

Primary health care for South American indigenous peoples: an integrative review of the literature*

Luiza Fernandes Fonseca Sandes,¹ Daniel Antunes Freitas,² Maria Fernanda Neves Silveira de Souza,¹ and Kellen Bruna de Sousa Leite¹

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ABSTRACT

Objective. To review the literature on access to primary health care (PHC) by indigenous communities in South America, identifying the main access barriers.

Method. Integrative review of articles published from 2007 to 2017 in the LILACS, PubMed, and SciELO databases. The search terms “indigenous AND health AND Brazil” and “indigenous AND health NOT Brazil” were used in Portuguese and English. Articles published in English, Portuguese, or Spanish, focusing strictly on PHC and South American indigenous populations were included.

Results. Forty articles describing aspects of PHC for indigenous populations in eight countries – Brazil, Peru, Colombia, Bolivia, Argentina, Chile, Paraguay, and Ecuador – were included. The main barriers to accessing PHC were difficulty reaching the health care facilities closest to villages; difficulty communicating with health care professionals; inadequate transportation to the health care units; lack of epidemiological data on indigenous villages; lack of information on local indigenous cultures; and fear of discrimination or humiliation on the part of indigenous patients.

Conclusions. Studies on the health of indigenous populations in South America are scarce. It is evident that national health systems still need to advance towards intercultural medicine that respects the social, cultural, and economic realities of all communities, with knowledge and consideration for different forms of care.

Keywords

Indigenous population; health of indigenous peoples; primary health care; Latin America.

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¹ Universidade Estadual de Montes Claros (Unimontes), Faculdade de Medicina, Montes Claros (MG), Brazil. Send correspondence to: Luiza Fernandes Fonseca Sandes, luizaffsandess@gmail.com

² Departamento de Saúde Mental e Saúde Coletiva, Universidade Estadual de Montes Claros (Unimontes), Montes Claros (MG), Brazil.

South America is home to numerous indigenous groups. These groups are small, fragmented, and scattered across the entire continent. Although they are culturally distinct from one another, they present similar health challenges and suffer from the same marginalization by health systems, as well as discrimination by the non-indigenous population. In the

last decade, despite significant advances in the health indicators in a number of South American countries, with reductions in infant and maternal mortality and chronic malnutrition, these improvements are not fully reflected in the indigenous populations. One reason is that they are not properly counted in the national censuses (1).

Among the South American countries with the largest numbers of indigenous groups are Peru, Bolivia, and Ecuador (2). In 2010, it was estimated that there were 826 indigenous groups in Latin America, together amounting to approximately 45 million people (3), who speak more than 1,000 languages and dialects (2). Centuries ago these populations, with genetics and epidemiology unlike those of their European colonizers, saw catastrophic death rates when they came in contact with new pathogens brought by the Spanish and Portuguese. Even today it is possible to see the repercussions of contact between indigenous and European people through the former's susceptibility to certain diseases and epidemics that continue to occur in their villages (4).

Ethnicity is an important determining factor in the health conditions of a given population, impacting morbidity and mortality rates in many ethnic groups and interfering with access to health services by certain population strata (5). Among indigenous populations, their self-perception of illness and its relationship to biomedical practice, industrialized medicines, and external health agents differs from group to group. The situation is complicated by geographic difficulties reaching the villages, language barriers, and information barriers, all of which make for differences between the health care provided to non-traditional urban populations and indigenous peoples.

At the end of the 1970s, the Alma-Ata Conference made it urgent to develop and promote egalitarian health care that encompasses all peoples. The 1978 Declaration of Alma-Ata made it a goal to find a health care approach that would lead to complete social, physical, and mental health and not merely the absence of disease (6). In Brazil, this declaration became one of the terms of reference for its Federal Constitution, promulgated in 1988, and the country's Unified Health System (*Sistema Único de Saúde – SUS*) (7–9). Through creation of the SUS, based on intercultural principles and specific health policies for indigenous populations, Brazil became one of the pioneering South American countries in the field and an influence on other countries on the continent.

During the 1980s and 1990s, in line with the experience in Brazil, projects for the creation of universal health systems

sprouted up throughout the rest of Latin America. However, a number of these systems in Latin America have failed to achieve universal access and continue to exclude various ethnic and minority groups, such as indigenous and Afro-descendant peoples (3).

Impelled by the rapid pace of globalization, several egalitarian movements emerged in the Americas at the end of the twentieth century that made cultural, social, and gender-related claims. These movements had the support of the Pan American Health Organization (PAHO), the World Health Organization (WHO), and the United Nations (UN). They proposed and encouraged the integration of health systems in Latin America, to be developed independently by each national government but incorporating an intercultural and ethnic-political approach that recognizes collective identities and the rights of indigenous peoples (10–12).

Taking into account the public policies proposed for creating better conditions for indigenous populations in South America, the objective of this study is to characterize the primary health care (PHC) received by these peoples. Based on an integrative review of the literature, details were gleaned regarding the panorama of indigenous health and the main obstacles that have not been resolved by indigenous patients without access to PHC in South American countries over the last 10 years.

MATERIALS AND METHODS

An integrative review of the literature was conducted using a database search in which the six steps proposed by Mendes et al. (13) were followed—namely: establishing a hypothesis or research topic; searching (or sampling) the literature; categorizing the studies; assessing the studies included in the review; interpreting the results; and synthesizing the knowledge or presenting the review. These steps were followed in order to ensure the methodological rigor of the study. The questions chosen to guide the investigation were: “What is the overall panorama of health care for indigenous peoples in South American countries?” And: “What are the main obstacles still faced by indigenous peoples that prevent their access to primary health care?”

The search for articles was conducted in December 2017 in the following databases: LILACS (<http://lilacs.bvsalud.org/>), PubMed (<https://www.ncbi.nlm.nih.gov/pubmed/>), and SciELO (<http://www.scielo.org/php/index.php>).

The search used a combination of three health sciences descriptors (DeCS) and phrases from the lists of Medical Subject Headings (MeSH). The following descriptors were used when searching the LILACS and SciELO databases: “indígenas AND saúde AND Brazil,” “indígenas AND saúde NOT Brazil,” “indígena AND salud AND Brazil,” “indígena AND salud NOT Brazil,” “indigenous AND health AND Brazil,” and “indigenous AND health NOT Brazil.” In the PubMed database, only the English-language descriptors were used. The database search was conducted by three researchers working independently without external interference. After each researcher had selected an individual sample, the three samples of articles were grouped together and the duplicates were discarded.

The data analysis followed the inclusion criteria based on the top proposed for the present research: studies conducted in the last 10 years, from 2007 to 2017; those that provided full text online with free open access; those published in English, Portuguese, or Spanish; and those that addressed health care conditions, as well as obstacles impeding access to PHC by indigenous people in South America. The following were excluded: studies on secondary and tertiary health care, those that did not refer to indigenous populations in South America, and those that were not conducted in the last 10 years.

Assessment of the articles' level of evidence in the final sample was based on guidelines proposed by Melnyk and Fineout-Overholt (14), as follows: I: systematic review or meta-analysis (highest level of evidence); II: controlled randomized studies; III: controlled studies without randomization; IV: case-control or cohort studies; V: systematic review of a descriptive or qualitative study; VI: qualitative or descriptive study; VII: expert opinions or consensus of authorities (lowest level of evidence).

RESULTS

Application of the descriptors made it possible to rate 5,234 articles in the three online databases: 613 in SciELO, 3,371 in PubMed, and 1,250 in LILACS. Following application of the previously

established inclusion and exclusion criteria, 67 articles were chosen to be read in full and 27 of these were eliminated because they were duplicates, leaving a total of 40 articles (1–5, 10, 15–48) in the final set (Figure 1).

Of the 40 articles, 11 were in English, 20 in Portuguese, and 9 in Spanish. Table 1 summarizes the studies that ended up comprising the systematic integrative review, categorized according to the aspects of indigenous health they addressed, the study design, the country of origin of the indigenous groups, and the language of the publications. Aspects of PHC for indigenous peoples were described in eight countries of South America. Brazil was the country with the largest number of studies ($n = 24$), followed by Peru ($n = 9$), Colombia ($n = 3$), Bolivia ($n = 3$), Argentina ($n = 3$), Chile ($n = 2$), Paraguay ($n = 2$), and Ecuador ($n = 1$).

Brazil

The total population of indigenous people in Brazil comes to approximately 817,000. According to data from 2016 (26), they live in 220 groups distributed across 4,774 villages in the country's 438 municipalities. The epidemiological profile of these peoples is notably distinct from that of non-indigenous communities, with high rates of morbidity and mortality, especially in the case of

parasitic infectious diseases (27). Because of the epidemiological transition that these groups are undergoing as a result of taking on Western social and nutritional habits, health workers are seeing an emergence of diseases that never before existed in their villages, such as arterial hypertension, diabetes, and cancer (27).

In Brazil, the movements to support indigenous health gained traction in the 1990s following establishment of the SUS as a universal health system and recognition in the 1988 Federal Constitution of the right of indigenous people to their land, culture, languages, and traditions (26, 28). These developments led to establishment of the National Health Care Policy for Indigenous Peoples in 1999, followed by creation of the Indigenous Health Care Subsystem (*Subsistema de Atenção à Saúde Indígena* – SASI) based on the Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas* – DSEIs), where multidisciplinary teams offer PHC on indigenous lands (26, 27, 29). However, despite creation of the DSEIs, the network of subsystems is not yet fully operational. Inadequate physical and human resources are resulting in personnel turnover and uneven delivery of services, especially because of the lack of professionals with experience in indigenous health (30–32).

Since 2011, there have been strong government incentives to strengthen

PHC services through the Family Health Program, which has expanded SUS coverage to citizens in remote areas (26). Since 2013, following implementation of the More Doctors Program (*Programa Mais Médicos* – PMM), more than 18,000 physicians have been assigned to regions where access is difficult and vulnerability is especially high, including indigenous territories. The PMM has received positive feedback from the indigenous groups that have received their care (26, 30, 33). Problems have also been encountered in implementing this program – for example, communication difficulties and culture clashes, which could have been mitigated if professionals had been given briefings on the culture and language of the native peoples (30). One of the strategies that has been used to address this problem has been introduction of an indigenous health agent (*agente indígena de saúde* – AIS) on the teams that provide PHC in the villages (34, 35). The AISs promote health and prevent disease by sharing information about popular, traditional, and biomedical health care practices (34, 36–40).

Most of the causes of death in Brazil's indigenous children are from preventable diseases. Some of the most prevalent illnesses are tuberculosis, malaria, diarrhea, parasitic diseases, malnutrition, dermatoses, and sexually transmitted diseases (26). In recent decades Brazil in general has seen a significant reduction in infant mortality rates, but the rates for indigenous children have not fallen as much as for the country as a whole (26). Between 2002 and 2007, infant malnutrition in the country fell by more than 60%, but the population of low-weight children was four times greater in the North Region, especially in indigenous communities (26). Vaccination coverage in Brazil has expanded significantly through systematic immunization strategies, even in indigenous populations (26).

Peru

Peru is one of the South American countries with the largest number of indigenous communities in its territory. It is estimated that one-third of the Peruvian population is indigenous, living mainly in the Peruvian Amazon. This region has the largest diversity of indigenous peoples, each with specific ancient traditions and traditional

FIGURE 1. Flowchart: Systematic and integrative review of articles on primary health care for indigenous peoples in South America and selection of final sample of articles

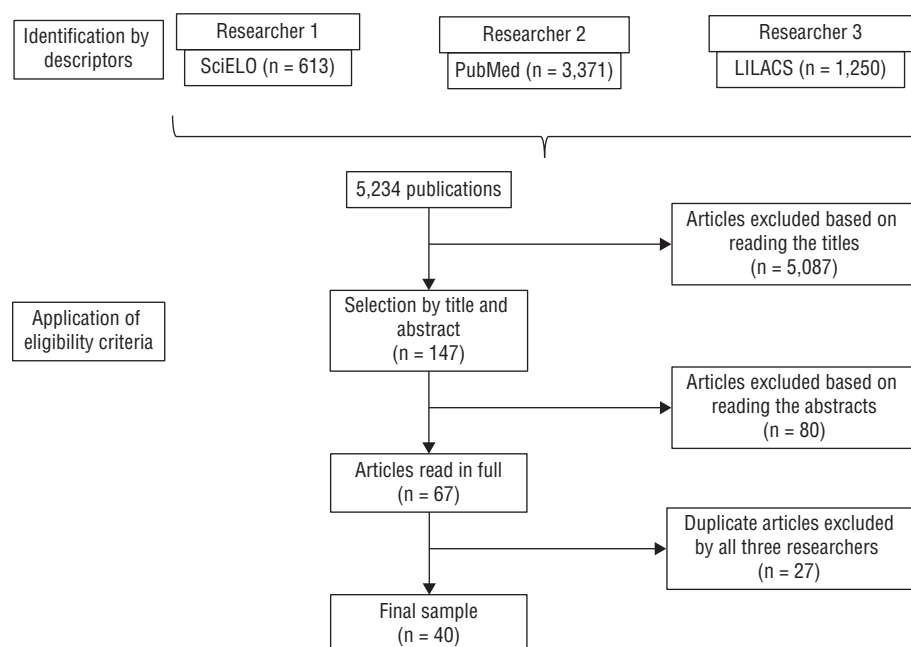


TABLE 1. Categorization of the studies in the final sample, all of them analyzed for whether or not they meet the criteria for a systematic integrative review of primary health care for indigenous peoples in South America

Reference	Aspects investigated	Level of evidence	Indigenous group country of origin	Language
Agudelo-Suárez et al., 2016 (5)	Analysis of self-perceived health in different ethnic groups	IV	Colombia	English
Aguirre et al., 2017 (41)	Prevalence of tuberculosis in indigenous groups of 20 ethnicities	IV	Paraguay	English
Borghi et al., 2015 (35)	Access of elderly indigenous people to public health services	VI	Brazil	Portuguese
Brierley et al., 2014 (20)	Health care access and health-related beliefs of indigenous peoples in the Amazon region	IV	Peru	English
Cardoso, 2014 (31)	Implementation of public policies that envision health improvements for the Brazilian indigenous population since the 1988 Constitution	VII	Brazil	Portuguese
Castro et al., 2015 (3)	Inequity in access to health by Latin American and black women	V	Brazil, Chile, Bolivia, Colombia, Peru	English
Coates et al., 2016 (26)	Indigenous child health in Brazil and related human rights issues	V	Brazil	English
Coelho and Shankland, 2011 (28)	Evolution of the public health system in Brazil since 1988, with emphasis on inequities in indigenous health	VI	Brazil	English
de Moura-Pontes and Garnelo, 2014 (37)	Role of the indigenous health agent	VI	Brazil	Spanish
Dell'Arciprete et al., 2014 (22)	Perception of indigenous people regarding Chagas disease and access to formal health services	VI	Argentina	English
Díaz et al., 2015 (1)	Nutritional status of indigenous and non-indigenous children	V	Peru	Spanish
Diehl and Jean Langdon, 2015 (29)	Indigenous participation in primary health care; conflicts, tensions, and negotiations before and after implementation of the Indigenous Health Care Subsystem in Brazil	VI	Brazil	Portuguese
Diehl and Pellegrini, 2014 (39)	Ongoing medical training and education in indigenous health	VI	Brazil	Portuguese
Diehl et al., 2012 (34)	Training, incorporation, and participation of indigenous health agents	VI	Brazil	Portuguese
Fontão and Pereira, 2017 (33)	Implementation of the More Doctors Program for Brazil in the Special Indigenous Health Districts	VI	Brazil	Portuguese
Gianella et al., 2016 (17)	Vulnerability of indigenous people to tuberculosis in the Peruvian Amazon	V	Peru	English
Gil, 2007 (48)	Approach to indigenous health in two indigenous communities in Peru and Brazil	VI	Peru Brazil	Portuguese
Hita, 2014 (23)	Intercultural approach in the Bolivian health system	VI	Bolivia	Spanish
Knipper, 2010 (16)	Intercultural health and ethnic groups	VI	Peru	Spanish
López-Cevallos et al., 2014 (25)	Socioeconomic and geographic inequities in access to health services	IV	Ecuador	Spanish
Mirassou, 2013 (24)	Health panorama of indigenous communities over a 34-year period	VI	Argentina	Spanish
Novo, 2011 (42)	Perception of indigenous health care in the Xingu	VI	Brazil	Portuguese
Nureña, 2009 (10)	Difficulties in adopting intercultural health care methodologies, especially among indigenous women	VI	Peru	Spanish
Patiño Suaza et al., 2014 (15)	Concepts of health and disease among indigenous people in the Colombian Amazon	VI	Colombia	Spanish
Pena and Heller, 2008 (43)	Sanitary conditions; the health picture; and correlation between these situations in the Xakriabá indigenous population.	VI	Brazil	Portuguese
Pérez et al., 2016 (18)	Factors that aggravate or facilitate implementation of an intercultural health policy	VI	Chile	Spanish
Pontes et al. 2014 (47)	Indigenous health practices and conflicts encountered by western medicine in the treatment of indigenous peoples	VI	Brazil	Portuguese
Pontes et al., 2015 (40)	Indigenous health practices and action by indigenous health agents	VI	Brazil	Portuguese
Ribeiro et al., 2017 (36)	The health care working and production process in an institution supporting indigenous health	VI	Brazil	Portuguese
Rissardo and Carreira, 2014 (44)	Organization of professional health care practices in caring for elderly Kaingang people	VI	Brazil	Portuguese
Rissardo et al., 2014 (45)	Practices of health professionals in caring for elderly Kaingang people	VI	Brazil	Portuguese
Santos et al., 2016 (27)	Access to health care for Krahô-Kanela and Guajajara peoples	VI	Brazil	Portuguese
Scopel et al., 2015 (38)	Action taken by indigenous health agents on the Kwatá-Laranjal reservation	VI	Brazil	Portuguese
Silva et al., 2015 (30)	Cultural differences and academic training of foreign professionals in the More Doctors Program, and impact from relating to indigenous patients	VI	Brazil	Portuguese
Sousa et al., 2007 (46)	Application of SIASI and difficulties encountered in implementing the system	VI	Brazil	Portuguese
Taveira et al., 2014 (32)	Implementation of telehealth in indigenous Brazilian communities; use of telemedicine and other technologies to overcome barriers	VII	Brazil	Portuguese
Undurragaa et al., 2016 (21)	Inequity and evidence thereof in Tsimané groups over a 10-year period	IV	Bolivia	English
Valeggia, 2016 (2)	Health of women in the Toba, Wichí, and Mayan Tz'utujil indigenous peoples	IV	Argentina	English
Walker et al., 2015 (4)	Compilation of reports on 115 epidemics in various indigenous Amazon groups over a 133-year period	I	Brazil Paraguay Peru	English
Yajahuanca et al., 2015 (19)	Health care among the Kukama-Kukamiria people in the Peruvian Amazon	VI	Peru	Portuguese

lore (19). According to official statistics, Peru has about 72 ethnic groups. These indigenous populations face high rates of infant and material mortality, malnutrition, and infectious diseases (10).

The Peruvian health system currently targets a homogeneous population and fails to consider the rich multiculturalism in its territory. In 2002, the Peruvian Government introduced Integrated Health Insurance (*Seguro Integral de Salud* – SIS), which has played an important role in reducing infant mortality rates, but it has not ensured comprehensive access to health for all (17). In 2004, the Government established National Health Strategies (*Estrategias Sanitarias Nacionales* – ESNs, which proposed health policies for indigenous peoples (10). However, it is important to note that as of 2014 the country still did not have a government agency responsible for managing policies aimed at indigenous populations (19).

In 2014, the Government declared that all indigenous peoples in the Peruvian Amazon were recognized to be living in extreme poverty and were therefore recognized to be eligible for SIS assistance, thereby considerably increasing their health system coverage. The authorities confirmed the need for intercultural health strategies and guaranteed the right to health for indigenous peoples (17).

The indigenous peoples in Peru eke out a living in areas that are rich in wood, minerals, and natural oils that regularly attract foreign workers, who in turn bring new pathogens to their villages (17). The illnesses with the highest incidence in these communities include tuberculosis, parasitic diseases, malaria, malnutrition, and acute outbreaks of diarrhea (10, 20). Access to basic health services has improved in recent decades, though it continues to be insufficient. Vaccination coverage and other health measures are still lower in indigenous children than in non-indigenous children. Furthermore, 78% of indigenous Peruvian children are living in extreme poverty (1, 17). A study conducted among indigenous groups in 2014 (20) found that 57% of the population surveyed did not receive medical assistance when it was needed, compared with 72% in 1999 (20). Traditional medicine practices such as faith healing and shamanism continue to be widely used by about 80% of indigenous Peruvians (17, 20). Response to low-complexity needs is provided by clinics in semiurban areas but rarely in the indigenous villages, where preventive

measures, early diagnosis, and timely treatment of illnesses in the community are provided (29).

Bolivia

Indigenous peoples in Bolivia, such as the Tsimané, live deep in the rainforest (21). Indigenous Bolivian women have high rates of morbidity during pregnancy and often choose not to seek the health services because they feel excluded and insecure in that environment (21). The Bolivian Aymara living in their villages cite difficult access to health care and poor communication between health professionals and the indigenous patients (22).

The Bolivian health system became universal in 2011, with emphasis on PHC and social medicine (23). However, this system still fails to respond to all the demands of the Bolivian people and does not guarantee community participation in the formulation of policies (23).

Colombia

Colombia is rich in ethnic and linguistic diversity, with a minority indigenous population that represents approximately 4% of the national total (2). The right to health of indigenous people is not guaranteed by the government. According to information from the Ministry of Health, the rates for infant and maternal mortality in the Colombian Amazon were the highest in the country (15).

Among the Colombian ethnic groups, indigenous groups have the highest rates of mental illness (2). Traditional medicine continues to be widely practiced, and even preferred, by Colombian indigenous groups for the treatment of diseases (15). An ethnographic study conducted from 2010 to 2013 in indigenous communities in the Colombian Amazon found that recognition of the traditional practices of their healers and respect for patients in the villages on the part of Western physicians were among the groups' leading requests (15).

Argentina

In Argentina, the proportion of indigenous populations, including the Mbyá-Guaraní and the Toba, is considerably smaller (2, 22). Some of the country's indigenous villages are undergoing an epidemiological transition, holding on to ancient pathologies that have not yet been eradicated while at the same time

dealing with emerging conditions related to the modern life, such as obesity, sedentary lifestyle, diabetes, and alcoholism (24). Censuses conducted by the Argentine Ministry of Health have shown a significant drop in child mortality among indigenous people following the implementation of PHC strategies in the country (24). Furthermore, recent decades have seen a reduction in the incidence of tuberculosis in some of the villages following expanded immunization (24).

Chile

One of the main ethno-cultural communities in Chile is the Mapuches, who represent 87% of the ethnic groups recognized by the Chilean Government in its territory (18). The Mapuches still have high rates of infant mortality and a high prevalence of tuberculosis.

In 1996, the Government introduced the Special Health and Indigenous Peoples Program (*Programa Especial de Salud y Pueblos Indígenas*) and in 2006 it formulated the Health and Indigenous Peoples Policy (*Política de Salud y Pueblos Indígenas*). These initiatives were based on an intercultural health model and on principles of equity and community participation (18).

The Chilean indigenous villages have a unique epidemiological profile that is currently in transition: one with typical diseases in developing regions coexisting with others associated with modern life (18). In order to properly care for the Mapuches, one of the main needs of Chilean health professionals is access to information and education on the culture and beliefs of these people (18).

Paraguay

Paraguay has approximately 20 ethnic groups, corresponding to about 1.7% of the total national population in 2012 (41). In these communities, 112,800 people belong to indigenous groups and have high prevalence rates for tuberculosis. Reports on Paraguayan indigenous groups indicate that this population usually delays seeking formal medical care because they tend to minimize their symptoms, which consequently delays the diagnosis and treatment of illnesses (41).

Ecuador

Ecuador's national health system has among the lowest coverage in

South America (approximately 25% of the total population in 2014) (25). Poverty affects approximately 40% of Ecuadorean citizens, with higher rates in rural and indigenous communities (25).

Statistical analyses show that only 18% of indigenous Ecuadorean people have access to curative health services, despite significant changes in the national health system over the last decade. Thanks to pressure from indigenous organizations like the Confederation of Indigenous Nationalities of Ecuador (*Confederación de Nacionalidades Indígenas del Ecuador – CONAIE*), Ecuador's new health system has incorporated intercultural principles, bringing together Western and traditional medicine in a partnership to reverse the precarious living conditions of these peoples (25).

DISCUSSION

Even though the indigenous peoples are ancient inhabitants of South America, their health has only begun to have a higher profile with national and international health organizations in the past 30 years (10). After the Declaration of Alma-Ata in 1978, several health care policies emerged in the Americas, based on the new concept of primary health care (PHC) and oriented toward universal health coverage and access for the entire population (1, 6, 15).

Since the 1990s, as a result of cultural tensions in various regions of the continent in the wake of rapid globalization, a discussion emerged on the sanitary and health conditions of indigenous peoples (10). In 1993, the Pan American Health Organization/World Health Organization (PAHO/WHO) launched the Health of the Indigenous Peoples Initiative, which supported: 1) the need for a holistic approach to health; 2) the right of self-determination of indigenous peoples; 3) the right to systematic participation; 4) respect for and revitalization of indigenous cultures; and 5) reciprocity in relations with other groups (7). Over the period from 2006 until 2011, PAHO/WHO proposed including the indigenous perspective in the development of national health policies, allowing for a blend of traditional indigenous medicine and Western scientific medicine. In fact, the term "intercultural medicine" was proposed to be included in health policies. In this way, it would be possible to form strategic partnerships in PHC while respecting the

resources and treatments of indigenous medicine as alternative approaches that addressed the holistic health of the individual as determined by social, economic, and cultural factors (15, 16). Most South American countries now have ministries and specific agencies dedicated to the subject of indigenous health management. Nevertheless, many regions do not have consistent political support, which means that the health policies are not effective for these people (10).

According to the articles studied, the main obstacles standing in the way of access to PHC by South American indigenous people include: insufficient longitudinal access to the patient's clinical history in the health services that are nearest to the villages; language and illustrations in the health education booklets that are inappropriate for the indigenous context; difficulty communicating with health professionals; inadequate transportation to health units; insufficient epidemiological data on the indigenous villages; lack of information about local indigenous cultures; and fear that the indigenous patient will be discriminated against or humiliated (3, 17, 18).

The study was limited in that only open access articles were used. Documents from the government or other sources on specific policies could not be included because the review of scientific articles on the subject might require a significant amount of time to reflect on changes. This may have resulted in the exclusion of important studies to which the authors only had limited access. Other significant limitations may have been the short time limit for the retrospective analysis (10 years) and the shortage of scientific articles on indigenous health, reflected in the scant and imprecise anthropological and epidemiological data. Despite these limitations, the study is an important contribution because it offers a current picture of indigenous health in South America and calls attention to the dearth of studies on indigenous health across the entire continent, absent a deeper analysis of the South American scenario. The missing health panoramas from some of the countries (Guyana, Uruguay, Venezuela, Suriname) and lack of sufficient detail in others (Bolivia, Ecuador, Paraguay) confirms the shortage of studies on these communities. In other words, research is needed to investigate the health panorama of indigenous people in South America more deeply and in greater detail.

Despite the shortage of information, it was possible to conclude that indigenous groups in South America, even with their cultural and health care differences, are facing similar situations, such as infectious and parasitic diseases alongside the illnesses of modern life, such as elitism and chronic noncommunicable diseases. In the face of cultural differences and obstacles to access to health care in indigenous villages, PHC cannot be implemented fully, effectively, and over time. Despite the public policy initiatives to provide care for the indigenous populations in South America, the hoped-for advances are not yet completely visible in the literature; Most of the villages are still facing the same problems as when the research began to appear, such as difficult access to the localities, high turnover of professionals, and mismatch between biomedical care and traditional practices.

Specifically, lack of geographic access to the health services was the main problem facing the indigenous peoples in Peru. In Bolivia and Brazil, the biggest issue was lack of adequate communication between health professionals and indigenous patients, making it difficult for these peoples to accept the formal health services. In Colombia, the right of indigenous peoples to health care is not guaranteed by the government, which is reflected in high mortality rates in these communities. In Chile, lack of information and education about the culture and beliefs of their indigenous peoples stands in the way of this population receiving adequate care.

Despite the expectations and policies aimed at improving PHC for indigenous peoples, there are still many barriers that need to be addressed with specific strategies, and investments need to be aimed at improving the health of these groups. Expansion of biomedical care and efforts to reach the indigenous villages need to be strategically allied with knowledge about these peoples in order to truly recognize indigenous health and its particular characteristics.

Conflicts of interest. None declared.

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RESUMO

Atenção primária à saúde de indígenas sul-americanos: revisão integrativa da literatura

Objetivo. Revisar a literatura acerca do acesso à atenção primária à saúde (APS) por comunidades indígenas da América do Sul, identificando os principais obstáculos a esse acesso.

Métodos. Revisão integrativa de artigos publicados de 2007 a 2017 nas bases de dados LILACS, PubMed e SciELO. Para a busca, foram utilizados os descritores “indígenas AND saúde AND Brasil” e “indígenas AND saúde NOT Brasil” nos idiomas português e inglês. Foram incluídos artigos publicados em inglês, português ou espanhol e que abordassem estritamente a APS em indígenas sul-americanos.

Resultados. Foram incluídos 40 artigos que descreveram aspectos da APS de indígenas em oito países: Brasil, Peru, Colômbia, Bolívia, Argentina, Chile, Paraguai e Equador. Os principais obstáculos de acesso à APS detectados foram a dificuldade de acesso aos serviços de saúde mais próximos das aldeias; linguagem e ilustrações das cartilhas de educação em saúde inapropriadas ao contexto indígena; dificuldade de comunicação com os profissionais de saúde; carência de meios de transporte adequados até as unidades de saúde; escassez de dados epidemiológicos das aldeias indígenas; ausência de informação sobre as culturas indígenas locais; e medo de discriminação ou humilhação por parte do paciente indígena.

Conclusões. Ainda são escassos os estudos sobre saúde indígena na América do Sul. Também é evidente que os sistemas de saúde nacionais ainda precisam avançar na direção de uma medicina intercultural, de respeito às realidades sociais, culturais e econômicas de todas as comunidades assistidas, com conhecimento e consideração pelas diferentes formas de cuidado.

Palavras-chave

População indígena; saúde de populações indígenas; atenção primária à saúde; América Latina.

Atención primaria en salud a indígenas de América del Sur: revisión integrativa de la bibliografía

RESUMEN

Objetivo. Revisar la bibliografía acerca del acceso a la atención primaria de salud (APS) de las comunidades indígenas de América del Sur, e identificar los principales obstáculos a ese acceso.

Métodos. Revisión integrativa de artículos publicados desde 2007 a 2017 en las bases de datos LILACS, PubMed y SciELO. Para la búsqueda se utilizaron los siguientes descriptores: “indígenas AND salud AND Brasil” e “indígenas AND salud NOT Brasil” en portugués e inglés. Se incluyeron artículos publicados en inglés, portugués y español que abordaran estrictamente la APS en indígenas de América del Sur.

Resultados. Se incluyeron 40 artículos que describieron los aspectos de la APS en indígenas de ocho países: Argentina, Bolivia, Chile, Colombia, Brasil, Ecuador, Paraguay y Perú. Los principales obstáculos de acceso a la APS detectados fueron la dificultad de acceso a los servicios de salud más próximos de las aldeas; lenguaje e ilustraciones de las cartillas de educación en salud inapropiadas al contexto indígena; dificultad de comunicación con los profesionales de salud; carencia de medios de transporte adecuados hasta las unidades de salud; escasez de datos epidemiológicos de las aldeas indígenas; ausencia de información sobre las culturas indígenas locales; y miedo de discriminación o humillación en el paciente indígena.

Conclusiones. Aún son escasos los estudios sobre la salud indígena en América del Sur. Es evidente que los sistemas de salud nacionales aún necesitan avanzar hacia una medicina intercultural, con respeto a las realidades sociales, culturales y económicas de todas las comunidades asistidas, con conocimiento y consideración de las diferentes formas de cuidados.

Palabras clave

Poblaciones indígenas; salud de poblaciones indígenas; atención primaria de salud; América Latina.