

# Special Presentation

## Cultural Diversity and the Challenges of Brazilian Indian Health Policy

During the last fifty years, the position of minority groups before the State has transformed significantly. International decrees, as well as national legislation, have recognized the pluri-ethnic nature of the State and the necessity to guarantee the rights and the respect for different ethnic groups. In Brazil, these legal changes have been accompanied by the emergence of indigenous organizations as an important force in the political arena. Increased visibility of ethnicity has resulted in changes in the policy and organization of Indian health services.

The Convention 169 of the International Organization of Work signaled international recognition of indigenous rights in 1989. This document was the first international legal instrument conceived with the objective of specifically protecting Indian rights, calling for the recognition of and respect for the cultural diversity of native peoples in all dimensions, including employment, education, and *health*, among others. Convention 169 reverted the ideal of integration of native peoples and also substituted the notion of eventual collaboration of the Indians for that of active participation in legislative measures and decisions that affect them directly.

The significant increase in the number and activities of Indian organizations in the last twenty-five years has influenced changes in policies regarding ethnic minorities in Brazil, and the 1988 Federal Constitution affirmed its pluri-ethnic composition. Questions of power, ethnicity, and interethnic friction dominate the discussions regarding the relation of the Indian with the larger society. In spite of the fact that the Indian has yet to experience full citizenship in a society without prejudice and exploration, the rise of ethnicity as an important political force has had important consequences in Indian health policy and in the role of social scientists involved in health research or intervention.

In Brazil, the Indian is a minority, numerically and ethnically. The Indigenous population composes approximately 0.2% of the population, estimated to be between 350,000 and 800,000. This population, however, is characterized by a multiplicity of groups and native languages. The majority of the Brazilian Indians belong to micro societies. Twenty-eight percent (28.2%) of the 216 indigenous groups have a population of fewer than 200 individuals and 77% have less than 1000. It is impossible to characterize a single Indian "culture".

To contribute to this situation of cultural diversity, the groups are in various states of contact: at one extreme a few remain isolated or semi-isolated and suffer from the impact of the violence and the diseases of contact. At the other, which is the situation of the majority, the Indians are in frequent or continual contact with the greater society. This latter situation characterizes most regions outside the Amazon. In the South, as well as in the Northeast, the Indians suffer from a health situation similar to that of the poor in general: high prevalence of disnutrition, tuberculosis, dental problems, intestinal parasites, alcoholism, high rate of infant mortality, low life expectancy, etc. Although there are no available statistics, it appears that AIDS may become the new epidemic threatening the survival of Indian peoples.

The Federal Constitution of 1988 was part of the return to democracy in Brazil. In this same decade, reform of the health system, establishing the National Health System (*Sistema Único de Saúde* - SUS), delegated more responsibility and power to the municipalities and to the consumer. In the face of this reform, the First National Conference for the Protection of Indian Health was organized in 1986 in order to evaluate their health situation and to create a special policy for them.

Up until the first Conference, no clear policy regarding Indian health existed and their health services were never adequate. Initially missionaries provided some health attendance. Indian health was among the responsibilities of the Service for the Protection of Indians (SPI), created in 1919. Throughout its exis-

tence, health services were few in number, sporadic and disorganized. Systematic data regarding health conditions were not maintained and there was virtually no research. The National Service of Tuberculosis (SNT) aided their activities in the 1950's, treating tuberculosis in the Upper Xingu and Araguaia regions. In 1956 the Service of Ariel Sanitary Services (Unidades Sanitárias Aéreas -SUSA) joined to attend isolated Indian populations. Indians in greater contact with the national society were not covered by these services.

The National Indian Foundation (FUNAI - Fundação Nacional do Índio), assumed the SPI's responsibilities. Health posts for the provision of primary attention were established within the Indian Areas (Terras Indígenas - TI). A single health attendant, whose activities were to be supplemented by visiting health teams, normally attended the Post. Difficult cases, needing sophisticated treatment or diagnosis, were to be attended by local hospitals, the rural health services, INAMPS, the Secretaries of State Health, with whom FUNAI had agreements.

These services were highly unsatisfactory, disorganized and ineffective. Often their main role was limited to the distribution of available medications shipped to the area periodically. Outside the Indian Area, the Indians suffered discrimination by the local hospitals and other services. The "Indian Houses" in the regional centers were over crowded with patients and their families and became known as centers of infection and the spread of disease, including sexually transmitted diseases.

Between the First National Conference and the establishment of the actual Sub-System of Indian Health, several attempts were made to resolve Indian health services and to model them to the National Health System principles, which included universal access, humanized health services and social control. Responsibility for the health services passed between the National Foundation of Health (Fundação Nacional de Saúde - FUNASA) and FUNAI, and there were chronic problems of disorganization, institutional confusion and lack of funding. In 1999, the Sub-System of Indian Health, establishing 34 Special Indian Health Districts (Distrito Especial de Saúde Indígena - DSEI) was established, delegating to FUNASA the full responsibility of administering the sub-system. Health necessities requiring attention

beyond Indian Health Posts should be articulated with those of SUS. The principles of universal access, differentiated attention and social control are governing principles of this sub-system.

Since the 1990's, the strategy of the provision of health services has been to create an integration of the governmental and non-governmental institutions with the universities. Their role, not always well defined, has included research, consultancies, provision of services and the provision of courses for health professionals and/or Indians. The Escola Paulista de Medicina, which established the Xingu National Park Health Program in 1965, has been perhaps the most notable of the institutions to provide health services as well as to conduct research, but others have also been important. The Fundação Oswaldo Cruz (FIOCRUZ) in Rio de Janeiro and Manaus assumed an important role in training health professionals and Indian health agents. Several other universities have joined these institutions in the last decade and there has been an important growth of research and intervention projects at the interdisciplinary level.

The establishment of the 34 DSEI's in 1999 was accompanied by a sizeable increase in financial resources dedicated to Indian Health and an increasing number of professionals and programs dedicated to Indian health. The trend of increasing research has continued and significant publications on the theme have risen.

However, after eight years, there has not been a global evaluation of the sub-system. Clearly there has been an important impact on access to health services. A second positive result has been the increasing participation of Indian Organizations. Part of this has been stimulated by the establishment of agreements between such organizations and FUNASA for the provision of health services to Indian Communities, eliminating the role of the municipalities in primary attention. Such agreements have caused conflicts of interests, and mutual accusations between the concerned parties may indicate an increase to municipal control of primary attention in Indian Areas. It is too soon to evaluate this situation, but whatever the outcome, the Indian Organizations have increased in strength as a result of their participation.

In spite of the positive benefits, several important questions are yet to be answered regarding the success

of the health policy, and the articles in this issue are extremely pertinent to three general problems. The first regards the current epidemiological situation and problems with FUNASA's information system. Designed in 2001, the information system continues to suffer from a number of problems, prohibiting an evaluation of the impact of increased health services on the prevalence and distribution of disease among the Indian populations. What we have, as evidenced in this issue, are results of individual research in specific situations, which do not always indicate favorable results.

A second question treated in this issue refers to the principle of differentiated attention. Differentiated attention implies that health professionals must consider the cultural particularity of the Indian community and respect traditional health practices and curing specialists. In spite of the fact that this principle is part of the National Policy of Health Attention to Indian Peoples (Política Nacional de Atenção à Saúde dos Povos Indígenas), FUNASA has failed to develop directives that effectively orient the health teams. Efforts to offer differentiated attention are

isolated, and there tends to be an "essentialization" of the notions of culture and tradition that become the center of the struggle for power between the communities and the health teams.

A third and important question regards the effectiveness of participation and social control by the Indian communities. A hierarchy of councils to guarantee effective participation and social control has been instituted. It begins with the local health council passes to the District Council and finally to the Intersectorial Commission of Indian Health (Comissão Intersectorial de Saúde Indígena), which advises the National Health Council. Although Indian participation is guaranteed at all levels, little research has been dedicated to examining whether these councils represent democratic processes and effective social control in practice, or whether, in fact, they continue to be dominated by interest groups.

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