Decentralisation and Difference: Indigenous Peoples and Health System Reform in the Brazilian Amazon

Alex Shankland and Renato Athias*

1 Introduction

The implications of decentralisation for minority and marginalised groups are complex and contested. It has long been an article of faith for 'decentralisation and participation' advocates that bringing decision making closer to the grassroots is a prerequisite for overcoming the unresponsiveness of monolithic, top-down state service delivery systems or unaccountable, exclusionary privatised ones (Tendler 1997). Other observers, however, have drawn attention to the difficulty of ensuring that decentralisation actually contributes to the democratisation of the 'authoritarian enclaves' (Fox 1994), where minority groups – and particularly indigenous peoples – tend to be concentrated. They have also noted that in general the process will tend to leave more power in the hands of local élites who are often implicated in maintaining and exploiting these groups' political and economic marginalisation (Manor 1999).

These issues are particularly salient in Brazil. In the two decades since the end of the military dictatorship in 1985, the country has undergone one of the most extensive decentralisation processes in the world, accompanied by the implementation of one of the most robust legal and policy frameworks for citizen participation. However, Brazil's notorious social and economic inequalities have remained stubbornly persistent, and their links with historical and continuing exclusion along the lines of gender, race and ethnicity have become increasingly apparent. Dominated for years by the discourse on universalising *cidadania* (citizenship) and fierce denunciation of the risk that 'neoliberal' strategies such as targeting and outsourcing pose to the securing of equal rights for all citizens, the Brazilian social policy debate now reflects on the implications of the country's 'pluri-ethnic' nature, and more generally on the need for service delivery to develop new approaches to dealing with difference.

This article explores these issues by examining the decentralisation of a specific service – healthcare – and its implications for a specific marginalised group – indigenous peoples. Section 2 gives a brief overview of decentralisation and participation in the Brazilian health sector. Section 3 outlines the particular issues affecting healthcare for indigenous peoples in Brazil and traces developments in policy from the struggles which preceded the 1988 Constitution, through the subsequent decentralisation reforms, to the recent changes brought in by the government of President Luís Inácio Lula da Silva (Lula). Section 4 describes the case study of the Rio Negro region in the northwest Amazon, and examines the trajectory of the Rio Negro Special Indigenous Health District. Section 5 focuses on the roles of indigenous movement organisations in two areas of health policy within the region – participation for service accountability and outsourced service management – and examines their effectiveness and limitations in their relations with other local and national actors in the health system. Section 6 concludes with the lessons from this case study, and discusses their relevance to wider debates on social movement engagement with the state, the creation of participation spaces and the relations between minority groups, local élites and central government policymakers under decentralisation.

2 Health system decentralisation in Brazil

Brazil has historically been characterised by alternating waves of centralisation and decentralisation, with the most recent cycle seeing the country emerge in the 1980s from two decades of strongly centralising military dictatorship to transform itself into a highly decentralised federation (Melo and Rezende 2004: 37). The 1988 post-military Constitutional settlement left Brazil with one of the world's highest levels of fiscal decentralisation and provided space for a wave of democratic innovation at the lowest level of sub-national government, that of the country's 5,500 municipalities. This combination of decentralisation and democratisation has now reached virtually all areas of social policy, but its progress has been uneven across sectors. It is in the health sector that the process began first and reached furthest – with health, as a result, 'coming to represent the paradigm of sectoral decentralisation' (Melo and Rezende 2004: 44).

The struggle for democratisation in the concluding years of the military dictatorship was marked both by deep mistrust of the 'bureaucratic-authoritarian' state among social movements and by the desire on the part of reformers aligned with these movements to maintain the centrality of the state in the implementation of policies to tackle the country's profound social and economic inequalities. This led to the framing of participation both as a right in itself and as a mechanism for *controle social* or 'citizen oversight' of state-implemented social policies.

In the reform process which resulted in the 1988 Constitution, the advocates of *controle social* found themselves converging with a resurgent 'municipalist' lobby of local and regional politicians who sought to increase the level of fiscal transfers to sub-national governments (Souza 1997). The urban Left, well-established in the major metropolitan centres (and soon to be victorious in municipal elections in key cities such as São Paulo and Porto Alegre), was happy to support a municipalist agenda, despite the reservations of rural social movements – including that of Brazil's indigenous peoples – who were reluctant to see further transfers of power to the local élites whom they regarded as among their most dangerous opponents.

The result of this convergence was a set of constitutional provisions which empowered the municipalities and institutionalised mechanisms of civil society and citizen participation in their governance. The Constitution mandated higher levels of (both earmarked and un-earmarked) fiscal transfers to the municipalities. It also mandated the coexistence of institutions of representative democracy (directly elected executive mayors and municipal legislators) with deliberative-democratic mechanisms such as the *Conselhos* (councils) for sectoral policy oversight. This transformed Brazil's municipalities into a key locus of struggle over the implementation of social policies (Coelho *et al.* 2002). At the same time, however, some of the policy areas which had been the focus of rural social movements' struggles – including land reform and indigenous rights – remained under federal control.

Until the mid-1980s, the Brazilian health system was characterised both by centralisation and by exclusion. State curative services were concentrated in urban-based hospital care and open only to the relatively small proportion of the population who were in formal-sector employment (Costa 2004: 2). For the most part, the rural and peri-urban poor only encountered state health services in the form of top-down programmes such as the military-style vector extermination campaigns run by the Public Health Campaigns Superintendency (SUCAM). Where sporadic outreach initiatives did extend some state curative services into rural areas, as in the case of the Amazonian field hospital network run by the Public Health Services Foundation (FSESP), these services were generally under direct federal control, with little effort made to engage the local population in their management.

As the deepening economic crisis of the late 1970s and early 1980s weakened both the military dictatorship's grip on power and the state's ability to fund even the limited existing public health services, policymakers began to cast around for alternative models (Coelho *et al.* 2002: 66). This provided an opening for reformers involved in piloting more inclusive 'community health' approaches in local projects (sponsored by universities or the Roman Catholic church) to begin occupying key positions in the federal and state level health bureaucracy, while still maintaining their links with the emerging grassroots health movement (Weyland 1995; Costa 2004).

This movement had gathered strength under the dictatorship, as health emerged as one of the few

arenas where popular mobilisation was not met with immediate repression and where middle-class professionals were able to engage with communities without attracting the attention of the secret police. One of its key centres was in the East Zone of São Paulo, where community activists set up the first *Conselhos* as popular spaces for demanding health service accountability. Although they were initially created outside the health system's legal framework, these *Conselhos* were to prove highly influential in shaping the provision for participation and *controle social* in later constitutional and sectoral reforms (Costa 2004: 5).

During the 1980s, this alliance between community activists and progressive professionals became consolidated as the Movimento Sanitarista (Movement for Public Health). Their high point was the Eigth National Health Conference in 1986, which proclaimed health to be 'the duty of the state and the right of the citizen' and enshrined key principles of universality, decentralisation and participation as the normative basis of health system reform. Two years later these principles were written into the Constitution, and in 1990 the framework for operationalising them was established by a Basic Health Law, creating the Unified Health System (SUS) as the mechanism for universalisation of services. This framework included a requirement for municipalities to establish *Conselhos* with 50 per cent user representation and extensive powers of service and spending oversight as a condition for federal transfers of funding for health services. While the first *Conselhos* had emerged as a result of bottom-up mobilisation, it was this federal 'participation conditionality' which spurred a massive proliferation of deliberative health councils at the municipal level throughout the 1990s – with no fewer than 98.5 per cent of municipalities having established a health *Conselho* by 1999 (Melo and Rezende 2004: 46).

Despite the strength of formal provision for user participation and *controle social*, a number of studies have drawn attention to the limitations of the *Conselho* system in ensuring accountability and pro-poor targeting of health spending. These failings have been attributed to the persistence of authoritarian social relations and the attempts by mayors to pack *Conselhos* with their own political clients (above all in smaller, more rural municipalities); as well as to the tendency of bureaucrats and health professionals to privilege 'technical' discourses, excluding traditional and popular knowledge from the Councils' deliberations (Coelho *et al*. 2002). In recent years, as the SUS has rolled out a series of standardised packages for extending access to services, the emphasis of social movement and civil society mobilisation has shifted towards demands for the recognition of social difference as a key element in securing genuine equity (Costa 2004: 11). These demands have brought a broader range of actors – including the feminist, Afro-Brazilian and gay rights movements – into a debate which had previously focused only on the 'special case' of indigenous peoples.

3 Indigenous peoples and the Brazilian health system

Historically, health services for indigenous peoples in Brazil existed separate to the mainstream health system. This disconnection reflected the 'special status' of indigenous Brazilians, who until the 1988 Constitution, were formally designated as wards of the state. For many years, any 'modern' medical services were provided by missionaries or (sporadically) by the 'flying health teams' of the government Indian Protection Service (SPI) and its successor, the National Indian Foundation (FUNAI) (Verani 1999). These services were unable to reverse or even allay the devastating impact of introduced diseases (sometimes deliberately spread as a means of 'pacifying' hostile tribes) and of the deteriorating living conditions which resulted from interethnic contact. Localised projects implemented by non-governmental organisations (NGOs) and university departments from the 1970s onwards developed more appropriate models, but they were unable to forge systematic links with government services and policy. With the growth of indigenous peoples' movements in the 1980s and their establishment of an alliance with elements of the Movimento Sanitarista this began to change, and in the 1990s the outline of a new policy framework emerged. However, the hostility of both indigenous movements and their allies to the local élites who dominated the remote and rural municipalities where the indigenous population was largely to be found, ensured that this new framework differed from the mainstream SUS in one important respect: it avoided municipalisation and instead maintained the health of indigenous people as a 'federal issue' under the direct responsibility of the Ministry of Health.

Despite the scarcity of reliable data, epidemics of introduced diseases are widely recognised as having been a major factor (alongside genocidal violence and exclusion from access to natural resources) in the vertiginous population decline following each indigenous group's contact with non-indigenous society. Even though the indigenous population (now reduced to fewer than half a million in a country of 170 million people) stabilised and grew again in the 1990s, health indicators remain significantly worse than for the population in general. According to one study, infant mortality rates among indigenous people in the Amazon in 2000 were 74.6 per 1,000; more than double the Brazilian average of 31.8 per 1,000 (Garnelo *et al.* 2003: 64). These problems are compounded by difficulties of access, with many communities living several days' walk or boat journey from the nearest hospital.

Although they have been unable to deal with many introduced diseases, traditional health systems remain an important resource for indigenous people. Encompassing a variety of practices from shamanic ritual to the use of medicinal plants, these systems include curative interventions and practices which contribute to the preservation of other aspects of well-being (Athias 2004). The need for integration of traditional knowledge has been mentioned in Brazilian health policy documents since the 1990s, though virtually no progress has been made in putting these statements of intent into practice (Coimbra *et al.* 2006: 143).

Current policy on health services for indigenous peoples centres on the 'Special Indigenous Health District' (DSEI) model. DSEIs are management units whose area of service coverage is based on the territories of one or more indigenous peoples, which often cross municipal – and even state – boundaries. This model emerged at the Second National Conference on the Health of Indigenous Peoples in 1993, supported by an alliance of indigenous movements and health professionals aligned with the Movimento Sanitarista. The conference mandated the creation of a 'specific subsystem' of the SUS to be managed by the Ministry of Health, but years of bureaucratic turf wars between the Ministry's executive arm – the National Health Foundation (FUNASA) – and the government indigenous affairs agency, FUNAI, ensured that it did not begin to be consolidated until the late 1990s, after an international outcry at the deaths from disease of hundreds of Yanomami people had prompted the creation of the Yanomami Health District as the first DSEI.

The process of establishing DSEIs across Brazil began in 1998. At the time, the Brazilian Social Democratic Party (PSDB) government of President Fernando Henrique Cardoso was heavily committed to the principle of outsourcing services, a commitment attributed to a combination of ideological belief in the virtues of the 'third sector' and practical need to comply with International Monetary Fund (IMF) agreements restricting new hiring in the civil service (Costa 2004; Melo and Rezende 2004). Given this context, FUNASA initiated the new system not by recruiting more field staff of its own but by signing service-delivery contracts with an assortment of different providers. In addition to NGOs, missionary groups and university departments, these included indigenous movement organisations and municipal health secretariats. The result was that in some areas, a *de facto* municipalisation began to take shape, while in others indigenous movements found themselves involved simultaneously on both the demand side and the supply side of service delivery.

This diversity of service delivery arrangements reflected a number of factors. One was the critical scarcity of human and organisational resources capable of responding to the challenge of establishing adequate services. Unable to hire new personnel of its own and with an existing staff consisting mainly of former FSESP field hospital administrators and SUCAM malaria control campaign managers with little or no previous experience of working with indigenous peoples, FUNASA was forced to look for partners wherever it could find them. Another factor was the heterogeneity of the social and political contexts in the 34 DSEIs, some of which covered scattered tribal groups with little previous contact with non-indigenous society, while others contained relatively numerous peoples with well-established movement organisations. The implications of this heterogeneity for the mechanisms of *controle social* which (in line with SUS principles) were supposed to be built into the DSEIs were significant. The DSEI model provided for 50 per cent indigenous representation on district level *Conselhos* as the main vehicle for participation, but the extent to which local indigenous movement organisations had the resources to make effective use of these spaces varied considerably.

With the establishment of the DSEIs, the federal government was able to channel significantly increased resources into meeting the health needs of indigenous peoples. The budget for indigenous health services reached 124 million *reais* (over US$40 million) in 2002, almost a fourfold increase in dollar terms on its 1995 level. However, the performance of the system failed to match these investments. Although some indicators (including immunisation coverage) improved significantly, indigenous movements repeatedly denounced the system's inability to meet community health needs, and reports of widespread deaths of indigenous people from preventable diseases continued to appear in the media (COIAB 2000; ISA 2004).

Explanations for the disappointing performance of the system focused on the relationship between FUNASA and the outsourced providers. One review noted that:

> FUNASA, which should have provided technical and operational support to the contracted service providers, attracted a range of criticisms, above all for trying to impose an unreconstructed version of the aims of the SUS on an indigenous health subsystem operating in a reality with which public health specialists had little familiarity ... allowing in by the back door some of the worst practices which had marked indigenous [health] services in the 'wards of the state' period. (Barroso-Hoffmann *et al.* 2004: 311, authors' translation)

Frustration with the inability of FUNASA to fulfil its enabling role adequately – and in particular with the frequent delays in funding transfers which left staff unpaid and medicine supply chains disrupted – led several NGOs to pull out of the service contracts. After the 2002 elections they added their voices to those calling for the new federal government of Workers' Party (PT) President Lula to 'renationalise' the service by providing an operational structure for the DSEIs to operate as decentralised units fully under the aegis of the Ministry of Health. There was little change in policy, however, until 2004 when a series of scandals over misappropriation of funds in several DSEIs led FUNASA to announce an abrupt shift in direction.

In the event, FUNASA's 'new model' combined heavy recentralisation of budgeting and purchasing decisions with the maintenance of the practice of hiring staff under outsourcing arrangements rather than directly through the Ministry (ISA 2004). For many NGO activists and indigenous leaders, this was the worst of both worlds. It did away with much of the potential for flexibility and adaptation to local needs offered by decentralisation, without replacing it with a state-delivered service that could be held to account through the rights-claiming strategies that the movements were accustomed to deploying. The government responded to the continued criticism by looking to the decentralisation model of the mainstream SUS. In the face of ongoing problems with the operationalisation of the DSEI model, by 2005 FUNASA had begun to float the idea of outright municipalisation of the indigenous health system. This sparked furious protests among indigenous movements, who despite their often traumatic experiences of dealing with the federal government continued to believe that it would be even more damaging if more power and resources were to be transferred to local administrations – whom they generally identified as complicit with systematic attempts by local élites to deny indigenous peoples' rights and plunder their natural resources.

4 Health system decentralisation in the Rio Negro region

Among the largest and longest-established DSEIs is that covering the Rio Negro region, located in the far northwest of the Brazilian Amazon (along the borders with Colombia and Venezuela), and which is one of the most important centres of indigenous movement organising in Brazil. Its main municipality, São Gabriel da Cachoeira, is inhabited by some 30,000 members of 22 ethnic groups belonging to four different linguistic families, and is one of the very few Brazilian municipalities with an indigenous majority among its citizens.

The Rio Negro region represents a valuable site for analysis of indigenous health service decentralisation because it has many of the potential preconditions for successful implementation of the DSEI model: a history of organising around access to health services, a clear regional identity and a strong local indigenous peoples' movement able to access support from technically competent NGOs. Although considered one of the more successful DSEIs, it too has failed to fulfil expectations and has seen its share of reports denouncing avoidable deaths among indigenous people in areas supposedly covered by its services (ISA 2004). In this context, the fact that the

cultural and political fragmentation and lack of management capacity which have bedevilled other DSEIs are largely absent from the Rio Negro region makes it easier for a case study of the region to isolate the systemic issues, which may have contributed to the broader failure of the model to live up to expectations.

Although there are some more favourable elements in its particular social and political context, in general the Rio Negro region resembles other Amazonian DSEIs in the practical challenges which it poses for efforts to establish a comprehensive indigenous health service. Its indigenous population inhabits over 600 villages scattered over a vast area (the municipality of São Gabriel da Cachoeira itself, which covers only two-thirds of the DSEI area, extends for 108,000 km^2). There are virtually no roads, and several sets of rapids make river access difficult, requiring health teams to carry their equipment long distances through the rainforest.

Two powerful actors, the army and the church, also complicate the outlook for indigenous participation in a decentralised health service. The region's strategic border location has long been associated with a heavy military presence, which has recently grown still further in response to the intensification of the conflict in neighbouring Colombia. Much of the Rio Negro region's health infrastructure – including the main hospital in São Gabriel – is run by a military that is traditionally hostile to indigenous rights-claiming. The Catholic Church's Salesian Mission, active in the region since 1916, maintains a heavy presence with schools and catechism groups in most villages and a number of local health centres staffed by nuns. In the Rio Negro region, the church has long maintained a policy of trying to stamp out the indigenous curative practices linked with shamanism – labelled by the missionaries as *coisas do diabo* or 'things of the devil'.

Following a 20-year campaign, most of the Rio Negro region was finally demarcated as an Indigenous Territory in 1998. This land struggle was led by the Federation of Indigenous Peoples' Organisations of the Rio Negro (FOIRN), which brings together 54 indigenous community associations based in the region. FOIRN and its affiliated associations are formally organised for engagement with non-indigenous society, but the practices of leadership selection and decision making through which they operate are closely articulated with traditional governance systems based on clan hierarchies and interethnic exchange relations.

FOIRN has emerged as a significant political actor at the national, regional and local levels, but it is far from hegemonic in São Gabriel da Cachoeira; the fact that 92 per cent of the municipal population is indigenous has not translated directly into economic or political power. The local economy is in the hands of non-indigenous traders to whom many indigenous people are permanently in debt, and migrants from elsewhere in the country dominate municipal politics, securing indigenous votes through the time-honoured clientelistic practices of the Brazilian interior. FOIRN-backed candidates have occasionally been elected to the municipal legislature, but internal divisions and the lack of resources for competitive vote-buying mean that the federation has yet to elect a mayor in São Gabriel.

Ironically, in view of the indigenous movement's broad adherence to DSEIs as an alternative to municipalisation, it was actually at a Municipal Health Conference in São Gabriel da Cachoeira in 1997 that the proposal for the Rio Negro DSEI took shape. The proposal resulted from an intense process of inter-institutional negotiation involving the indigenous movement, NGOs, the church, local politicians and even the army, with groups who were often in conflict over their competing visions for the region demonstrating an impressive level of political maturity in coming together in the search for joint solutions to the challenges that none was capable of addressing individually. There was broad agreement both on the need to divide up areas of responsibility and on the importance of training indigenous health workers to ensure coverage at the village level. In the event, the region was divided into five zones, with a different organisation taking lead responsibility for primary care provision in each zone while following joint plans on village health worker training, immunisation and other core strategies.

FUNASA duly signed service provision contacts with the different organisations (two NGOs, two church agencies and the municipal health secretariats of São Gabriel and the neighbouring municipality of Santa Isabel), which reflected this territorial distribution. A district level *Conselho* was established, with a leading role reserved for FOIRN, which received health policy advisory support from one of the NGOs,

Associação Saúde Sem Limites (SSL). The regional office of FUNASA was confined largely to a supporting role, above all in procurement. Despite teething troubles as the different institutions struggled to get used to their new roles, initial levels of enthusiasm were high. Parts of the region which had never had regular access to biomedical services began to receive visits from immunisation teams, indigenous health workers travelled to town for training courses and permanent health posts were built in the upriver areas and equipped with speedboats for evacuation of critical cases to the military hospital in São Gabriel.

It was not long, however, before the cracks began to show. Federal budget squeezes reduced the flow of funds, and FUNASA transfers to the contracted service providers became erratic. Dozens of medical and nursing staff went unpaid for months, exposing the institutions that had hired them to potentially ruinous labour court actions. Differences in approach and capacity among the different providers caused friction, and neither FUNASA on the technical front nor FOIRN on the political side was able to impose a common line. In the absence of effective overall coordination, an alliance of like-minded organisations (SSL, one of the church agencies and FOIRN) proposed forming a consortium to take over management of the whole DSEI. The strategy foundered on the difficulty of getting the necessary contractual arrangements in place and, in 2002, as the delays in resource transfers became worse, first SSL and then the other providers decided to pull out, refusing to renew their contracts. Without service providers willing to accept outsourcing contracts and prevented by austerity measures from hiring field teams of its own, FUNASA faced the prospect of the collapse of the DSEI. In the event, it was FOIRN itself that stepped in to accept a service provision contract, leaving the movement uneasily straddling both the demand and the supply side of indigenous health services in the Rio Negro region.

5 Indigenous movement organisations and health policy in the Rio Negro region

Since its foundation in 1987, FOIRN had responded to its constituents' priorities by placing health high on the list of demands around which it coordinated indigenous mobilisation in the Rio Negro region. Unlike other regional indigenous movements, however, the federation was reluctant to accept management responsibility for providing the services it accused the government of failing to deliver, even when invited to do so by NGOs with access to international funding. It was only after the collapse of FUNASA's initial outsourcing arrangements in 2002 that FOIRN agreed to take on management responsibility for the DSEI. Before that, the federation and its affiliated organisations had been engaged in other participation strategies: occupying officially created spaces to press for accountability and recognition of community needs, and organising outside the official system to promote a different approach to health.

FOIRN's initial reluctance to take on a management role in the district had an organisational dimension as well as a political one: the federation had seen the administrative strain, which complying with FUNASA contracting arrangements had placed even on well-established NGOs, and had no illusions about the difficulty of managing a large contingent of assertive and opinionated non-indigenous professionals as well as the growing corps of indigenous village health workers. Why then did FOIRN give in to FUNASA's pressure and agree to sign an outsourcing contract when the NGOs pulled out?

When asked this question during the authors' initial research in 2004, the federation's outgoing president responded that 'we accepted the management of the district to fulfil our commitment to represent the grassroots, and to avoid the DSEI being handed over to the municipal government.' This answer reveals the extent to which accountability to communities and resisting municipalisation had become intertwined in the movement's political logic. There is no doubt that FOIRN's leaders were under intense pressure from their constituencies as well as from FUNASA not to allow the DSEI to fail and services to be withdrawn. The fact that they rejected the alternative strategy of encouraging the transfer of responsibility to the municipality while simultaneously intensifying their efforts to hold the elected local government to account for the delivery of the service suggests a complete lack of faith in the possibility of a genuinely accountable municipal administration. It may also suggest that in recognising the potential of health service delivery to pay political dividends, FOIRN's leaders not only wanted to keep this potential out of the hands of the non-indigenous municipal élite but also had their eye on what it could yield for their own political projects.

Initially, this strategy seemed to pay off. Although there were some administrative difficulties, the FOIRN-managed Rio Negro DSEI encountered nothing like the scandals over resource misappropriation by subcontracted providers – indigenous and non-indigenous alike – which crippled other districts. While tensions between non-indigenous professionals and the indigenous leaders who were officially their line managers did occasionally flare up, they were generally handled with skilful diplomacy by the FOIRN-appointed DSEI coordinator, a former president of the federation. The Rio Negro DSEI even began to gain a reputation as something of a model, looked to enviously by movements in other parts of Brazil. One former FOIRN health representative interviewed during the initial research in 2004 commented that 'in Rio Negro the District has strengthened our movement; in other Districts, though, the professionals were too strong ... the movements ended up as functionaries of the health policy ... for the other movements, it seems like health work was a separate thing, which couldn't be combined with political work, but FOIRN has developed health work and political work together.'

Significantly, however, FOIRN's vision for 'political work' did not extend to challenging the 'technical' priorities for resource allocation. These priorities continued to be decided by non-indigenous health professionals working in the district, following policy parameters determined by FUNASA in Brasília. There was no scope for adapting the DSEI's management approach to reflect indigenous political culture and styles of decision making, as the demands of bureaucratic routine consumed the energies of the FOIRN leaders involved in running the district. Initiatives such as cultural sensitisation training of newly arrived professionals (started by SSL when it and other NGOs had been playing a leading role in running the district) fell by the wayside as the DSEI's management concentrated on meeting centrally set targets.

In an ironic reversal of the conventional wisdom, the Rio Negro DSEI under indigenous movement management was both more efficiently run and less distinctively 'indigenous' in its priority-setting than it had been when non-indigenous service providers were in charge. The traditional healers' association CERCI (Centro de Estudos e Revitizalização da Cultura Indígena) made little headway in its efforts to promote a broader understanding and inclusion of traditional healing practice within the DSEI, despite CERCI's status as a FOIRN affiliate and the supportive statements made by many FOIRN leaders. As the FOIRN-appointed DSEI Coordinator made clear when interviewed, there appeared to be no way to translate the demands of the healers' movement into the language of health policy and 'technical' priority-setting:

> Even those [indigenous people] who have a university education aren't managing to do the translation for their relatives in the villages. In the area of traditional medicine [health professionals] aren't understanding it because we don't know how to explain it to them. We need the movement to translate for the professionals and the professionals to take this way of thinking on board. The difference in understandings is very great.

Despite its close adherence to the official model, it was not long before FOIRN found itself confronting the same problems with FUNASA which had led the NGOs to abandon their outsourcing contracts. Funding transfers became erratic, exposing the federation to the risk of legal action by unpaid medical staff. In 2004, FUNASA's new policy on recentralising budgeting and procurement decisions – prompted by the corruption and mismanagement scandals in other DSEIs – was enforced in the Rio Negro region despite the district's relatively good record, and FOIRN was pushed into agreeing to scale back its management role to little more than that of a contracting agency for health staff.

This agreement failed to preserve the level of services. Resource transfers were repeatedly held up, and in December 2004 NGOs again denounced the deaths from preventable diseases of several indigenous people living in areas where drug supplies had dried up and health centres had been abandoned by staff who had gone unpaid for months. FOIRN and its indigenous movement allies responded by occupying the headquarters of FUNASA in the state capital, Manaus, to protest at the delays in funding transfers (ISA 2004). Although the federation did not formally withdraw from its contract with FUNASA, by this resort to direct action FOIRN signalled that the movement it represented had not abandoned its original rights-claiming strategies established long before it became involved in outsourcing.

After a temporary respite, the problem of delayed transfers recurred, and by mid-2005 FOIRN was openly discussing withdrawal from the contract. When, in early 2006, FUNASA signalled that it was planning further recentralisation measures, FOIRN's leaders formally stated that they would end the outsourcing agreement. However, when a series of local health council meetings were held throughout the Rio Negro region to discuss the situation, they voted overwhelmingly for the movement to retain formal responsibility for the district and campaign for FUNASA to implement the proposals for granting management autonomy to DSEIs which had been approved by the March 2006 National Indigenous Health Conference. The result was a stand-off with FUNASA, whose national policy was increasingly shifting towards municipalisation of indigenous healthcare delivery combined with centralised control of budgeting and procurement. Finally, in November 2006 FOIRN formally withdrew from management of the DSEI and announced its intention to return to a role focused solely on ensuring effective user participation in service oversight, or *controle social*.

In contrast with the federation's initial reluctance to become involved in service management, from the outset FOIRN and its affiliated organisations had played an active role in the district's arrangements for *controle social*. The Rio Negro DSEI followed the standard SUS pattern of establishing formal accountability of the district management to a Health Council with significant user representation and broad powers of budget and planning oversight. In addition to this district *Conselho*, the management structure of the DSEI also included local health councils at the subregional level, intended to monitor the performance of local health units and identify priority issues to be referred upwards for action at the district level.

The boundaries of the local councils' subregions followed those of FOIRN's own administrative units, and the federation used its network of local movement organisers as facilitators to provide political and logistical support for council meetings. This support was coordinated by a department staffed by FOIRN-appointed indigenous leaders, housed within the DSEI and funded from the district budget. Several participants interviewed during the research confirmed the importance of this political and material support, pointing out that local health council meetings generally happened only when the FOIRN organisers visited local leaders to encourage them to participate and the DSEI released funds to transport representatives from the scattered communities of each subregion to the villages where meetings would be held. Nevertheless, the department was repeatedly threatened with closure – first when FUNASA imposed drastic cuts in funding for *controle social* support as part of the reorganisation of DSEI services in 2004, and subsequently as the stand-off over recentralisation developed in 2006. Though there were many complaints at this threat, there was no mass mobilisation to resist it on the part of the movement.

The relative absence of political struggle over the fate of the *controle social* system suggests a lack of ownership linked to evidence of widespread indigenous disenchantment with the system's capacity to provide genuine space for voice and influence. Interviews with participants and examination of the minutes of local health council meetings painted a picture of spaces where non-indigenous professionals set the agenda, and where indigenous leaders recited complaints and wish lists but little genuine deliberation took place. Even where the discussion ranged more broadly – reflecting the indigenous vision of health as inseparable from issues around land, natural resources and social and spiritual well-being – the issues referred up to the district level almost always concerned the narrow specifics of drug supply, health-post location and the attendance records of non-indigenous health professionals.

At the district level, the bureaucratisation of the participation process was even more apparent. One of the DSEI's *controle social* workers described a typical *Conselho* meeting as follows:

> Technical and bureaucratic questions end up taking all the time that's available for discussion ... Councillors don't manage to speak because of the demands of the agenda, going through the accounts eats up a lot of time and then you end up going from a more shared discussion to a very technical discussion, you end up focusing the discussion on the professionals' work ... When a leader arrives in these spaces where it's the doctor's word or the administrator's word that carries more weight ... he [*sic*] ends up leaving without having said anything.

Significantly, this description was applied to the operation of the district *Conselho* during the period when FOIRN had assumed management responsibility for the DSEI – and therefore had an absolute majority of seats, with indigenous representatives sitting on both the service-provider and service-user sides of the table. This unprecedented level of formal power in the hands of an indigenous organisation failed to change the character of the deliberative process in the *Conselho*, which continued to mirror the bureaucratic procedures and narrow focus of discussions familiar to observers of municipal health councils in the mainstream SUS (Coelho *et al.* 2002; Cornwall 2005).

6 Conclusion

The examples discussed in the previous section illustrate the multiple roles which organisations representing marginalised groups can play under a decentralisation process. In Brazil, this decentralisation process on the face of it appears as participatory and enabling as any described in the literature. In comparison with other marginalised groups in Brazil and beyond, the indigenous organisations of the Rio Negro region seemed very well equipped to play these roles successfully, and thereby to strengthen the position of their constituents. Yet on closer examination, it seems that they failed to achieve any significant transformation in the nature of the service.

By managing the DSEI in strict accordance with the prescriptions emanating from FUNASA and the Health Ministry in Brasília, FOIRN undoubtedly gained political credibility as an interlocutor for the non-indigenous state. However, this credibility was not used to challenge the logic of existing policy or argue for different priorities. Nor did FOIRN's leaders use their political abilities to change the bureaucratic practice of district management. Paradoxically, the competent management performance which enhanced FOIRN's external credibility served to reinforce an approach to health-service delivery whose bureaucratic and technocentric nature was being challenged by elements of FOIRN's own movement base, as well as by non-indigenous NGOs with which it had formed alliances.

Part of the explanation for this outcome undoubtedly lies with the gulf in understanding between the specialist holders of medical knowledge in the indigenous and non-indigenous health systems, and the lack of cultural translation skills on both sides to help bridge this gulf. We would argue, however, that a more significant role was played by the partial nature of decentralisation in the official Brazilian system of healthcare for indigenous peoples.

Although the DSEIs were supposed to function as decentralised units, in contrast to the municipalities which were the focus of mainstream SUS decentralisation, they lacked broader political structures capable of defending their autonomy. FOIRN may have perceived its own legitimacy and authority as analogous to that of a municipality in the non-indigenous system (perhaps influenced by the experience of neighbouring Colombia, where indigenous territories are constitutionally guaranteed minicipal status), but it was never recognised as such by FUNASA. Resisting municipalisation allowed the indigenous peoples' movement to avoid submitting their health services to political manipulation by unscrupulous local élites, but it left them exposed to creeping top-down control by a centralised bureaucracy.

This control operated not through direct political command, but rather by hemming in the outsourced service providers with arbitrarily imposed budget ceilings, standardised prioritisation criteria, centrally defined targets and complex, initiative-stifling planning and accounting procedures. This mesh of rules and procedures was imposed in a way which made no distinction between service providers – whether NGOs, municipal health secretariats or indigenous movement organisations – and which had the intended or unintended consequence of ensuring the very standardisation which the DSEI model was supposed to overcome, turning devolution into simple deconcentration or outsourcing of predefined functions.

The weight of centrally defined rules and procedures was also felt by the participatory spaces that were supposed to ensure flexibility and responsiveness to local priorities: the local health councils and district *Conselho*. This ensured that participants' energies were absorbed by the need to comply with formal requirements for vertical accountability, leaving little space for questioning the broader policy framework and system of priorities. The effect was reinforced by the dominance of bureaucratic and technical framings of health problems and their potential

solutions which flowed from the DSEI's dependence on non-indigenous professionals, and from the absence of permanent mechanisms for educating these professionals in indigenous culture or providing for cultural translation between them and the indigenous specialists.

Despite a longstanding tradition in the development literature (paradigmatically represented by Rondinelli *et al.* 1989) which uncritically classifies outsourcing as a form of decentralisation, the case of indigenous health services in Brazil demonstrates that such conflation obscures the specific political implications of different processes for different actors. The experience of the Rio Negro DSEI suggests that far from representing 'community empowerment', the outsourcing of service provision to social movement organisations may lead them to develop their skills as players while trapping them in a position where they lose the ability to challenge the rules of the game. The power of these rules is not limited to centrally defined performance targets, budget frameworks or accounting procedures; it extends to and through the technical and managerial discourses which define what problems can be included in a given policy area and what solutions can be prescribed for them. This is especially relevant for minority or marginalised groups with different cultural styles of debate and decision making, or different framings of health policy issues. Unless decentralisation, participation and outsourcing processes build in a greater degree of flexibility about where resources can be invested and how decisions can be made, such groups are likely to find that these processes leave them with more responsibility for delivering services over which they have ultimately less control.

Note

* This article draws extensively on R. Athias, A. Shankland and R. Nonato (2004) *Saber Tradicional e Participação Indígena em Políticas Públicas de Saúde na Região do Rio Negro* (Rio de Janeiro: ActionAid Brasil), and on fieldwork carried out by the authors as part of the *Olhar Crítico* research and reflection process, funded by DFID Brazil and supported by ActionAid Brasil and IDS. The authors would like to thank Maximiliano Menezes, Patrícia Torres and Cléia Linhares for their assistance in São Gabriel da Cachoeira, and all the members of the Federação das Organizações Indígenas do Rio Negro (FOIRN), the Centro de Estudos e Revitizalização da Cultura Indígena (CERCI), Associação Saúde Sem Limites (SSL) and other institutions which took part in the discussions which formed part of the research. The opinions expressed are, however, the authors' alone.

References

Athias, R. (2004) 'Indigenous Traditional Medicine among the Hupd'äh-Maku of the Tiquié River, Brazil', paper presented at the International Conference on the Health Rights of Indigenous Peoples, Health Unlimited/London School of Hygiene and Tropical Medicine, 8–10 December

Barroso-Hoffmann, M., Iglesias, M., Garnelo, L., Oliveira, J. and Lima, A. (2004) 'A Administração Pública e os Povos Indígenas', in *INESC A Era FHC e o Governo Lula: Transição?*, Brasília: Instituto de Estudos Socioeconômicos (INESC)

Coelho, V., Araújo, I. and Cifuentes, M. (2002) 'Deliberative Fora and the Democratisation of Social Policies in Brazil', *IDS Bulletin* 33.2

COIAB (Coordenação das Organizações Indígenas da Amazônia Brasileira) (2000) *Visão Política da COIAB com Relação à Saúde Indígena* [COIAB's Political Perspective on Indigenous Health], Manaus: COIAB

Coimbra, C., Garnelo, L., Basta, P. and Santos, R. (2006) 'Sistema em Transição' in B. Ricardo and F. Ricardo (eds) *Povos Indígenas no Brasil: 2001 – 2005*, São Paulo: ISA

Cornwall, A. (2005) 'Deliberating Democracy: Scenes from a Brazilian Municipal Health Council', paper presented at the Citizenship DRC Spaces for Change workshop, San Cristóbal de las Casas, Mexico, 4–8 April

Costa, M. (2004) 'Luta pela Reforma Sanitária', in *Sistematizações do Olhar Crítico* (CD-ROM edn), Rio de Janeiro: ActionAid Brasil

Fox, J. (1994) 'Latin America's Emerging Local Politics', *Journal of Democracy* 5.2

Garnelo, L., Macedo, G. and Brandão, L. (2003) *Os Povos Indígenas e a Construção das Políticas de Saúde no Brasil*, Brasília: Pan American Health Organization (PAHO)

ISA (2004) 'Falta de Assistência Médica Provoca Mortes no Alto Rio Negro' [Lack of medical care

causes deaths in the Upper Rio Negro], *Notícias Socioambientais* 15 December, www.socioambiental.org
Manor, J. (1999) *The Political Economy of Decentralisation*, Washington DC: World Bank
Melo, M. and Rezende, F. (2004) 'Decentralization and Governance in Brazil', in J. Tulchin and A. Selee (eds), *Decentralization and Democratic Governance in Latin America*, Washington DC: Woodrow Wilson Center
Rondinelli, D., McCullough, J. and Johnson, R. (1989) 'Analysing Decentralization Policies in Developing Countries: A Political-Economy Framework' *Development and Change* Vol. 20 No 3
Souza, C. (1997) *Constitutional Engineering in Brazil: The Politics of Federalism and Decentralization*, Basingstoke and London: Macmillan
Tendler, J. (1997) *Good Government in the Tropics*, Baltimore: Johns Hopkins University Press
Verani, C. (1999) 'A Política de Saúde do Índio e a Organização dos Serviços no Brasil', *Boletim do Museu Paraense Emílio Goeldi, Série Antropologia* 15.2
Weyland, K. (1995) 'Social Movements and the State: The Politics of Health Reform in Brazil', *World Development* 23.10