2**.

Figure 2: Environment/Farmland of the Guariba Community/T.I. A – Amajari-Roraima (RR)



Source: Luan Richardson Tavares da Silva (2021)

The area also features rivers, streams, and lakes, named as follows: Amajari River; Paraíso Stream; Galego Stream; Inferninho Stream; Inácio Stream; Guariba Stream; Veado Stream; Igreja Stream; Trajano Stream; Sucuri Stream; São Luiz Stream; Sapo Stream. Additionally, there are various uniquely named lakes: Roça Lake; Maravilha Lake; Chico Sozinho Lake; Espera Lake; Casa Velha Lake; Hugo Lake; Aninga Lake; Escuro Lake; São Domingo Lake; Pinto Lake; Grande Lake. These lakes and rivers are home to various fish species, including traíra, cará, mandi, pirapucu, pirarucu, pacu, aracu, piranha, matrinxã, curimatã, branquinha, surubim, caparari, tucunaré, and others, along with marine and terrestrial animals such as capybaras and alligators. These are obtained through traditional and non-traditional methods.

The community features areas of farmland and forests, with small forests named: São Domingo Island; Cajueiro Island; Ponte Island; Fernandes Island; Saúva Island; Panelada Island; Grande Island; and Mirixi Island, where hunting and crop cultivation are practiced. Game such as white-lipped peccary, collared peccary, agouti, deer, armadillo, paca, curassow, and junglefowl, among others, can be found. In the cultivated fields, crops such as cassava, banana, papaya, sugarcane, pepper, sweet potato, yam (cará), corn, beans, and others are grown.

In **figures 3** and **4**, one can observe the physical structures of the dwellings in the community, which consist of traditional houses. The materials used include najá palm straw (roof), buriti palm straw (roof, capote, and guieiro), envira for tying the straws (vine from tree bark), wood, mud (walls), and masonry houses.

Figures 3 and 4 - Housing structures, masonry and traditional/straw and wood
Source: Luan Tavares (2021)



Source: Luan Richardson Tavares da Silva (2021)

In Figures 5, 6, and 7, one can observe that the community's food is sourced from their own crop production, including cassava flour, white flour (tapioca), beiju, banana cultivation, pumpkin, sugarcane, papaya, yam (cará), sweet potato, beans, buriti, and beverages such as caxiri, aluá, moco-roró, and buriti wine. Meat is provided by community projects and hunting practices, fish from aquaculture ponds as well as fishing activities in streams, lakes, and the river. The diet is supplemented with industrialized foods, processed and canned goods, such as sausages, pepperoni, frozen chicken, frozen meat, rice, beans, coffee, sugar, pasta, savory snacks, packaged snacks, cookies, filled biscuits, chocolates, sausages, and beverages like packet juices, bottled juices (glass and plastic), and sodas.

Figures 5, 6, and 7: Foods produced in the fields:
Banana Pepper Cassava, and Corn



Source: Luan Richardson Tavares da Silva (2021)

The Guariba community, in the current context, has a population comprising the Macuxi and Wapichana ethnicities, with a predominance of the Wapichana ethnicity accounting for 95% of the population. Culturally, we engage in the Parixará dance, enjoy damurida cuisine, speak the Wapichana language, participate in sports games, practice hunting and fishing, manage farms and gardens, and celebrate with festive events (forró, church festivities), as well as sports games (soccer, volleyball, dodgeball, capture the flag, and others).

In the educational field, the community has two schools and one daycare center. We have the Tuxaua Manoel Horácio State Indigenous School, which offers regular elementary and secondary education, serving 127 students in Elementary I, Elementary II, and High School. Its staff comprises a total of 24 professionals, including managers, the Parent-Teacher Association (PTA), Pedagogical Coordination, and Student Assistance. There are 18 teachers and 6 staff members: 1 kitchen assistant, 1 custodian, 1 secretary, and 3 security personnel. The Municipal School and the daycare center cater to a total of 29 children in daycare, first and second period, and have a total staff of four professionals, including a manager, teachers, a student assistant, and a cook.

The community is served by the state electrical grid 24 hours a day, with 95% of dwellings covered. The community is also served by a water supply network that reaches 90% of the community, sourced from an artesian well with distribution via a 5,000-liter water tank; water treatment is only performed using sodium hypochlorite. Water analysis is conducted by the sanitation agent and sent to the base station to be tested for microorganisms and substances that may affect the population's health. The trash produced in the community is managed as follows: the more solid waste is deposited in a 5 meter deep earth pit, and household waste is the responsibility of each family, with paper being incinerated and glass disposed of in holes in the yard.

The community's economy is focused on local commerce, with money circulating from the salaries of public servants such as teachers, security personnel, indigenous health agents, indigenous sanitation agents, market sales, self-employment, pensions, government assistance, and community and family projects such as

fish farming, domestic cattle projects, along with family farming, small-scale crop farming, and the raising of small animals such as poultry and pig farming.

The Guariba Indigenous Community is served by the Araçá Base Pole, which is linked to the Special Indigenous Sanitary District East Roraima (DSEI EAST-RR). This facility is located in the Araçá community, Araçá Indigenous Land, situated ten kilometers from the Guariba community. The community has a health post located in the center of Guariba with three health professionals: two Indigenous Health Agents and one Indigenous Sanitation Agent. The community receives monthly visits from Multidisciplinary Indigenous Health Teams (EMSI), on a rotating basis. The first team consists of a vaccinator, a nursing technician, and a doctor, while the second team comprises a nurse, a dental assistant technician, and a dentist. Due to the service demand at the base pole, the visits by the Multidisciplinary Indigenous Health Teams are scheduled for two days once a month. The structure of the local health post is made of masonry and includes two rooms for medical and dental services, a room for conducting anamnesis, and a medication room (Pharmacy for primary care only).

The services provided by the Indigenous Health Agents (IHA) are carried out through home visits, weight monitoring, patient follow-up, medication administration and monitoring, emergency care (first aid), and support to multidisciplinary teams, such as in transfers to secondary care and, in severe cases, to tertiary care. Additionally, the community turns to the care and treatment of health conditions using medicinal plants (phytotherapy) due to the scarcity and lack of medications in primary care. The Indigenous Basic Sanitation Agent (IBSA) is responsible for environmental care, water treatment and supply, and provides support to the IHA and EMSI.

At the Base Pole, the following programs are implemented: Women's Health, Men's Health, Oral Health, Child Health, and Hiperdia. The Hiperdia Program serves 19 hypertensive and 12 diabetic patients, totaling 31 patients in the Guariba community. The Hiperdia Program is the Registration and Monitoring System for Hypertensive and Diabetic Individuals (HIPERDIA), established in 2002 to register and monitor individuals with hypertension and/or type 2 diabetes, generating information for professionals and managers at the Municipal, State Health Departments, and the Ministry of Health (Pereira, 2013).

The services offered by the EMSI include: immunization, blood pressure measurement, weight measurement, pharmaceutical assistance, control of endemic diseases, malaria diagnosis, monitoring of chronic patients, low-risk prenatal care and referrals for high-risk cases, nutritional surveillance, home visits, dental care, follow-up of the elderly/Hiperdia, children, adolescents, adults, and the elderly, collection of preventive samples, rapid HIV testing, laboratory tests, recording of health actions, and maintenance of medical records.

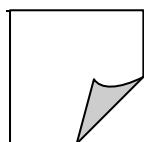
The main health problems identified by the community include the rise of chronic non-communicable diseases (NCDs), excessive alcohol consumption, drug-related issues, an increase in respiratory diseases among children, adults, and the elderly, and seasonal diarrheal diseases, typically at the beginning and end of winter, which usually occurs from May to September each year. According to a discussion with the health team, the most prevalent diseases in the community population are diarrhea, influenza, and boils (tumors), along with NCDs such as Systemic Arterial Hypertension (SAH) and Type 2 Diabetes Mellitus (T2DM), and health complications (accidents involving vehicles and venomous animals). In the community, there are 12 patients diagnosed with T2DM and 19 with SAH. The care for diabetic and hypertensive patients involves frequent assessments, the administration of controlled medications, and the use of phytotherapy, such as teas and herbal mixtures, which help control diabetes and hypertension. The incidence of Type 2 Diabetes in the community remains a current issue.

III. Intervention Proposal

The health issue, highlighted by the situational health diagnosis, was the incidence of Type 2 Diabetes (DM 2) and the consumption of healthy food among the residents of the Guariba indigenous community, which is caused by multiple modifiable factors. The main factors observed were sedentary lifestyles and the disordered consumption of industrialized foods and beverages (such as dairy and packaged products), which are consumed in addition to natural foods (obtained through hunting, fishing, and family farming).

Given the exposure to conditioning factors for the acquisition of health conditions and diseases, the relationship between diet and physical inactivity was prioritized to promote, prevent, and control the prevalence of Type 2 Diabetes (DM 2) in the Guariba community. As DM 2 is an emerging disease in populations undergoing Westernization, it is necessary to disseminate information to prevent, promote, and control the health-disease situation and care. This involves explaining which factors and causes are identified from empirical and scientific knowledge concerning the incidence of DM 2.

Non-communicable diseases (NCDs) among indigenous peoples assisted by DSEI EAST RR have shown an increasing level over recent years, necessitating preventive and health care actions. The NCD Program in 2019 followed a number of 1,044 patients registered with Systemic Arterial Hypertension (SAH), and 481 patients with Diabetes mellitus, 329 with both Hypertension and Diabetes, of which 85 patients regularly use



Insulin (Brazil, 2020). The progression of the increase in NCDs among the indigenous peoples served by DSEI EAST RR from 2016 to 2019 can be observed in **Table 1**.

Table 1 - Progression of the increase in NCDs among the indigenous peoples served by DSEI East Roraima, from 2016 to 2019.

Injuries or Harm	Period			
	2016	2017	2018	2019
Systemic Arterial Hypertension (SAH)	879	928	1.009	1.044
Type 2 Diabetes Mellitus (DM 2)	388	405	461	481
Systemic Arterial Hypertension (SAH) and Type 2 Diabetes Mellitus (DM 2)	230	220	254	329

Source: Adapted from the District Indigenous Health Plan of DSEI East-RR for the period 2020 to 2023 (Brazil, 2020).

As a serious issue, non-communicable diseases (NCDs) among indigenous peoples arise due to a complex and broad epidemiological profile that includes: "the expansion of agricultural frontiers, environmental degradation, the restriction of traditionally traversed territories, land conflicts, and increasing contact [...]" (Chagas et al., 2020, p. 2). Bringing this to the specific reality of the Guariba indigenous community, although there are some local differences, one can also add to this issue the community's proximity to urban centers and easy access to ultra-processed foods, as well as changes in work processes and an increase in sedentary lifestyles (Basta; Orellana; Arantes, 2012).

Given the observed situation, it is possible to plan an action aimed at promoting the consumption of healthy food with an emphasis on indigenous diets and encouraging physical activity. Understanding the dietary conditions of indigenous peoples plays a crucial role when considered in its broadest possibilities. This involves concretely supporting the proposal for differentiated care, which takes into account "the cultural, epidemiological, and operational specificities of these peoples" (Brazil, 2002, p. 6). This principle ultimately guides the National Policy for Health Care of Indigenous Peoples and necessarily applies to the nutritional dimension.

Bringing this to the local reality, as a future manager in indigenous collective health, it is perceived that some managers do not focus on the concern with social determinants of health, the provision of quality services, prioritizing the real needs of the communities, the standard of well-being socially valued by specific cultures, as well as the appreciation of the social representation of health and disease. There is a greater demand on the institution and operationalization of care services, which allows reflection on how relevant the discussion of Health Promotion is and how it permeates the addressing of various challenges in indigenous health, given its specificities in the health-disease-care dimension.

Given the above, the following is a description of the problem to be addressed and the action programming matrix (**Table 2**):

Problem to be addressed: Consumption of industrialized foods among the indigenous populations of the Guariba community;

Causes: The consumption of industrialized foods high in sugar, salt, and fat;

Descriptors: Some of the diseases affecting the indigenous populations of eastern Roraima include diabetes mellitus and arterial hypertension (Brazil, 2020);

Indicator: Percentage of the Guariba community's indigenous population participating in health education actions, thereby facilitating a dialogue with indigenous knowledge in the process of health, disease, and care;

Goal: Reduction of 0.5% in the incidence of major morbidity and mortality in the indigenous population of the Guariba community. To provide the necessary knowledge to favor transformations in health practices and empower the community to become agents of change in the sanitary profile and the consolidation of practices more suitable to their health needs;

Impact to be generated (outcome): It is expected to share knowledge about health and quality of life with the indigenous population of the Guariba community and to value all ways of life in relation to the consumption of healthy foods. This encourages healthy practices and a critical sanitary awareness. The aim is to prevent and reduce the occurrence of chronic non-communicable diseases (diabetes, hypertension, neoplasms, etc.);

Target audience: Indigenous population of the Guariba community. We hope to reach approximately 50 people with the activity;

Location of the action: Indigenous community of Guariba;

Table 2: Action matrix for education on the consumption of healthy foods

Action	Healthy Food Education
Resources	Human resources; informative pamphlets; conversation circles; lectures for health prevention and promotion.
Products	Development of booklets with clear information and accessible language about type 2

	diabetes mellitus. And the importance of physical activity in the control of Type 2 Diabetes Mellitus and Systemic Arterial Hypertension.
Impact/Results	The aim is to promote understanding of what healthy eating entails, encourage the consumption of traditional foods, and reduce the intake of ultra-processed foods; to promote regular physical activity; and to facilitate social interaction with individuals with Type 2 Diabetes Mellitus and other community members.
Health Indicators	Prevalence of Type 2 Diabetes Mellitus
Goals	To prevent, promote, and control health-disease-care in 5% of the population participating in the action; To encourage healthy eating in 5% of the population participating in the action; To promote the practice of physical activities and exercise in 5% of the population participating in the action; To expand knowledge about Type 2 Diabetes Mellitus and other NCDs in 5% of the population participating in the action;
Deadlines	Implemented during the course of Internship I, with the projection to be established in community contexts continuously (to be scheduled with the community during assemblies and meetings, and in conversations with the Indigenous Health Agents (AIS), and in the care provided by the Specialized Multiprofessional Indigenous Health Teams (EMSI), suggesting that it occur once every semester when possible).
Responsible for the action	Academic: Luan Tavares; AIS: Marta Maria Tavares Santiago AIS: Francineide Tavares de Souza AISAN: Jocildo Santana Santiago EMSI: Physician, Psychologist, Nurse, Nursing Assistant, Social Worker, Nutritionist.

Source: Ana Paula B. Alves; Luan Richardson T. da Silva (2022)

The methodology to implement the action will be through discussion circles among IHA, IBSA, and other members of the EMSI, with meetings negotiated with the population for the distribution of information according to each point of action, prevention, promotion, and health control. Health care talks will focus on chronic non-communicable diseases. By promoting joint actions for the dissemination of information about DM 2 and SAH, the important concepts and ways to prevent these health conditions, and how to establish effective care practices for those diagnosed with DM 2 in the Guariba Indigenous Community will be crucial for our well-being.

The outcomes achieved by the developed action included the promotion of healthier eating practices, rich in natural and traditional foods, a life with more regular physical exercises, and the acquisition of knowledge about chronic non-communicable diseases, particularly type 2 diabetes mellitus—its prevention, treatment, control, and how to manage the disease in a safe and healthy way. Encouraging indigenous diets with our traditional foods and reducing the consumption of industrialized foods could be a way to prevent the future incidence of these health conditions in our population. Regarding the encouragement of physical activities and exercises, groups will be formed to foster and carry out these practices regularly, such as daily walks, for example, and health agents and EMSI consultations will be primarily responsible for their monitoring.

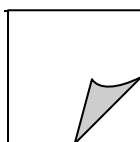
IV. Conclusion

During Stage I - Community Time, the health situation along with the conditioning and determining factors were presented. Observing these factors, it is evident that they directly impact the local population of the Guariba Indigenous Community. Accordingly, based on our governability, we propose actions for prevention and health promotion to prevent NCDs and to encourage healthy eating, especially from our traditional diet, and emphasize the importance of physical activity and exercise, considering our cultural context.

As future managers in indigenous collective health, we can support, plan, and execute health promotion activities such as health education practices. To make these health actions more effective and promote healthier conditions in our community is our goal. Our desire is to advocate for differentiated and high-quality health care in conjunction with health professionals working in primary care services. In addressing the issue of preventing and promoting health among the indigenous population, it is essential to establish favorable access to primary care, where it is necessary to include various strategies to combat situations and conditions of vulnerability.

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