



# The challenge of providing primary healthcare care to indigenous peoples in Brazil\*

Anapaula Martins Mendes,<sup>1</sup> Maurício Soares Leite,<sup>2</sup>  
Esther Jean Langdon,<sup>3</sup> and Márcia Grisotti<sup>4</sup>

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## ABSTRACT

*In Brazil, the right to health claimed by indigenous peoples interacts with various regulatory frameworks, including the Alma-Ata Declaration, which proposes and emphasizes primary health care (PHC) as a means to increase access and minimize health inequalities. As part of the Brazilian Unified Health System (SUS), the indigenous health subsystem (SASI) was established, along with the National Health Care Policy for Indigenous Peoples (PNASPI), as a strategy to ensure health care access for these populations. PNASPI aims to provide differentiated health care to indigenous populations, considering the sociocultural diversity and the specific epidemiological and logistic factors associated with the care of these peoples and focusing on the provision of comprehensive care. The present article discusses the implementation of PNASPI, highlighting achievements and challenges faced during this process. Despite the growing financial resources made available for the implementation of the indigenous health subsystem, the initiatives developed thus far have had little impact on health indicators, which reflect historical inequalities in relation to other population segments. Indigenous social control is still fragile, and the discussions in this arena show the dissatisfaction of users toward the system. Factors that challenge the effectiveness of PNASPI include gaps in continuity of care, shortages and high turnover among health care workers, and the need to establish intercultural dialogues that promote coordination with traditional knowledges. Care remains centered on palliative and emergency measures, usually based on relocation of patients for treatment, which is associated with high cost. To overcome these challenges, PHC must be strengthened and recognized as an important regulatory framework within the PNASPI organizational model.*

## Keywords

Primary health care; health of indigenous peoples; indigenous population; Brazil.

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<sup>1</sup> Universidade Federal de Santa Catarina, Programa de Pós-Graduação em Saúde Coletiva (PPGSC/UFSC), Florianópolis (SC), Brazil. Send the correspondence to Anapaula Martins Mendes, [anapsosa@hotmail.com](mailto:anapsosa@hotmail.com)

<sup>2</sup> Universidade Federal de Santa Catarina (UFSC), Centro de Ciências da Saúde, Departamento de Nutrição, Florianópolis (SC), Brazil.

<sup>3</sup> Universidade Federal de Santa Catarina (UFSC), Programa de Pós-Graduação em Antropologia Social, Florianópolis (SC), Brazil.

<sup>4</sup> Universidade Federal de Santa Catarina (UFSC), Programa de Pós-Graduação em Sociologia Política, Florianópolis (SC), Brazil.

According to the latest Brazilian Institute of Geography and Statistics (IBGE) census, Brazil has more than 890,000 indigenous people distributed across all states, corresponding to 0.4% of the Brazilian population. Indigenous Brazilians are distributed across 505 indigenous

territories which cover 12.5% of the country. Although they account for a very small portion of the overall population, there is great social diversity among the indigenous peoples of Brazil, with 305 ethnic groups speaking 274 languages. Central to the discussion proposed by this article is an epidemiological scenario generally characterized by largely unfavorable health indicators compared to the rest of the Brazilian population, notwithstanding the particular features of each people (1-3).

Prior to the reformulation of the Constitution of Brazil in 1988, indigenous people were considered wards of the State. Deprived of any rights, they were expected to assimilate progressively into the overall population. This stance prevented these groups from leading decision-making to meet their actual needs. The 1988 Constitution had a massive impact on the creation of public policies geared to indigenous peoples, who were no longer considered wards of the State, but rather citizens in their own right. Among the rights granted to them is the guarantee of “differentiated health care” (2-4).

The Alma-Ata International Conference, held in 1978, was a milestone in discussions regarding the development of primary health care (PHC) as the basis for realization of the fundamental right to health and the reduction of established inequalities among peoples. Within this context, PHC is realized through a series of actions that focus on connecting different sectors, with an expanded concept of health (5).

Accordingly, it is the responsibility of governments—with participation from civil society—to establish standards and policies that regulate strategies to reduce inequities and inequalities in health that have a direct impact on national development. These initiatives, always taking the local situation into account, should promote comprehensive care, including access to the services of various care providers; this includes “traditional practitioners” (5, 6).

In the 1980s several movements arose, calling for changes in the Brazilian health system and resulting in the creation of the Unified Health System (SUS). The indigenous population, which did not see itself and its specific needs represented in the generalist proposals of the SUS, also mobilized (2, 4). The Alma-Ata Declaration enshrines the implementation of

PHC as a means of reducing health inequalities, with a focus on the specific needs of each people. In Brazil, this principle was followed during construction of the Indigenous Health Care Subsystem (SASI), arising from health conferences led by indigenous peoples (5-7).

Within this context, the objective of this article is to discuss the implementation of the National Health Care Policy for Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas*, PNASPI) in Brazil since the year 2000, as well as its regulatory frameworks. We reflect on the challenges experienced during implementation of PNASPI and on the reduction of longstanding health inequalities in Brazilian indigenous peoples.

### THE NATIONAL HEALTH CARE POLICY FOR INDIGENOUS PEOPLES

The First National Conference for the Protection of Indigenous Health (CNPSI), held in 1986, was one of the first times the Brazilian government called on different indigenous leaders to discuss proposals for the development of guidelines for indigenous health care, acknowledging the legitimacy of their specific needs, with a focus on PHC. Until then, indigenous health care had been managed successively by a wide range of sectors and agencies; most actions had been palliative and lacked continuity, with little impact on the health situation of these populations (3, 4, 7).

The basic proposal of the first CNPSI was that management of indigenous health care be transferred to the Ministry of Health, which runs the SUS. This discussion carried over into a second conference, which mobilized an even larger native population and had equal participation of indigenous and non-indigenous delegates. At the time, the proposal sought to change the prevailing model of indigenous health care to one of “differentiated health care”, with a focus on PHC (7).

In 1999, Law 9836 created SASI, transferring management of indigenous health care to the Brazilian National Health Foundation (FUNASA). SASI was tasked with establishing PHC and continuity of care at the different levels of care within the indigenous territories of Brazil, taking into account the specific features of each people (ranging

from sociocultural issues to logistical and epidemiological aspects), respecting their traditional knowledge, and ensuring social participation and social oversight of management process (3, 4, 8). Furthermore, in line with the Alma-Ata guidelines, the healthcare teams included indigenous workers, who were assigned the novel roles of indigenous health agents and indigenous sanitation agents (4, 5).

Once SASI had been established, the PNASPI was created. This policy was meant to be implemented in accordance with SUS principles, with particular emphasis on decentralization of actions and resources; universality, comprehensiveness, equity, and social participation; and issues related to cultural, ethnic, geographical, epidemiological, historical, and political diversity. The organizational model was built around the concept of Indigenous Special Health Districts (*Distritos Sanitários Especiais Indígenas*, DSEIs). In all, there are 34 DSEIs in the country. Within each DSEI, other health agencies are responsible for providing care at different levels and facilities, such as base stations, basic health units and clinics, and indigenous health centers (8).

Social participation takes place through local indigenous health councils—usually located in a particular village or group of villages in a particular indigenous territory—and district indigenous health councils, which support regulation of district management and ensure that local discussions are brought to the attention of district conferences. Council members are selected by indigenous communities. Above the district level, broader discussions take place at National Indigenous Health Conferences (8).

### CREATION OF THE SPECIAL SECRETARIAT FOR INDIGENOUS HEALTH AND CURRENT SITUATION OF INDIGENOUS HEALTH CARE

During the 4th National Conference on the Health of Indigenous Peoples, held in 2006, many calls were made to improve the health situation of indigenous peoples and FUNASA’s management was called into question. The agency had long been subject to harsh criticism, which included repeated allegations of corruption and misuse of

resources. In a discussion on SASI funding and management, Garnelo and Maquiné (9) provide a list of websites which have published a massive volume of such allegations, including major newspapers, non-governmental organizations, and government oversight and communication agencies. As a result, working groups were established, which subsequently led to the creation of a secretariat linked directly to the Ministry of Health.

Creation of the Special Secretariat for Indigenous Health (SESAI) was approved in 2010 (7, 9). Ultimately, this move represents the establishment of an agency solely responsible for indigenous health, which had until then been coordinated by several sectors within other agencies or institutions with broader mandates, sometimes not even limited to indigenous peoples. This new format, however, is still beset by operational challenges. Garnelo and Maquiné (9) note that, among the special secretariats linked directly to the Ministry of Health, SESAI is the only one simultaneously responsible for both management and implementation of health actions and programs, which requires a robust administrative structure.

The 5th National Conference, in 2013, was the first one held after the creation of SESAI. Among the main demands made at this event were that provision of comprehensive care be ensured, in addition to primary care; and also that primary care be strengthened while respecting traditional indigenous knowledge, something that did not appear to be happening even after the special secretariat was created. Furthermore, the 5th Conference itself was the object of harsh criticism, including suggestions of limited social oversight, limited participation by indigenous delegates, and the adoption of proposals viewed as contradictory (3, 4, 10).

## A CRITICAL APPRAISAL OF PNASPI IMPLEMENTATION

Despite the creation and implementation of SESAI, the problems and challenges previously faced by FUNASA persist. It is worth noting that the availability of financial resources was never an obstacle during the FUNASA management period or after the creation of SESAI. In fact, an analysis of funding available to SASI shows substantial,

near-steady growth in available resources since its earliest years of operation, except perhaps in the first few moments after establishment of the agency. By way of example, the 2010 budget (R\$379 million) was three times greater than the 2002 budget (3, 4, 9). By 2015, the agency's budget had surpassed the billion-real mark (R\$1,533,659,105.00) (11).

However, while the data show significant, consistent growth in the resources approved and implemented, there has not been proportional improvement in health indicators (3, 9, 11, 12). Despite the relative scarcity of demographic and epidemiological data on the indigenous peoples of Brazil when compared to the data available for the overall Brazilian population, a clear panorama of inequalities persists nearly 20 years after the establishment of a specific subsystem for indigenous health. Several major indicators, including overall and maternal mortality, number of hospitalizations and deaths due to respiratory diseases and infectious and parasitic diseases in childhood, and communicable diseases, demonstrate stark inequalities in indigenous health (13-15). This precarious situation was confirmed by the National Survey on the Health of Indigenous Peoples, the only nationwide health survey conducted among the indigenous Brazilian population. This survey revealed a high prevalence of anemia (affecting not only children but also pregnant women) and malnutrition, especially among children under 5, in contrast to obesity and overweight in adult women. This profile provides evidence of the growing importance of chronic noncommunicable diseases among indigenous peoples. The survey also detected poor sanitation conditions and high rates of hospitalization for children due to diarrhea and respiratory infections, which suggests that PHC interventions have low problem-solving capacity (16).

Another challenge in implementation of this policy concerns the Indigenous Health Care Information System (*Sistema de Informações da Atenção à Saúde Indígena*, SIASI), access to which is restricted to providers and managers who use the subsystem. In addition to the limitations this places on access to information, there are other problems related to data reliability (3, 13, 17) and communication with other SUS information systems.

This hinders planning to address the needs of each location and makes it difficult to monitor and assess the implementation of interventions, the advances and limitations of PNASPI, and the health situation of the indigenous population (2, 13, 14).

Some authors have described precarious health facilities and a lack of supplies and equipment. This, combined with high provider turnover and logistical complexity in some regions, have negative impacts on the quality of service delivered within indigenous territories. Palliative and emergency care have been prioritized to the detriment of PHC. The high turnover of health professionals makes it very difficult for them to establish bonds and to recognize the cultural specificities of delivering health care to indigenous peoples (3, 4, 18).

The creation of the Health Councils seems to represent a real gain for indigenous peoples with regard to policy guidelines. The purpose of social participation is to allow indigenous people to participate in strategies for planning and evaluating the services provided to them and, consequently, to enhance the capacity of these services to solve their problems. However, actual social oversight faces major barriers, despite the legal provision for social control entities within the subsystem. And during conferences, the most active voices are not always those of native Brazilians (3, 4). Cardoso (4) and Shankland et al. (15) report experiences in which indigenous Brazilians themselves judged the performance of some counselors to be poor.

A major persisting challenge is implementation of the guideline on links between "traditional medicine" and the official health system. Recent studies suggest that official initiatives to incorporate native practices and knowledge have resulted in the creation of mechanisms whereby the State exercises control from an essentially integrationist perspective. In addition, the official proposals for "differentiated health care" seem to be viewed as problematic by managers themselves, and the logic of the biomedical model itself prevents greater flexibility towards intercultural dialogue (3, 4, 18-20).

## CONCLUSIONS

Although desirable, a categorical assessment of the PNASPI implementation

process in Brazil would appear to be unproductive and perhaps not even feasible. Certainly, important advances have been made, with real gains in indigenous health in the country. However, overall, the available data continue to demonstrate a massive gap between the provisions of PNASPI and the precarious nature of its implementation in the daily lives of indigenous Brazilians. On the one hand, despite the many challenges faced since the creation of the indigenous health subsystem, the policy has had positive impacts on indigenous health in the country; on the other hand, these impacts have been limited.

It seems more reasonable to think in terms of partial gains, positive in many regards, but far short of the goals proposed by PNASPI. Undeniable progress has been made, such as increasing the access of indigenous peoples to health services, including in the most remote regions of the country. The PHC focus proposed by Alma-Ata, although fragilely implemented in the context of indigenous

health, has brought about an important shift in perspective in relation to the way things were done before indigenous health was placed under the purview of the Ministry of Health. Social participation and social oversight have advanced significantly, but their implementation still faces serious barriers. SESAI management remains centralized and is limited by its staffing structure; also, high turnover and the problems involved in training health professionals to work in interethnic settings appear far from any solution.

It bears stressing that several health indicators show an unacceptable gap persists between indigenous peoples and the rest of the Brazilian population, with the indigenous population being systematically disadvantaged. These persistent inequities in health are at the forefront of discussions in the national indigenous health conferences and are reflected by users' recurrent complaints of dissatisfaction with the health care delivered to their peoples. In structure and form, PNASPI

upholds the principles of the Alma-Ata Declaration: it focuses on PHC as a strategy to enable enjoyment of the right to health through access to services in order to reduce inequalities, while encouraging social participation, training for health care professionals, and maintenance of the bond between these professionals and the population they serve. However, we must conclude that, overall, this vision of PHC is not being put effectively into practice.

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## RESUMEN

### El desafío de brindar atención primaria de salud a los pueblos indígenas en Brasil

En Brasil, el derecho a la salud reclamado por los pueblos indígenas interactúa con varios marcos regulatorios, incluida la Declaración de Alma-Ata, que propone y destaca la atención primaria de salud (APS) como un medio para aumentar el acceso a la salud y minimizar las desigualdades en materia de salud. Como parte del Sistema Único de Salud de Brasil (SUS), se crearon el subsistema de salud indígena (SASI) y la Política Nacional de Atención de Salud de los Pueblos Indígenas (PNASPI), como estrategias para garantizar el acceso a la atención médica de estas poblaciones. La Política tiene como objetivo brindar atención de salud diferenciada a las poblaciones indígenas, considerando la diversidad sociocultural y las peculiaridades epidemiológicas y logísticas asociadas con la atención de estos pueblos y centrándose en dispensar una atención integral basada en la APS. En este artículo se discute la implementación de la Política, y se destacan los logros y desafíos enfrentados durante este proceso. A pesar de los crecientes recursos financieros disponibles para la implementación del subsistema de salud indígena, las iniciativas desarrolladas hasta ahora han tenido escaso impacto en los indicadores de salud, que reflejan desigualdades históricas en relación con otros segmentos de la población. La participación social aún es débil, y las discusiones en este campo revelan la insatisfacción de los usuarios con el sistema. La falta de continuidad de la atención, sumada a la escasez y alta rotación de los trabajadores de la salud, así como la necesidad de establecer diálogos interculturales que promuevan la articulación con los conocimientos tradicionales, cuestionan la efectividad de la Política. La atención aún se centra en prácticas paliativas y de emergencia, generalmente basadas en la reubicación de los pacientes para tratamiento, lo que se asocia con un alto costo. La superación de estos desafíos depende del fortalecimiento de la APS y de su reconocimiento como marco regulador importante del modelo organizativo de la Política.

#### Palabras clave

Atención primaria de salud; salud de poblaciones indígenas; población indígena; Brasil.

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**O desafio da atenção primária na saúde indígena no Brasil****RESUMO**

No Brasil, o direito à saúde pleiteado pelos povos indígenas dialoga com diferentes marcos regulatórios, incluindo a Declaração de Alma-Ata, a qual propõe e valoriza a atenção primária à saúde (APS) como promotora de maior acesso e forma de minimizar as desigualdades em saúde. No âmbito do Sistema Único de Saúde (SUS), o subsistema de atenção à saúde indígena (SASI) e a Política de Atenção à Saúde dos Povos Indígenas (PNASPI) foram criados como estratégia para garantir o acesso à saúde aos povos indígenas. A PNASPI prevê atenção diferenciada às populações indígenas com base na diversidade sociocultural e nas particularidades epidemiológicas e logísticas desses povos e focando no desenvolvimento da APS com garantia de integralidade da assistência. O presente artigo traz reflexões acerca da implementação da PNASPI, destacando os avanços e desafios apresentados durante esse percurso. Apesar dos crescentes recursos financeiros disponibilizados para implementar o subsistema de saúde indígena, as ações têm apresentado poucos resultados nos indicadores de saúde, que refletem desigualdades historicamente descritas entre esses povos e os demais segmentos. A participação social ainda se mantém frágil, e suas discussões refletem a insatisfação dos usuários. A descontinuidade do cuidado somada à carência e alta rotatividade de profissionais, assim como a necessidade de estabelecer diálogos interculturais que promovam a articulação com saberes tradicionais, são fatores que desafiam a efetividade da PNASPI. O cuidado ainda é centrado em práticas paliativas e emergenciais, geralmente baseado na remoção de pacientes, gerando altos custos. A superação desses desafios depende do fortalecimento da APS e de seu reconhecimento enquanto importante marco regulador do modelo organizacional da PNASPI.

**Palavras-chave**

Atenção primária à saúde; saúde de populações indígenas; população indígena; Brasil.

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