

Critical analysis of interculturality in the National Policy on Health Care for Indigenous Peoples in Brazil*

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ABSTRACT

Concern for culturally appropriate and intercultural care, based on linkages and complementarity among health knowledges, has been a priority for ensuring primary health care for indigenous peoples since the Alma-Ata Conference. In Brazil, a country with significant sociocultural variety in the South American indigenous context, a National Policy on Health Care for Indigenous Peoples (PNASPI) was established 16 years ago, focusing on the notion of differentiated care. This concept, considered incomplete and contradictory, has been variably operationalized in indigenous primary health care. Therefore, the present article proposes an analysis of the formulation and operationalization of this concept in PNASPI. The analysis brings to light the ethnocentric nature of PNASPI, the numerous contradictions and oversights that fail to encompass the exchanges and linkages with traditional knowledges and with indigenous emic views of health and processes of illness/cure. Overcoming these limitations will require greater epistemological reflexivity, questioning, and surveillance in both the social and political sciences, as well as social movements and indigenous social control, to redefine indigenous primary health care in Brazil in intercultural terms.

Keywords

Health of indigenous peoples; cultural competency; public policy; health care (public health); Brazil.

For 40 years, the guidelines of the Declaration of Alma-Ata have served as the basis for the design of national public

health models centered on equal access to primary health care (PHC). PHC in Brazil—considered the point of entry, coordinator of care, and organizer of activities and services in the Unified Health System (SUS)—must be provided universally and free of charge in accordance with territorial demand, needs, and health determinants (1). In the country's indigenous territories, PHC is offered through the Indigenous Health Care Subsystem (SASI), using a participatory

intercultural approach in which indigenous community health workers and traditional healers participate as “important allies” of primary care professionals “in the organization of measures to improve the health of the community” (2).

Like other nations, Brazil also seeks to guarantee appropriate, comprehensive, and integrated universal public health services (3) and culturally appropriate care, respecting sociocultural identity and rights pursuant to Convention 169 of

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the International Labor Organization (ILO) (4). These actions and services must be grounded in linkage with traditional indigenous knowledges and practices in health through the introduction of new concepts in public policy, changes in the organizational models of care, and the development of new health care practices. Nevertheless, worldwide, indigenous people are still considered one of the most vulnerable population groups. The gap between the health conditions of indigenous peoples and those of the surrounding national societies persists, making inequity in indigenous health a priority issue on the global agenda (5).

In South America, the historical path in the creation of diverse institutional PHC models and strategies for indigenous populations, based on interculturality, has been marked by the struggles of indigenous social movements and the post-colonial critical approach of academic analyses (6). Moreover, Brazil, a country with a vast territory and enormous ethnic, linguistic, and cultural diversity, enshrined recognition of the differentiated rights of its indigenous population in the Constitution of 1988 but limited them to the social and cultural dimension, giving a back seat to ensuring the right to sovereignty, self-determination, and representation in political decision-making, thus perpetuating vestiges of the historical legacy of colonialism and slavery.

With respect to the right to health, at the National Conference on the Protection of Indigenous Health in 1986, the indigenous movement called for a subsystem of care that would address the specific needs of its peoples. This materialized years later through the "Arouca Law," which created a model of care with a comprehensive and differentiated approach (7), given that:

The health/disease process of indigenous peoples is the product of socioeconomic and cultural determinants that range from territorial integrity and environmental protection to preservation of the traditional medical systems of these peoples and their culture as a whole, to political self-determination—not simply the health care provided. It is of the utmost importance to ensure the training of human resources capable of providing medical and

health care to indigenous peoples, taking the knowledge of these populations and respect for their traditional medicines into account, searching for strategies to change the ethnocentric and strictly technological approach of health professionals at all levels of the country (Deputy Sérgio Arouca, Sessions Room, 29 June 1994) (8).

The "comprehensive differentiated approach" envisaged in the National Policy on Health Care for Indigenous Peoples (PNASPI) (9, p. 28) includes the creation of SASI, defined as a "complementary and differentiated subsystem" of the SUS (9, p. 13) whose design is based on differentiated elements specific to the indigenous population and organized under the banner of differentiated care in settings considered intercultural (10).

Empirical studies of the operationalization of the PNASPI reveal a model of care that results in "inclusive standardization" (11) and a predominance of health care practices that give primacy to differences (12). This model is characterized by functional interculturality in which recognition and respect for cultural diversity have become a new strategy for domination that at once obscures and maintains colonial differences through the discursive rhetoric of multiculturalism. (13, p. 4).

Thus, the studies show that operationalizing the PNASPI has not fostered the emergence of health activities aligned with the cultural mores and real demands of indigenous communities. In fact, it has produced effects that run contrary to the underlying principles and premises of the policy, especially when it comes to the improvement and tailoring of SUS operations and capacity to meet the specific health needs of "culturally different communities," referenced in "differentiated health" (14).

Public health and anthropology coincide in emphasizing the opacity and complexity of the concept of differentiated care, reflected in both the text of the PNASPI and its implementation (15). Furthermore, some studies are largely uncritical of the weaknesses noted, helping to obscure the inconsistencies, gaps, and ethnocentric assumptions of the policy. In this context, this article proposes to investigate which aspects of the complex concept of differentiated health

care are clearly defined in the PNASPI in terms of its operationalization and which are neglected or contradictory in terms of (dis)orienting the *modus operandi* of health professionals.

To tackle the issue of differentiated care, we evoke the concept of critical interculturality propounded by Catherine Walsh (16, p. 4-5), in which we find categories applicable to the field of indigenous health: a relationship, communication, and learning process between cultures, based on respect, mutual legitimacy, symmetry, and equality; an exchange between culturally different people, knowledges, wisdom, and practices to develop new common meaning within their differences; a space for negotiation and transformation, where inequalities and power relations in society are acknowledged and confronted.

"Differentiated": meanings and practical applications in the PNASPI

The term "differentiated" appears in the PNASPI above all in relation to the "differentiated health service organization model," considering "conventional Western forms" (9, p. 1), with less emphasis on "health practices" (9, p. 13). The concern about "adapting" the public health system to traditional health systems is therefore centered on matters of form and "appropriate technologies" (9, p. 6) in the generic sense, based on an ethnocentric vision of service organization.

In the guideline on "monitoring health activities," the biomedical *habitus* is reflected in the concern for defining strictly epidemiological criteria and indicators as tools that should "permit identification of the special risks and conditions that intervene in the disease process" and "that evaluate health and, indirectly, health care" (9, p. 16). Indeed, the monitoring of indigenous health is not defined in intercultural terms: it does not include indicators for monitoring intercultural care practices or consider the participation of indigenous communities in management, implementation, or access to data (17). The Indigenous Health Information System (SIASI) is not an open-access system, and in its implementation, quantitative targets are given priority over qualitative indicators of the effectiveness of intercultural care.

Another section of the PNASPI makes reference to “differentiated services” (9, p. 15) under the comprehensive approach, understood as accessibility and continuity of treatment between different levels of complexity and through differentiated financing. The SASI management model is shaped like a pyramid in which numerous private entities and nongovernmental organizations operate. The model of care in this SUS subsystem is characterized by its greater dependence on outsourcing care: fragmentation that affects people and activities ranging from health workers to essential services such as health transport and cleaning.

Within the PNASPI, the aspects most clearly geared to an intercultural and indigenist approach—such as linkage between knowledges, respect for the practices and values of the traditional system, and consideration and recognition of diversity—are found in the section on pharmacological guidelines (9, p. 17). These guidelines call for appreciation of traditional pharmacological practices as a strategy for connecting phytotherapeutic knowledges through “the evaluation and adaptation of standard intervention protocols,” in addition to stressing the issue of “quality control and the surveillance of potential iatrogenic effects” (9, p. 18). Notwithstanding, this linkage between Western and traditional indigenous pharmacology remains open to ambiguous interpretations: there is concern about the impact of the cultural exchange of an object—a pharmaceutical product—for a predatory one-way, non-reciprocal, and non-complementary appropriation of the knowledge, phytotherapeutic practices, and secrets of traditional healers.

It is clear that the elements of differentiation in SASI are defined in the initial PNASPI guidelines, which emphasize the formal organization of the services. The substance of differentiated care is marked by conflict between the dominant biomedical vision of health and indigenous health care.

The one-way monocultural rationale underlying the national policy is also revealed in the guideline on “linkage of traditional systems,” since, as the very heading suggests, the SUS is not considered the object of linkage with traditional medicine systems, which are viewed as subordinate or peripheral.

The epidemiological nature of the criteria that determine the profile and competencies of the multidisciplinary indigenous health teams (EMSI) that serve indigenous people in PHC is another aspect that stands out, since its composition and parameters will vary with “the number of inhabitants, population dispersion, conditions of access, epidemiological profile, specific needs for controlling the principal endemic diseases” (9, p. 14). The lack of reference to the communication, relational, linguistic, and cultural competencies necessary for mediation in intercultural settings is evident, considering the 274 indigenous languages spoken in Brazil (18).

Thus, the multidisciplinary aspect of the make-up of EMSIs is reduced *a priori* and *a fortiori* almost exclusively to public health professionals in the strictest sense, exactly replicating the team model used in the Family Health Strategy (ESF) of the undifferentiated SUS. The organizational definition of the model of care in PHC therefore excludes the contribution of practitioners of other health knowledge, such as traditional indigenous healers, or academic fields and disciplines focused on interculturality in health, since the “systematic collaboration of anthropologists” (9, p. 14) does not necessarily influence the everyday delivery of care to Brazil’s indigenous communities. In the Eurocentric vision of the PNASPI, EMSI professionals are considered “whites” and representatives of “white people’s medicine,” which is Western and biomedical—this, despite the substantial increase in recent years in the professionalization of indigenous people who work in indigenous health alongside indigenous health workers (19).

Another significant void is the lack of investment in differentiated training based on traditional knowledge of the local context and intercultural relational and communication competencies capable of producing effectively differentiated care relationships (20). Although the PNASPI recognizes the key role of training “as the basic instrument for tailoring the activities of SUS professionals and health services to the specific health care needs of indigenous peoples” (9, p. 16), it is provided exclusively to one category of professional—indigenous health workers—based on a concept that, in assimilationist and integrationist terms, risks turning into “a strategy designed to

encourage the appropriation by indigenous peoples of the technical knowledge and resources of Western medicine.”

This is reflected in the hierarchy of relations in the EMSI, based on specialized knowledge of pathologies, clearly demonstrating the hegemony of biomedicine in the concept of differentiated care. There is no expectation of reciprocity in the appropriation and integration of other health knowledges by other EMSI professionals (physicians, dentists, nurses, technicians, and assistants).

Efforts to understand how to deliver care to the communities served and the approach to the health-disease process and traditional wisdom in health are not based on intercultural exchange, interaction, and different reciprocal, two-way, polysemic practices in the production of health. This reveals another contradiction with the underlying assumptions of the national law about linkage and mutual respect between knowledge systems, since paradoxically, their operationalization does not provide for the inclusion of specialized traditional healers (*pajés*, *rezadores*, *benzedeiros*, *raizeiros*, midwives) in the public health system.

FINAL CONSIDERATIONS

Analysis of the text of the PNASPI reveals a functional intercultural vision of differentiation with respect to indigenous health care—rather than a critical and operational vision. It ranges from extreme ethnocentrism to contradictory assumptions about the nature of linkages between knowledges—a key concept of differentiated care. Using the concept of critical interculturality as a reference, such analysis shows the elements that create obstacles and barriers to understanding differentiated care as a mutually constructed, shared, and validated process of interaction. The ambiguities or ambivalences that permeate the concept of differentiated care are obstacles to the development of the new intercultural health care practices intended in the underlying premises of national legislation.

National conferences that express the perspectives of indigenous people and indigenist public health professionals, continue to call for intercultural strategies such as the inclusion of traditional healers in indigenous health services and intercultural training for non-indigenous professionals. In institutional

terms, however, giving a voice to indigenous emic visions of health is severely constrained by the consultative nature of indigenous authorities (national indigenous health councils and conferences), which sometimes hinders real participation in decision-making on indigenous public health.

A critical approach to health care policy can thus be a strategic means to overcome the barriers erected by the monolithic tendency of biomedicine, an expression of cultural hegemony over the silent resistance and domain of the ancient wisdom of the indigenous community.

What is needed, therefore, is a rigorous exercise in epistemic self-evaluation and vigilance that will lead to a virtuous process of critical intercultural reflection through institutional and scientific recognition of the epistemologies of indigenous wisdom in health and analysis of

traditional community self-care practices and knowledge (21), including the indigenous emic vision of the sickness/healing process in a multi-systemic therapeutic approach. This will make it possible to identify hybridization processes and distinctions between the epistemes and visualize the potential for linkage and integration with indigenous health care praxis in an intercultural sense. The review of the PNASPI, which will culminate in the upcoming 6th National Conference on Indigenous Health must (re)consider the intercultural foundations of the concept of differentiated care in policy and the scientific episteme and develop strategies to implement them in the praxis of those who deliver health care to indigenous peoples.

Considering that health sector reform in Brazil is an ongoing process (22), we can imagine a new era of interculturality promoted by the activism of the

indigenous population in synergy with committed, applied, and collective scientific research. We therefore hope that this analysis will prove useful in developing new strategies to restructure and indigenize interculturality in health care practices in the public subsystem for Brazil's indigenous peoples.

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Análisis crítico de la interculturalidad en la Política Nacional de Atención a las Poblaciones Indígenas en Brasil

RESUMEN

La preocupación por un cuidado culturalmente apropiado e intercultural, basado en la articulación y complementariedad entre saberes en salud, es una prioridad para garantizar la atención primaria de salud de los pueblos indígenas desde la Conferencia de Alma-Ata. En Brasil, un país con una significativa variedad sociocultural en el contexto indígena de América del Sur, existe desde hace 16 años una Política Nacional de Atención a la Salud de las Poblaciones Indígenas (PNASPI) enfocada en el concepto de atención diferenciada. Este concepto, considerado incompleto y contradictorio, es ejecutado de manera variable en la atención primaria de salud de las poblaciones indígenas. Este artículo propone un análisis de la formulación y ejecución de ese concepto en la PNASPI. Este análisis hace evidente el carácter etnocéntrico de la PNASPI, las numerosas contradicciones y negligencias que no contemplan de hecho el intercambio y la articulación con el saber tradicional y las visiones émicas indígenas de salud y de los procesos de enfermedad/curación. La reversión de esas limitaciones requerirá mayor reflexividad, cuestionamiento y vigilancia epistemológica tanto desde las ciencias sociales y políticas como desde los movimientos sociales y de control social indígenas para redefinir en términos interculturales la atención primaria de salud de estas poblaciones en Brasil.

Palabras clave

Salud de poblaciones indígenas; competencia cultural; política pública; atención a la salud; Brasil.

Análise crítica da interculturalidade na Política Nacional de Atenção às Populações Indígenas no Brasil

RESUMO

A preocupação com um cuidado culturalmente apropriado e intercultural, baseado na articulação e complementariedade entre saberes em saúde, vem sendo uma prioridade para garantir a atenção primária à saúde (APS) dos povos indígenas desde a Conferência de Alma-Ata. No Brasil, país de significativa variedade sociocultural no contexto indígena sul-americano, existe há 16 anos uma Política Nacional de Atenção à Saúde das Populações Indígenas (PNASPI) focada no conceito de atenção diferenciada. Esse conceito, considerado como incompleto e contraditório, é variavelmente operacionalizado na APS de indígenas. Sendo assim, o presente artigo propõe uma análise da formulação e operacionalização desse conceito na PNASPI. Essa análise torna evidente o caráter etnocêntrico da PNASPI, as numerosas contradições e negligências que não contemplan de fato o intercâmbio e articulação com o saber tradicional e as visões émicas indígenas de saúde e dos processos de padecimento/cura. A reversão dessas limitações exigirá maior reflexividade, questionamento e vigilância epistemológicos tanto das ciências sociais e políticas quanto dos movimentos sociais e de controle social indígenas para redefinir em termos interculturais a APS de indígenas no Brasil.

Palavras-chave

Saúde indígena; interculturalidade; política pública; atenção à saúde; Brasil.