

## **In the land of Iara, Iracema and Macyrajara, what health practices will I offer? Analysis of the trajectories and perspectives of health policies for indigenous peoples in Brazil**

**Em terra de Iara, Iracema e Macyrajara, quais práticas de saúde vou ofertar?: Análise das trajetórias e perspectivas das políticas de saúde aos povos indígenas no Brasil**

**En la tierra de Iara, Iracema y Macyrajara, ¿qué prácticas de salud ofreceré?: Análisis de las trayectorias y perspectivas de las políticas de salud para los pueblos indígenas en Brasil**

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**Edson Oliveira Pereira**

ORCID: <https://orcid.org/0000-0002-8933-8141>

University of Brasília, Brazil

E-mail: [edsondirec@gmail.com](mailto:edsondirec@gmail.com)

**Bernardino Vitoy**

ORCID: <https://orcid.org/0000-0002-2933-4114>

Pan American Health Organization - World Health Organization, Brazil

E-mail: [vitoerber@paho.org](mailto:vitoerber@paho.org)

**Daniel Ignacchiti Lacerda**

ORCID: <https://orcid.org/0000-0001-7701-5380>

Várzea Grande University Center, Brazil

E-mail: [daniel.ignacchiti@gmail.com](mailto:daniel.ignacchiti@gmail.com)

**Damaris Silveira**

ORCID: <https://orcid.org/0000-0003-1851-5224>

University of Brasília, Brazil

E-mail: [daniel.ignacchiti@gmail.com](mailto:daniel.ignacchiti@gmail.com)

### **Abstract**

There are indigenous people on the North and South American continents who dwelled there before the Portuguese, Spanish, French, English, or Dutch invasions. With the European colonization, much of the indigenous population was enslaved, Christianized, and decimated almost completely. Presently, besides everyday challenges, such as rights and access to the homeland, agribusiness clashes, and other threats, there is a precariousness in the management and provision of healthcare provided to the Amerindians. This paper aims to draw a timeline on the state of health of Brazilian indigenous people, identifying its subjects, assessing its contexts, and discussing the legal milestones. Indigenous health policies hold (or at least should hold) a central position in the provision of healthcare to the indigenous population wherein they offer integral, universal, and equanimous healthcare services. Despite this, the urge to recognize some fragility restrains the management and provision of the health policies for the indigenous people.

**Keywords:** Indigenous health; Public health policy; Public health.

### **Resumo**

Os indígenas são caracterizados como os povos que já habitavam o continente americano antes mesmo das invasões portuguesa, espanhola, francesa, inglesa e/ou holandesa. Com a colonização europeia, muitas dessas populações foram escravizadas, cristianizadas e dizimadas quase que completamente. No cenário atual, além dos desafios cotidianos, tais como o direito e acesso à terra e os conflitos com o agronegócio, percebe-se também uma precariedade na oferta/gestão do cuidado em saúde direcionado aos ameríndios. Este artigo teve como objetivo descrever a trajetória histórica da saúde dos povos indígenas brasileiros, com a identificação dos seus sujeitos, retratação dos contextos e diálogo com os marcos legais. Percebeu-se que essas políticas são (ou pelo menos deveriam ser) um lugar de centralidade na oferta de cuidado em saúde às populações indígenas, ao oferecer uma saúde integral, universal e equânime. Apesar disso, é preciso reconhecer a existência de algumas fragilidades/dificuldades que cotidianamente circunscrevem a gestão/oferta do fazer saúde aos indígenas.

**Palavras-chave:** Saúde da população indígena; Políticas públicas de saúde; Saúde pública; Saúde indígena.

## Resumen

Los pueblos indígenas se caracterizan por ser personas que ya habitaban el continente americano incluso antes de las invasiones portuguesas, españolas, francesas, inglesas y / o holandesas. Con la colonización europea, muchas de estas poblaciones fueron esclavizadas, cristianizadas y diezmadas casi por completo. En el escenario actual, además de los desafíos cotidianos, como el derecho y acceso a la tierra y los conflictos con la agroindustria, también existe una precariedad en la provisión / gestión de la atención de salud dirigida a los amerindios. Este artículo tuvo como objetivo describir la trayectoria histórica de la salud de los pueblos indígenas brasileños, identificando a sus sujetos, retratando los contextos y dialogando con los marcos legales. Se percibió que estas políticas son (o al menos deberían ser) un lugar de centralidad en la provisión de atención de salud a las poblaciones indígenas al ofrecer salud integral, universal y equitativa. A pesar de ello, es necesario reconocer la existencia de algunas debilidades / dificultades que circunscriben cotidianamente la gestión / prestación de atención de salud a los pueblos indígenas.

**Palabras clave:** Salud de la población indígena; Políticas de salud pública; Salud pública; Salud indígena.

## 1. Introduction

According to Brazil's last demographic census (2010), more than 890,000 indigenous people live in Brazil, corresponding to 305 ethnic groups that speak 274 languages. These people are distributed across all states, corresponding to 0.4% of the country's population. There are 505 indigenous lands occupying about 12.5% of the national territory (Brazil, 2010). Generally speaking, these populations, known as indigenous or Amerindians, are characterized as people who inhabited the American continent before the Portuguese, Dutch, French and English invasions (Brazil, 2006).

Despite the vast ethnocultural diversity, some common aspects characterize these people, such as (a) historical existence prior to the colonization process; (b) strong attachment to the idea of territory; (c) well-established social, economic, political, cultural, and symbolic systems; and (d) an identity different from the one that is hegemonically assumed by the rest of the national population (Garnelo, 2003).

In general, it is important to emphasize that the aggressions and attempts to decimate indigenous people at the beginning of the 16th century employed different tools, from pathological diseases triggered by contact with the "white" people to the slavery process, involving forced labor, ill-treatment, confinement and compulsory sedentarization in villages and boarding schools, which generated negative impacts on self-esteem, besides significant social, economic, cultural and symbolic disruption (Lima Junior, 1998). Owing to this tragic past, Amerindians have a specific epidemiological profile, marked by indicators such as higher deaths than in the rest of the population and high incidence of diseases such as malnutrition, tuberculosis, sexually transmitted infections (STIs), and vaccine-preventable diseases (Oliveira, 1995).

Since the promulgation of the Federal Constitution of 1988 (Brazil, 1988), healthcare took on new directions in Brazil and began to be considered a right of all and a duty of the State. With the democratization of the sector, discourse on the health policies for indigenous people came to the forefront. However, this path was intertwined with social, economic, and political inequalities in the country. The major regulatory milestone in the healthcare of the indigenous population was the approval of the National Policy for Health Care for Indigenous Peoples (PNASPI), but there were other important events in this construction (Brazil, 2002).

Taking into account a significant knowledge gap throughout history and the scarce scientific contributions in the subject of 'indigenous health', this article describes a historical trajectory of the state of health of Brazilian indigenous people, along with the identification of subjects, portrayal of contexts, and discussion of legal frameworks. Thus, in this theoretical essay, some advances, challenges, and possibilities in the field of indigenous health are presented, in addition to fostering a socio-critical reflection on the various public health policies and actions offered to these people. Thus, the main normative documents concerning the health of the Amerindian population were analyzed. Parallel to this process, relevant authors were brought in to discuss the identified regulatory frameworks.

## 2. Origin of Indigenous Health: a Path of Scars

The approval of PNASPI (Brazil, 2002) through Ordinance No. 254, on January 31, 2002, of the Ministry of Health, signified, without doubts, a great advance pertaining to indigenous health, while also valuing cultural diversity, acknowledging the growing acquisition of rights by these people, promoting their citizenship and increasing their visibility within the society. However, it was not an easy or instant trajectory. Indigenous peoples present themselves as survivors of processes that exposed them to conditions of great vulnerability, such as the epidemics of infectious diseases caused by the way of life imposed by colonization and Christianization.

The fact that these events are dated to remote periods does not exclude the possibility of present-day repetitions, even if in minimized proportions, because “even today there are regional situations of conflict, in which the entire web of economic and social interests is exposed, they configure the relationships between indigenous peoples and other segments of national society” (Oliveira, 1995). These conflicts are based on economic interests concerning land tenure, exploitation of natural resources, and implementation of large development projects.

Missionary assistance since the beginning of colonization had no visible effects on the state of indigenous health. However, the expansion of economic frontiers to the Brazilian west-central region, mainly through the construction of telegraph lines and railways in the early 20th century, caused numerous massacres, sharply increasing the mortality rates caused by communicable diseases (Martins, 2013).

At a time when indigenous people were thought to be posing serious threats due to conflicts caused by contact with non-indigenous people, the Protection Service, a policy focused on control and domination over the natives, was established in 1910, with the objective of exercising the power of the State. The Indian and National Workers (SPITN), linked to the Ministry of Agriculture, Industry and Commerce (Lima Junior, 1998; Oliveira, 1995) which, in 1942, through Decree No. 10.652, of October 16, underwent restructuring, was transformed into the Indian Protection Service (SPI), still linked to the Ministry of Agriculture.

The idea that the Indians were susceptible to “evolution” and society considered them “in an infant stage of humanity” contributed to an indigenist policy that began to be outlined through educational and agricultural projects. However, these attempts to integrate the indigenous people into the national society were unsuccessful owing to existing conflict of interests, causing more destruction to the indigenous population, such as “losses of land and living conditions, and disrespect for the rights of ethnic differences” (Martins, 2013).

The Indian Protection Service did not bring advances in indigenous healthcare but instead resulted in disorganized and sporadic emergency responses to epidemic outbreaks (Brazil, 2002; Costa, 1987). In a systematic analysis of the actions of the SPI, Ribeiro (1982) claimed that the positive fact of having prevented tribes from becoming extinct did not make the system ideal; the pacification of hostile tribes brought about by the SPI led to the spread of hunger and diseases, and social disintegration, wherein the indigenous people became the most miserable and marginal segments of society.

While epidemics only increased in the 1950s, the Ministry of Health, during the Juscelino Kubitschek government in 1956, created the Air Sanitary Units Service (SUSA), administratively linked to the National Tuberculosis Service (SNT), to provide assistance to indigenous populations that lacked access to proper healthcare (Costa, 1987), but its objectives went beyond the care of tuberculosis patients and extended to vaccinations, and dental care, in addition to actions aimed at other communicable diseases (Brazil, 2002). However, the Indians with the greatest contact with the national society were deprived of the services provided by SUSA (Langdon, 1999).

When the military came to power in 1964, the concept of the indigenous people as an obstacle to the country’s development resumed (Martins, 2013), and the SPI became increasingly fragile. The SUSA model inspired the creation of the Volante Health Teams (EVS) in 1967, when the SPI was extinguished, giving way to the National Indian Foundation

(FUNAI). The EVS performed sporadic medical assistance, administered vaccines, and supervised the work of local teams, which generally comprised nursing assistants or attendants in the community of their jurisdiction (Brazil, 2002). Meanwhile, SUSA was renamed the Special Care Unit (UAE) in 1968 and restricted care to people with tuberculosis. Moreover, this system remained focused on sporadic and individual care actions, not evolving in a way that suited an effective model; its main problems were related to the unpreparedness of health professionals, lack of resources, and lack of coordinated management services (Costa, 1987). FUNAI, over decades of operation, has always distanced itself from discussions regarding the absence of local health systems capable of assisting with the health needs of indigenous people, that is, systems in which regular, continuous, and systematic services focused on primary healthcare and disease prevention are offered (Garnelo, 2003).

As proof of the disruption of their actions, the EVS, over time, settled in urban centers, and their assistance to villages decreased until it no longer existed, thus negatively impacting communities that were provided medical assistance by unqualified people (Brazil, 2002).

### **3. From the Federal Constitution to the Unique Health System**

The Federal Constitution (FC), approved in 1988, established a new treatment for indigenous people, recognizing and respecting their cultural identity as their own; it differentiated social organization, customs, languages, beliefs, and traditions while ensuring the right to remain in the condition of their origin and the original right to usufruct the lands they traditionally occupied (Martins, 2013). The role of the State then shifted from the protection of people to the protection of rights.

Undoubtedly, the FC was a great demonstration of development and social maturity in the consolidation of the democratic regime as it established the legal bases for the recognition of social rights in Brazil. The right to health as a citizenship right was one of the most consecrated achievements, and the State's duty to ensure the exercise of this right was perhaps one of the greatest challenges approved by the FC, which thereby incorporated the principles of universality, integrality, and equity. The fact that the FC recognized and respected cultural diversities and also stipulated territorial protection is configured as one of the most advanced legal documents regarding indigenous issues (Langdon, 1999).

The mobilization of the indigenous movement by non-governmental organizations linked to indigenous issues, universities, and churches, between 1970 and 1980, was decisive in the inclusion of indigenous rights in the FC (Oliveira, 1995). Thus, approved by the 8th National Health Conference, the 1st National Conference for the Protection of the Health of the Indian took place in 1986; the proposal was repeated at the 9th National Health Conference, which again approved the holding of the 2nd National Health Conference for Indigenous People, which took place in 1993.

Based on indigenous claims debated and approved in these two conferences for the creation of a specific and universal health system that would guarantee the participation of indigenous people in the decision-making processes of planning, execution, and evaluation of actions and activities (Martins, 2013), a model of differentiated care was structured; Special Indigenous Sanitary Districts (DSEI) were formed to guarantee healthcare access based on universality and integrality proposed by the Unified Health System (SUS). One year after the SUS regulation, in 1991, Presidential Decree No. 23 was published.

This same decree instituted the strategy of the DSEI as a new standard for the organization of health services, thus creating, in the MS, the Indigenous Health Coordination (COSAI), linked to the Department of Operations (DEOPE) of the National Health Foundation (FUNASA), with the objective of implementing a new model for indigenous healthcare. That same year, the National Health Council (CNS) established the Intersectoral Commission for Indigenous Health (CISI) to advise on the development of government policy principles and guidelines in the field of indigenous health. Contrary to this process of construction of the indigenous health policy, in 1994, through a presidential decree, the Intersectoral Health Commission (CIS) was created, involving the participation of several ministries related to indigenous health.

The CIS approved, through Resolution No. 2, on October 1994, the Model of Comprehensive Health Care for the Indian, which was assigned the responsibility for the recovery of the health of the Indians, and the Ministry of Justice. of Health, which undertook the responsibility for prevention, through actions of immunization, sanitation, training of human resources and control of endemic diseases (Brazil, 2002; Martins, 2013; Ribeiro, 1982).

In this scenario, FUNASA and FUNAI shared responsibility for indigenous healthcare, starting to execute, as in previous historical contexts, the actions in a fragmented and conflicting manner. Each organization began to define its agreements with municipalities, universities, and organizations in a disorderly way, without the definition of clear and objective goals (Brazil, 2002; Langdon, 1999).

#### **4. Indigenous Health from the Subsystem**

Of all the achievements in the field of indigenous health, one of the most remarkable feats regarding public actions was the institution of the Subsystem for Indigenous Health Care (SASI), as a component of the SUS, through Law No. 9,836/99; it was popularly known as Lei Arouca because deputy Sérgio Arouca was the author of the bill (PL) that gave rise to this law. Among other measures, the law transferred indigenous health actions to the Ministry of Health, which became responsible for establishing policies and guidelines for the promotion, protection, and recovery of the Indians' health. That same year, Decree 3,156, on 27 August, delegated to FUNASA, a foundation linked to MS, the competence to carry out these actions.

In the scenario of the decentralization of SUS and its approximation with the various social, political, and administrative realities in Brazilian states and municipalities, SASI-SUS, in its practice, traced completely different paths. So, it was up to FUNASA to implement the Subsystem to Indigenous Health Care, through the creation of 34 DSEI, whose management and execution of indigenous health actions took place through services belonging to FUNASA's Regional Coordinations, "without sufficient human resources to enable the production of health services and activities and without bureaucratic capillarity to carry out the local management of health districts" (Martins, 2013) and also with the mission of planning services based on the ethnic and cultural specificities of indigenous peoples (Brazil, 1999).

In this context, to operationalize the National Health Care Policy for Indigenous Peoples (Brazil, 2002), FUNASA services in each DSEI did not have administrative, technical, and financial autonomy to manage their resources and address indigenous social problems, making these services politically and institutionally subordinated to that foundation. Administratively, the DSEI was subordinated to FUNASA's Regional Coordinations for the purchase of medicines, strategic health supplies, office supplies, health equipment, tickets and per diems, contracts in general, budget management, and payments (Martins, 2013).

Within FUNASA, the Department of Indigenous Health (DESAI) administered political-administrative relations and coordinated the SASI nationwide. Within the scope of the MS, SAS restricted itself to decentralizing financial resources, in the form of incentives, to municipalities and hospitals that had an indigenous population in their coverage areas.

To overcome the challenge of hiring human resources to carry out indigenous health actions, there have been failed attempts to establish partnerships. FUNASA and MS then signed agreements with various non-governmental organizations, many of them constituted by the indigenous communities themselves, but most of them without any experience to assume such responsibility (Martins, 2013).

In a holistic analysis of SASI's early years, outsourcing, through signed agreements, was the most feasible measure for FUNASA to implement the Indigenous Health Care Subsystem on a national scale, even with a strong centralization of power within the scope of DESAI, and faced with an unfavorable context, especially regarding the quality and number of staff (Garnelo, 2005).

From this context, with the failure to comply with Law 8080/90, in which SASI was included with regard to financing, it is up to the Brazilian federal government to do so with its own resources, with the complementary participation of states, municipalities and other government and non-governmental institutions. However, in practice, during the first years of implementation of the Subsystem for Indigenous Health Care the complementary participation was unsuccessful:

But the complete transfer of the execution of indigenous health care actions by FUNASA to non-governmental organizations, which is not only a violation of the aforementioned norms, relating to transfers to the private sector, but circumvents the constitutional norm that determines the prior holding of public examinations for hiring personnel, as it routinely creates serious embarrassments and compromises the efficiency of indigenous health care actions otherwise (Martins, 2013).

This is a complex and ambiguous situation because, on the negative side, the outsourcing of healthcare to indigenous organizations did not grant them autonomy and self-management but required them to learn bureaucratic management actions that are not common to their organizational practices. However, it entailed an administrative and managerial strengthening of indigenous entities, earning them more respect during interactions between ethnic minorities and the Brazilian State (Garnelo, 2005).

## **5. The Birth of PNASPI**

In this context, in 2002, approved by the National Health Council and regulated by Ministry of Health Ordinance No. 254, the National Policy for Health Care for Indigenous Peoples (PNASPI) was formed from the need of the health sector to have a specific policy for indigenous people, as opposed to consultations with different segments directly or indirectly involved with indigenous issues. This policy was built in compliance with the determinations of the Federal Constitution of 1988 and the Organic Health Laws (8,080/90 and 8,142/90), regulated by Decree No. 1,356 on August 27, 1999, by Provisional Measure No. 1.911-8 and by Law 9,836/99, on September 23, 1999.

Until the creation of PNASPI, indigenous healthcare was managed by various sectors and agencies, which performed palliative actions and discontinued activities with little impact on the health situation (Brazil, 2016; Cardoso, 2015; Garnelo, 2018). Thus, to ensure indigenous peoples the access to healthcare in accordance with the principles and guidelines of the SUS while also incorporating diversity (ethnic, social, cultural, geographical, historical, and political) and recognizing the processes of traditional indigenous healing systems and their rights and culture (Brazil, 2002), the PNASPI challenged the previously implemented management system by proposing that the DSEI should have greater autonomy and that social control should be strengthened (Brazil, 2002; Oliveira, 1995).

To implement the objectives proposed by the policy, guidelines were created to guarantee and sustain the processes of planning, implementation, evaluation, and control of health actions for the indigenous population, such as organization of healthcare services for indigenous peoples in a format of DSEI; preparation of human resources to work in an intercultural context; monitoring of health actions aimed at indigenous peoples; articulation of traditional indigenous health systems; promotion of the adequate and rational use of medications; promotion of specific actions in special situations; promotion of ethics in research and healthcare actions involving the indigenous community; promotion of healthy environments and protection of indigenous health; and social control (Brazil, 2002).

The DSEI is conceptualized in the policy as a “model of service organization, oriented towards a well-defined and dynamic ethnocultural, geographic, population and administrative space,” with the responsibility to include, in its set of activities and actions, rationality and quality of services of attention to health, with a reorganization of the assistance and health network through social control (Brazil, 2002).

Reordering a service that was already installed and running, even if it was in bad condition, was an arduous challenge



that demands, in addition to changes in actions and services, a differentiated training of professionals who make up the existing staff and even a multicultural preparation for new admissions.

The Ministry of Health, through the Special Secretariat for Indigenous Health (SESAI), created by Decree No. 7336 on October 20, 2010, is responsible for managing the DSEI, as a consequence of an old structural claim proposed by the indigenous peoples. SESAI thus assumed responsibility for organizing and providing healthcare actions for these populations, which was previously carried out by FUNASA.

For a more reliable and systematic analysis of the model proposed by PNASPI, several aspects should be taken into account, such as population, geographic area, epidemiological profile, availability of services, human resources, infrastructure, logistics, and even the traditional demographic distribution of indigenous people. These aspects lead us to a reality endowed with negligence and historical conflicts in the health field, which discredit the population in public defense mechanisms. Therefore, it was up to the current subsystem to recover the indigenous population's trust in public actions capable of providing universal and integral healthcare, guaranteed by equity, which is only possible through an actively consolidated and social control. strengthened.

The observance by the current organization of the SUS of an integrated and hierarchical primary care system applied to the indigenous health organization proposed by the policy has obtained positive results, but a better political articulation of the DSEI with the Bipartite Inter-Management Committees (CIB) is still necessary, as they are fundamental to guarantee the effectiveness in the implementation of the proposed political actions, in the complementarity of the actions of primary care and of medium and high complexity.

One of the differences between the family health teams established in the SUS and those of the SASI is the inclusion of the Indigenous Health Agent (AIS) worker, which is essential to guarantee the integration of other professionals with the indigenous communities, strengthening healthcare in the villages, as it is a member of the community who knows the health actions of individuals in their area of jurisdiction and has an influence on them.

PNASPI also provides assistance mechanisms in the context of medium and high complexity and has created strategies and opportunities capable of guaranteeing access to care of medium and high complexity while offering differentiated services that influence the recovery and healing process of indigenous patients (Brazil, 2002).

However, the lack of anthropological training of professionals who work in reference centers is still a hindering factor for a more humanized relationship in the care of indigenous people. New partnerships with public institutions must be evaluated and signed so that coverage and access are broader. The challenge that the federal administration faces to implement the policy in the context of medium and high complexities is the legacy of an outsourced service to institutions that does not meet the specificities required by the population.

The Indigenous Health Houses (CASAI) are establishments defined by the policy, but in a more dynamic approach with regard to carrying out integrative artisanal activities, health education, and leisure, with a focus on rehabilitation, including nursing care, especially in the monitoring of cases that require a more continuous assistance, before being assisted by SUS services and after the return of these services until arrival in the villages (Brazil, 2002).

Regarding the preparation of human resources to work in an intercultural context, PNASPI devised a model that mainly advocates indigenous education and training to favor the appropriation of knowledge and technical resources available in each geographic context. The training process takes place primarily but not only, through the Indigenous Agent Training Program, with guidelines described in the body of the policy.

The training of human resources for indigenous health is treated as a priority, "being a fundamental instrument for adapting the actions of SUS health professionals and services to the specificities of the healthcare of the indigenous people" (Brazil, 2002). In addition to the technical, legal and political adjustments, the organization's adaptations and services are also,

until today, necessary through refresher/improvement/specialization courses for all professionals who work in promotion, prevention and recovery, whether indigenous or not.

The in-service continuing education strategy has been used by the DSEI, associated with specific short-term and specialization courses, mainly for professionals who are part of the Multidisciplinary Indigenous Health Teams (EMSI) and for professionals who work in the management of Comprehensive Care Prevalent Diseases in Childhood (AIDIPI), Rapid Test, Immunization, Women's Health, Mental Health, Water Quality, Bidding, Contract Inspection, Construction Inspection, among others.

For the AIS, some initiatives were implemented from the perspective of professionalization (DSEI Alto do Rio Negro in partnership with FIOCRUZ/Manaus; SESAI, in partnership with the Ministry of Work Management and Health Education (SGTES) of the MS), and disseminated a training program for AIS and Indigenous Sanitation Agents (AISAN), implemented in November 2015, considering that in many remote locations, they are the only health reference in the community.

Aiming at a systematic follow-up within the scope of the DSEI, the policy provides for the organization of an information system in accordance with the perspectives of the Health Surveillance System but fully adapted to indigenous health. This information is able to provide subsidies for the survey of indicators capable of measuring the quality of health and also point out structural deficiencies in certain territories, helping the management in the decision-making process, which has never been done before.

The idea that "every human society has its own systems of interpretation, prevention and treatment of diseases" (Brazil, 2002) makes PNASPI guarantee indigenous peoples their main resource for healthcare, the traditional indigenous systems. Considering the respect for the conceptions, values, and practices related to the health-disease process, the National Policy for Health Care of Indigenous Peoples promotes the articulation of the stimulation of the knowledge and practices aiming to improve the health status of the indigenous people. However, in the practical sphere, it is not possible to visualize actions that reflect what PNASPI prescribes.

PNASPI regulates and also creates mechanisms to promote the adequate and rational use of medicines. With the involvement of pharmaceutical care, in the context of primary care, aspects ranging from selection, programming, and acquisition to packaging, stocking, distribution, dispensing, control, and surveillance are observed, ensuring the standardization and quality of care in accordance with the assumptions of the National Pharmaceutical Assistance Policy (PNAF).

With regard to specific actions in special situations, PNASPI prioritizes actions characterized by the imminent risk of death, health-disease specificity, the economic and social impact of large projects under development, vulnerability derived from the type of contact, exposure to certain injuries, suicide, and environmental disasters, among others. The idealized actions are based on the field of prevention of injuries and exposures and also on immediate interventions in case of catastrophes.

It is well known that the PNASPI is concerned with addressing broad and relevant topics ranging from the promotion of ethics in research involving indigenous individuals and communities to the promotion of healthy environments, understanding that indigenous health has a strong interdependence with land and the environment.

In all actions advocated and implemented, the involvement of social control is foreseen by PNASPI, which determines that all stages of planning, implementation, and operation of the DSEI are formally through the participation of councils and legal representations, and even informal social movements.

The main mechanisms of social control established by the policy are the Local Indigenous Health Councils (CLSI), consultative, made up only of indigenous representatives, and the District Indigenous Health Councils (CONDISI), equal and deliberative (50% of representatives of indigenous users, 25% of workers of the SASI and 25% of representatives of managers), forum of CONDISI presidents and indigenous organizations (advisory), meetings, national health conferences and national indigenous health conferences, in addition to indigenous representations in national, state and municipal health



councils .

After the creation of SESAI, an advance was observed regarding the participation of indigenous users in the planning, monitoring, and evaluation of indigenous health policies through social control instances, which were regulated by Ordinance No. 755 on April 18, 2012. The last survey had 397 CLSI, totaling 5,997 councilors and 34 CONDISI, with 1,550 district councilors, but with the weakening of councils over the years owing to political and economic factors, it is currently unknown as to which councils persist and what the pattern of action in micro and macro systems is. However, government studies and data point to greater investments and significant evolution between decentralized and approved resources and actions.

## **6. Actors and Dynamics of Brazilian Indigenous Health**

The actors involved in the process of social struggles that triggered the National Health Care Policy for Indigenous Peoples are composed of different audiences, represented at different stages of the claims. The representative entities of indigenous people, indigenous health council, social movements, and government spheres were the most active actors in the construction of PNASPI, but the mobilization through the indigenous movement, non-governmental organizations linked to indigenous issues, universities, and churches between 1970 and 1980 was fundamental and determinant for the inclusion of indigenous rights in the 1988 FC (Martins, 2013).

The interests involved in the process are directed towards the coordination and management of a subsystem until established by law, but without practical applicability, in addition to the tireless search for the integrality of indigenous health, respecting, in fact, the peculiarities, epidemiological profile and health condition of each Special Indigenous Sanitary District, which is always in line with the SUS.

One of PNASPI's most challenging interests is to promote articulation and integration with governmental and non-governmental sectors that interface with indigenous healthcare, in addition to strengthening social control in the subsystem, restoring the indigenous population's trust in programs and public health policies, making them subjects and actors of their rights and health.

Considering the need for a broad articulation both in the intra-sectorial and in the inter-sectorial scope, demanding coordinated and joint actions between different agencies and ministries, aiming to achieve its purposes in a satisfactory manner (Brazil, 2002; Garnelo, 2003; Ribeiro, 1982), institutionality and actors, as established by PNASPI, take place as specified below.

The Ministry of Health, as specified in the PNASPI, has the greatest responsibility toward other bodies, which is the responsibility of the management and direction of the National Policy for Comprehensive Health Care for Indigenous Peoples. FUNASA, in conjunction with the Department of Health Assistance (SAS) and the Department of Health Policies, was extremely important in establishing guidelines and standards for the execution of PNASPI until the creation of SESAI in October 2010, which took over this responsibility of promoting inter-sectorial and intra-sectorial articulation with other instances of the SUS; it also assumed responsibility, in indigenous territories, of the coordination, implementation, and execution of health actions, the indigenous health information system in Brazil, as well as the basic sanitation actions in the villages and buildings of indigenous health.

The follow-up and advisory services to the DSEI are carried out by SESAI and its departments, in partnership with other secretariats and bodies that are part of the structure of the Ministry of Health. State and municipal health secretariats, in partnership with the Ministry of Health, work significantly to assist actions aimed at promoting the health of the Indians in each state or municipality, including the indigenous population in specific programs and campaigns, such as vaccination, women's health, sexually transmitted diseases, among others. More complex diseases such as cervical cancer and diabetes have affected a large part of the indigenous population, and it is up to states and municipalities to provide preventive and

curative care for them (Brazil, 2002).

The National Indian Foundation, linked to the Ministry of Justice, is responsible for the actions of the federal government, with the purpose of ensuring indigenous constitutional rights and carrying out intersectoral articulation for the construction and implementation of indigenous policies in Brazil. Thus, based on PNASPI, its attributions permeate the guarantee of territories, demarcation of lands, inspection, and removal of invaders, as well as the monitoring of any action developed to promote the health of the Indians.

The Ministry of Education is of great importance in the implementation of the PNASPI as it provides subsidies for the integration of the policy in the basic curriculum of educational institutions, including indigenous schools, besides special programs aimed at educating young and adult Indians, as well as training indigenous health and sanitation agents. The support of Higher Education Institutions (HEIs) provided for in the National Policy for Indigenous Health Care is based on the field of specialization courses in indigenous health, research, extension, training and certification, in addition to health promotion through actions and appropriate educational activities based on specific cultures, as well as on the curative actions offered by university hospitals (HU).

To guarantee the principles of autonomy, equity, and respect for cultural diversity, the Public Prosecutor's Office actively participates in PNASPI, ensuring that compliance with the constitutional and legal precepts of any political action is implemented in accordance with the assumptions of the laws.

Since the publication of PNASPI, the National Research Ethics Commission (CONEP) of the CNS is responsible for ensuring compliance with the principles of Resolution No. 196/96 of the National Health Council, and also observing, mainly, Resolution No. 304/2000, which gives the indigenous population protection from additional risks arising from their exceptional condition.

Finally, the representation at the national level for monitoring and implementing the PNASPI is the Intersectoral Commission for Indigenous Health (CISI), an advisory body of the CNS. CISI counts on the assistance of several public institutions and has, as a continuous function, the recommendation of measures aiming at a better execution of the actions contained in the PNASPI.

## **7. Final Considerations**

The legacy left by historical gaps led to current serious structural problems and care actions focused on the sporadic, emergency, and non-systematic provision of basic health services, which over time generated a vicious cycle on the part of professionals in resisting the actions of primary care. It is necessary to recognize that some of these historical debts of the Brazilian government to the indigenous populations had only limited relief in the governments of the then presidents of the republic, Luiz Inácio Lula da Silva (2003–2011) and Dilma Vana Rousseff (2011–2016), as a result of greater dialogue between these rulers and indigenous movements. However, the articulation of the Federal Government with representatives of ruralists and agribusiness prevented further achievements, especially in the field of health.

The constitution of the Indigenous Health Care Subsystem, as a component of the SUS, generated considerable changes in the structural principles of PNASPI in Brazil, replacing a model hitherto more fragmented between campaigning and emergency actions, vulnerable in its funding base and without infrastructure and qualified technical staff to coordinate and execute health actions.

The execution of work in remote areas isolated and distant from urban centers, the prolonged stay of professionals in villages with different work schedules and without being provided for in the legislation that instituted the Single Legal Regime (RJU), as well as the difficulties in acquiring inputs, equipment and contract works due to the unorganized bureaucracy of the public administration, contributed to the execution and management of PNASPI becoming even more challenging and

complex, considering that the legal-legal framework elaborated after the 1988 Constitution did not observe, during its discussion and approval, the specificities of indigenous peoples provided for in article 231 of the 1988 Constitution.

This whole situation contributed to FUNASA, from 1999, not fulfilling its role successfully, and these difficulties were also repeated after the approval of PNASPI in 2002 and, now, under the political management of SESAI.

The organization of SASI-SUS and the execution of actions are carried out through a network constituted as follows: 34 DSEI, 365 Base Poles, 751 Health Posts and 67 Indigenous Health Homes (CASAI), able to meet the needs of 755,898 Indigenous people in 5,852 villages, totaling 305 ethnic groups that speak 274 languages distributed over 448 municipalities, the vast majority with less than 20,000 inhabitants (Brazil, 2021)

The existing indicators embody relevant guidelines in the field of healthcare of indigenous people, such as coverage of 77.0% of the indigenous population with a complete vaccination schedule in 2010; 45.2% reduction in the incidence of Tuberculosis (TB) between 2003 and 2009; average percentage of 82% cure for TB from 2006 to 2008; nutritional status monitoring coverage of 60.2% for children under the age of five in 2009; percentage of indigenous people who completed basic dental treatment and are free of caries and periodontal disease increasing from 12.7% in 2004 to 23.0% in 2009 (increase of 79%); average of 4.7 prenatal consultations per woman recorded by the health and nutrition survey in 2009; and Indigenous Infant Mortality Rate (IMR) surpassing 74.6 per thousand live births, in 2000, to 41.0 per thousand live births in 2009 (reduction of 43.8%) (Brazil, 2010; Martins, 2013).

With regard to the novel coronavirus (COVID-19) pandemic, by July 2021, 25,482 cases were reported in the Indigenous Health Care Subsystem, of which 9,186 (36.0%) were confirmed, 15,133 (59.4%) were discarded, 590 (2.3%) were excluded and 573 (2.2%) suspected. Considering the confirmed cases, 8,837 (96.2%) were by laboratory criteria and 349 (3.8%) by clinical epidemiological. Of the total number of confirmed cases, 194 (2.1%) led to death by COVID-19. Mass contamination within the most isolated indigenous territories often occurred by the health workers themselves who moved between the community and urban environments. Health management by the Federal Government is heavily criticized, and the high number of deaths is still underreported.

The healthcare model, although has achieved immeasurable gains, has not yet managed to impact infant mortality indicators, which are still twice the national average for the non-indigenous population; most deaths have occurred in the post-neonatal period (death between 28 and 264 days), indicating that there is still a weakness in the articulations between the DSEI and the municipal health networks, which constitutes a major impasse in ensuring greater comprehensiveness, with health professionals, in general, still being little prepared and qualified to work in an intercultural context.

Although the creation of the Special Secretariat for Indigenous Health (SESAI) represents progress in the field of guaranteeing the right to health for indigenous people, the frequent dissatisfaction of FUNASA's performance in conducting the PNASPI culminated in a movement that led to the publication of the Decree no. 7.336/2010, which created, within the scope of the MS, the Special Secretariat for Indigenous Health, to which the responsibility for indigenous health actions was transferred.

The perspectives that surround the interests of organizations, managing bodies, and actors involved with indigenous healthcare are based on the strengthening of the subsystem to expand coverage of prenatal, childbirth, and postpartum care; reduce and even eradicate child mortality from preventable causes; provide the appropriate logistical means, ranging from specific means of transport to places of difficult access to supplies generally needed for better execution of health actions; review the financial incentives that are transferred to municipal health systems and referral hospitals for the indigenous population; strengthen disease prevention and health promotion mechanisms; and subsidize indigenous health councils.

It is necessary to recognize the weaknesses and difficulties existing in the management of the subsystem currently in force so that it can be strengthened, through the joint work of social representations, to overcome the difficulties of offering

regular, systematic, differentiated, and even comprehensive services amidst a complex and dynamic universe of indigenous peoples. In this sense, it is expected that future research will analyze experiences in public health with regard to the provision and management of healthcare for Amerindian populations.

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