THE NOTION OF INCLUSION IN BRAZILIAN INDIAN HEALTH POLICY: SERVICES AND CULTURAL PRACTICES

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During the last fifty years, the position of minority groups with respect to the larger society has transformed significantly. International decrees, as well as national legislations, have recognized the pluri-ethnic nature of the State and the necessity to guarantee the rights and the respect for different ethnic groups. In Latin America, these legal changes have been accompanied by the emergence of indigenous organizations as an important force in the political arena. In Brazil increased visibility of ethnicity has resulted in changes in the policy and organization of health services that aim at inclusion of indigenous peoples through "differentiated attention". Differentiated attention aims at inclusion of Indian peoples through the creation of a subsystem of health services that is separate from the Unified National Health Service (SUS), which is responsible for providing health attention to Brazilian citizens. Like SUS, the subsystem is based on the principles of social control by the community and includes special reference of "recognition" and "respect" for the cultural particularities of each group and its "traditional" knowledge. After a review of the changes in the Indian health policy and services, I present recent research that highlights the problems facing the organization of differentiated attention and the problems hindering implementation of a health system that pretends to include not only the members of a minority group, but also their knowledge and practices in health.

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The Rise of Ethnicity

Convention 169 regarding Indigenous and Tribal people in Independent Countries, approved by 85% of the member States of the International Labor Organization in 1989,[1] was the first international legal instrument designed to protect Indian rights (Luz 1995:102). It called for the recognition of and respect for the cultural diversity of native peoples in all dimensions, including employment, education, and *health*, among others (italics by the author). An earlier Convention, adopted in 1957, promoted the gradual integration of Indians into their national societies and regarded the native peoples as collaborators in the efforts to achieve their integration. Convention 169 reverts this directive and defends their rights to social and cultural distinctiveness. Besides calling for full citizenship and equality, the latest Convention also substitutes the notion of *eventual collaboration* for that of *active participation* of the indigenous community in legislative measures and decisions that affect it directly.

The changes between the first and second Convention reflect the growth of indigenous movements in all of Latin America. During the 1950′s, the Indians were an ethnic and cultural minority, excluded from the national ideologies (Guss 1994). Their presence in various countries was ignored. They were invisible in the laws, national censuses, and activities of governmental institutions such as those related to health. In Brazil, as in many countries, the Indian was seen as an obstacle to progress, which justified the policy of integration. The formation of Indigenous movements and political associations over the last three decades, is evidence of the importance of identity politics and points to the growth of consciousness of Indian identity that is expressed in various forms (Turner 1991a, 1991b; Langdon and Wiik 2008). Within the last 30 years, Indigenous movements have become particularly visible,

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[1] It must be noted that Brazil only signed this document in 2002.

giving voice to their identity and demands for inclusion, and Indians are increasingly elected to public offices in various countries.

The significant increase in the number and force of indigenous associations has influenced national and international politics regarding ethnic minorities, and the pluriethnic composition of the Latin American States can no longer be negated. Questions of power, ethnicity, and interethnic friction[2] permeate efforts for inclusion of Indian peoples. Indigenous associations are far from realizing fully their objectives, and the attempts to guarantee the Indians their rights have not been a simple, nor always peaceful, process. In spite of the fact that indigenous peoples have yet to experience full citizenship in a society without prejudice and exploration, the rise of ethnicity as an important political force in Latin America has had important consequences in Indian health policy.

It is necessary to consider the rise of ethnicity as a central factor in the history of Latin America in the recent decades and as a factor that confronts the Latin American governments, resulting in the reformulation of health policy and the provision of health services for native peoples. Brazil, which began this discussion in the 1980's, is considered by many to have taken the lead.

The Ethnic Situation in Brazil

In Brazil, the Indian is a minority, numerically and ethnically. The Indigenous population composes approximately 0.2% of the Brazilian population (Ricardo 2002:15), estimated to be between 450,000 (FUNAI) and 600,000 (Instituto Socioambiental 2010). Besides being numerically few in comparison with the

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[2] Interethnic friction is a concept developed by Roberto Cardoso de Oliveira (1976) to characterize the tensions between the indigenous and non-indigenous societies in Brazil.

total population, they are characterized by a multiplicity of groups and native languages. The majority of Brazilian Indians belong to micro societies. Twenty-eight percent (28.2%) of the 227 indigenous groups have a population of fewer than 200 individuals and 77% have less than 1000. Consequently, it is impossible to characterize a single Indian "culture" or "indigenous medicine".

To contribute to this situation of cultural heterogeneity, the groups are in various states of contact. At one extreme, isolated or semi-isolated groups suffer from the impact of the violence and diseases of contact. At the other, which is the situation for the majority, Indian communities 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 malnutrition, tuberculosis, dental problems, intestinal parasites, alcohol and substance abuse and sexually transmitted diseases, as well as high rate of infant mortality and low life expectancy (Santos & Coimbra 2003).

Legislation

The Brazilian Federal Constitution of 1988, considered to be progressive in its inclusion of indigenous rights, devoted an entire chapter to the issue. It guarantees their "original rights to the lands that they traditionally occupy" and recognizes the authenticity of their social organization, customs, language, beliefs and traditions. In practice, the Constitution has not resulted in the guarantee of these rights and there have been various attempts to modify it and to reduce native lands. However, it must be recognized that the Chapter was the result "of a strong movement of Indian leaders and their organizations, as well as the different non-governmental organizations, scientific entities, churches, etc." (Santos

1995:104). The number of Indian organizations has continued to grow, and various "emergent" groups have risen from anonymity as a result of the advantages of inclusion in a society that has traditionally excluded them (Oliveira 1999, Bartolomé 2006).[3]

Indian Health Policy and Organization

The Constitution of 1988 signaled the return to democracy in Brazil. In this same decade, the sanitary health reform movement resulted in the Unified National Health System (Sistema Único de Saúde, SUS), that delegates more responsibility and power to the municipalities and participation of its citizens in a process of decentralization. In the face of this reform, the first National Conference for the Protection of Indian Health was organized in 1986 in order to evaluate the health situation and to formulate a special policy that would guarantee Indians the right to inclusion in health services, including in the municipalities where they have been traditionally excluded.

Until the first Conference, there was no defined health policy for Indian populations and primary and specialized attention for them was never adequate. Initially missionaries provided some health services to Indian populations. In 1910, the Service for the Protection of Indians (SPI) was created and health was among its responsibilities. While the Service may have saved many tribes from extermination, "pacification of hostile tribes occasioned the spreading of hunger, illnesses, disintegration, making the Indians part of the most miserable group of the

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[3] For an excellent discussion regarding the importance of the Indian in the political arena, in spite of their small percentage of the Brazilian population, see Ramos (1998).

marginal segments of society" (Costa 1989:68).[4] Throughout its existence, health services were few in number, sporadic and disorganized.[5] Systematic data regarding health conditions were not maintained and there was little research.

Established in 1952, The National Service of Tuberculosis (SNT) was perhaps one of the most effective programs during the period of SPI. It was not aimed specifically at Indian groups, but directed its efforts to the treatment of tuberculosis among rural populations in the region of Upper Xingu and Araguaia Rivers. In 1956 the Service of Air Sanitary Units (Unidades Sanitárias Aéreas - SUSA) also began to treat isolated Indian populations.[6] However, Indians in greater contact with the national society were not covered by these services.

The SPI was extinguished and the National Indian Foundation (FUNAI – Fundação Nacional do Índio) was created in 1967 with a Department dedicated to Indian health and charged with prevention, through vaccinations, control of agricultural toxins, and parasites provision of primary health services in Indian lands and mediation with specialized health services in urban areas. However, a system of adequate and regular primary attention was never created due to lack of financial and human resources. Health posts established within the Indian Areas[7] were generally staffed by a single attendant, whose activities were supplemented by infrequent visits of health teams. Difficult cases and those needing sophisticated treatment or

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[4] This can be clearly witnessed in the history of the genocide of the Xetá Indians in Paraná in the 1960´s (Silva 1998).

[5] Noel Nutels, a well known medical doctor, is the most known of the SPI´s health professionals for his dedication to isolated Indian groups.

[6] In 1967, the Paulista School of Medicine founded its health assistance and research program in the Xingu Indigenous Park, which treated a number of Indian groups of the park.

[7] Indian Area (Área Indígena) is the designation for territory that has been demarcated as Indian land and is equivalent to a reservation in many respects.

diagnosis were to be referred to the local hospitals and/or the Minister of Health services with which FUNAI maintained agreements. When required, patients were sent to FUNAI's regional headquarters, where they would stay at the "Indian House" (Casa do Índio) while receiving treatment.

These services were highly unsatisfactory and ineffective. The network did not function well, and health services were unprepared, disorganized, inefficient and insufficient to attend all the Indian communities. There was not full coverage of vaccinations, contributing to high mortality rates. Attendants working in Indian health posts lacked adequate training, systematic evaluation and continuing education programs (Costa 1989). Often their role was limited to distribution of available medications shipped to the area periodically. Outside their reservations, Indians were excluded from access to local hospitals and other services due to discrimination. The "Indian Houses" in the regional centers had inadequate funding and were over crowded with patients and their families. Food, health supplies, and professionals were often insufficient to care for the ill. These houses became known as centers of infection and the spread of disease, including sexually transmitted diseases.

At the same time, Indian health status was deplorable due to factors of marginalization and exclusion, as well as to territorial loss and environmental degradation that undermined the practice of traditional subsistence techniques. The following diagnosis characterized Indian health at the time of the First National Conference for the Protection of Indian Health in 1986:

> Their sanitary conditions in general are not satisfactory. Among other problems, we can cite the high prevalence of endemic diseases such as tuberculosis, malaria, intestinal parasites and the frequent epidemic outbreaks of diseases provoked by viruses. There is a high prevalence of diseases due to deficiencies, among these, malnutrition; mental problems due to alcoholism; precarious oral health; and poor basic sanitation conditions (Miranda et al. 1988:25).

In sum, at the time of the First Conference in 1986, the situation of Indian health was precarious and the services were characterized by inadequate infrastructure in the Indian Areas and lack of health professionals, economic resources and an efficient network of primary, secondary and specialized attention. There was no systematic collection of epidemiological data. Furthermore, FUNAI, with its various problems and incapacity to attend the demands of Indian health, intended to abandon its educational and health responsibilities and dedicate its efforts to land demarcation.[8]

Attended by health professionals, anthropologists, members of non-governmental organizations and governmental functionaries, the First Conference also had a sizeable group of Indian representatives. Their inclusion was indicative of the growth of the political force of their organizations in Brazil and was important for the success of the Conference (União das Nações Indígenas 1988).[9] Among the concluding resolutions, three are important for understanding subsequent Indian health policies and organization of services designed to guarantee universal right to health: immediate establishment of a *specific subsystem, with the creation of an agency linked directly to the Ministry of Health*; a model of differentiated attention that respects the cultural particularities and traditional practices of each group; and inclusion of community members in planning, organization, execution, and evaluation of health services (italics by the author). In 1988, the National Constitutional

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[8] Oral communication made by Marcos Antonio Guimarâes, Head of the Health Sector of FUNAI, in a symposium on Indian Health and the Unified System of Health, 26-27 of October of 1989, Rio de Janeiro. FUNAI´s position regarding its responsibilities in the area of health has changed several times during the last fifteen years depending upon the legislation in vigor and political and economic factors.

[9] In spite of their active and respected participation in the Conference, the better hotels in Brasília were not accustomed to receiving Indians, and certain problems arose between the Indian guests and the hotel workers where I and other anthropologists were lodged.

Assembly incorporated these principles and guaranteed the right to complete and differentiated health attention for Indians. However, it took another ten years for legislative approval of the differentiated sub-system.

In 1991, a Presidential Decree set in motion re-organization of Indian health services by creating the Coordination of Indian Health (Coordenação de Saúde Indígena - COSAI), within the National Foundation of Health (Fundação Nacional de Saúde - FUNASA)[10]. The Coordination was charged with the responsibility for health attention in Indian areas but it did not have the autonomy specified by the First Conference. In addition, the Decree resulted in a series of conflicts and bureaucratic confusions with FUNAI that continued throughout the decade.

In an attempt to resolve the problems and establish an adequate system, the Second National Conference on Indian Health in 1993 called for the creation of an autonomous subsystem of primary services in Indian Areas organized through Special Indian Health Districts (Distrito Sanitário Especial Indígena – DSEI) (Varga & Adorno 2001). It also reaffirmed the principle of community participation fundamental to the concept of the health district (Mendes 1995) as well as respect for indigenous cultures and their traditional health practices. In 1994 a second Decree attempted to resolve the dispute between FUNASA and FUNAI by dividing their responsibilities respectively between prevention (vaccinations, sanitation) and primary attention, but it failed to recommend a system based on Sanitary Districts. Throughout the 1990s, Indian health services continued to be based on an unsuccessful distribution of responsibilities between governmental and non-governmental institutions, including FUNASA, FUNAI, municipalities, non-governmental organizations and universities. There was a lack of coordination

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[10] FUNASA was created out of a series of other health institutes and Indian health has never been its most important responsibility (Teixeira 2008).

and clear delegation of responsibilities. The exact role of the universities was not well defined, and it included research, consultancies, provision of services and the training of health professionals and/or Indians. A law proposing the Indian Health subsystem called for by the First and Second National Conferences and based on the democratic principle of Sanitary Districts was presented to Congress in 1994, but it was not approved until mid-1999.

During the 1990s, discussion about the role of the Indian Health Agent (AIS) emerged as a strategy promoting community participation in the delivery of health services and culturally sensitive health care (Langdon et al. 2006, Langdon et al. in press). The Indian Health Agent was conceived of as the mediator between biomedical services and indigenous health practices. In order to fulfill this role, training was supposed to include anthropology, health politics and the organization of the health system as well as basic notions of biomedicine (etiology, diagnosis, treatment), nursing techniques and community health. It should also include a discussion on traditional medicine and indigenous views of the health-illness process, curing and death as related to the cosmology of the community (Santos et al. 1996, cf. Cardoso 2001). Sponsored by NGOs, universities, and FUNASA, a number of courses were implemented. Some Indians were also trained and employed in a parallel governmental program of Community Health Agents (PACS). However, throughout the 1990′s those trained often were not subsequently employed due to lack of funding, and those lucky to be contracted frequently lacked adequate supervision (Langdon 2004).

Social control, another important principle associated with the health politics of inclusion, is defined by Machado (1986:299) as “a set of interventions in which the different social forces influence the formulation, execution and evaluation of public policy in health”. It functions through the creation of health councils and national conferences with democratic representation. During the 1990s there were attempts to create local and regional Indian health councils to guarantee Indian participation, but their institutionalization confronted various problems and few were effectively established prior to 1999. At the national level, the Intersectorial Commission of Indian Health (Comissão Instersetorial de Saúde do Índio - CISI) was created in 1991 as an advisory committee to the National Health Council (Conselho Nacional de Saúde). Over the years its composition has varied, and Indians have gained in representation and leadership. CISI fought for the establishment of a subsystem of Indian health and for indigenous representation on the National Health Council throughout the decade.

In spite of these activities, the question of Indian health occupied little space in the National arena. Financial resources were insufficient. The Indians did not benefit from full inclusion in the Unified System of National Health and their health situation continued to be deplorable (Verdum 1995). Epidemiological data were lacking for most groups, and neither FUNASA nor the municipal health services that were part of the Unified National Health System responded adequately to various outbreaks of disease. The voice of CISI remained weak, its recommendations having little impact on the deliberations of the National Health Council.

Research conducted during this period reveals a state of abandonment of primary health services in Indian areas. One analysis, which examined one of the municipalities with adequate quantitative data, compared mortality figures between non-Indian and Indian populations in the State of Rio Grande do Sul between 1986 and 1995. The study found that the Indian Areas differed from the rest of the State by a higher number of deaths due to illnesses with poorly defined causes or to those that can be avoided through basic health assistance, such as malnutrition, tuberculosis, and cervical cancer (Hökerberg et al. 2001). Rio Grande do Sul is located in

Southern Brasil, a prosperous region but one in which Indian health statistics reflect those of the poorest regions of Northeastern Brazil.

In 1995 a new actor entered the scene in the form of the National Program for Sexually Transmitted Illnesses and AIDS (Programa Nacional de Doenças Sexualmente Transmitidas e AIDS), linked directly to the Minister of Health. In 1996 it initiated activities with Indian communities. As opposed to the situation of FUNASA and FUNAI, this program benefited from more autonomy and much greater financial resources in the form of international loans. Under the direction of a sociologist assisted by an anthropologist/physician, regional meetings were held in 1997 in all parts of the country in order to stimulate prevention and educational programs for the Indian population. In 1998 the Program financed various projects proposed by the universities and non-governmental organizations in a prevention campaign. In 1999, it expanded its activities and financing to include the problem of alcoholism among Indian communities. Between 1996 and the approval of the Special Indian Health Districts in 1999, this Program, with a far better financial situation than FUNASA, perhaps contributed more to the discussion of Indian health than any of the other governmental programs.

Presidential Decrees of 1991 and 1994, aimed at delegating institutional responsibilities for the organization of the Indian health services, failed to establish a viable structure of differentiated attention. The organization proposed resulted in confused and complicated bureaucratic and administrative structures characterized by the lack of a clear definition of responsibilities in planning and administration and by conflict of interests between the institutions involved. Health services for the Indian peoples continued to be chaotic and their health problems were without effective solution. Indian communities did not know who was responsible for the resolution of their chronic and emergent health problems. Some good experiences of collaboration between the various governmental and non-governmental institutions occurred in certain locations; however, they were few in comparison to the general situation in which services for indigenous peoples suffered from organizational problems, conflicts between the participating institutions, lack of human and financial resources, lack of community participation, and an increasing dependence upon the non-governmental organizations to provide health services.

The Creation of the Special Indian Health Districts (DSEI)

The 1994 proposal for the creation of a subsystem of Indian Health, based on the organization of Special Indian Health Districts (DSEIs), was finally approved in 1999, and FUNASA was delegated full responsibility for the administration of Indian health. The Coordination for Indian Health became the Department of Indian Health and began to receive substantial financial support. By the end of that year, thirty-four Special Indian Health Districts had been organized, and the numbers of professionals working in Indian health increased significantly as multidisciplinary health teams were contracted throughout the country to attend in the Indian Areas. In the following year, attempts to create system of local and District Health Councils were initiated for the purpose of social control.

Geographical boundaries of the Health Districts do not follow those of the municipalities or states, and Districts vary significantly in size and ethnic composition. Some encompass several states and multiple ethnic groups; others correspond to part of a state's territory with a single or a few ethnic groups residing within it. Each District has an administrative headquarters which is in charge of organizing and re-passing financial resources for health services that are carried out by non-governmental organizations and municipalities. District health services are organized through "central bases," which has one or more multi-disciplinary medical teams, composed minimally of a physician, surgeon dentist, and nurse, charged with the delivery of primary attention of the health posts located in Indian Areas within the base's territory. Indian health posts have permanent nursing auxiliaries or Indian Health Agents, who provide attention between the team's visits.

In most cases, Indian health teams providing primary attention are contracted by non-governmental organizations, which in turn receive financing from the District headquarters. Municipalities, hospitals and other institutions that are part of the Unified National Health System provide secondary and tertiary attention. They receive funding directly from FUNASA's national headquarters for their services delivered to Indians. In certain places, the NGOs that contract the multidisciplinary medical teams are indigenous organizations themselves or NGOs that have experience with Indian health. In others, such as in two extremely large Districts in southern Brazil, a special NGO was created to contract health teams to provide primary attention in Indian Areas. In the absence of a NGO, municipalities receive funds destined for provision of primary attention in Indian Areas. The question as to whether municipalities, as part of the National Unified Health System, or NGOs, as part of the subsystem, should provide primary attention is a controversy that has plagued Indian health policy since the creation of the Special Districts. Also, interface between the subsystem and the Unified System has not resulted in adequate coordination between it and the secondary and tertiary services.

The Indian health subsystem has been criticized since its inception. Varga (Varga & Adorno 2001), director of the Coordination of Indian Health in the early 1990s, argued that the organizational structure of the DSEIs violates the original idea of Indian health districts as proposed by the II National Conference of Indian Health in 1993 and criticized the increasing dependence upon NGOs for the provision of primary health services, which he saw as a federal obligation. The rapid organization of the DSEIs occurred in some parts of the country without community input, violating the principle of social control in the decision making process (FIOCRUZ 2000). One of the few comparative evaluations regarding the implantation of DSEIs shows differences in inclusion of indigenous participation between the District of the Rio Negro and that of Pernambuco (Athias e Machado 2001). In the first case, there was a good interinstitutional articulation between the municipality, NGOs and native organizations, while in the second, the implementation occurred in a vertical manner, without Indian participation.

Social control is an important principle for the strategies of inclusion within Brazilian health policies, and once the subsystem was implemented, there were concerted efforts to create local and district health councils in preparation for the III National Conference of Indian Health held in 2001. However, this process has demonstrated a series of weaknesses at the local level as well as the District level. Local health councils tend to be dominated by the Indian Health Agents and other political leaders, rather than by members from the community at large. Selection of members follows the existing power distribution within the community (Garnelo and Sampaio 2003; Garnelo 2003). District council membership has parity between Indian representatives and those of FUNAI, FUNASA and other participating institutions. However, in many cases, Indian participants are employees of FUNAI, FUNASA, or NGOs, indicating possible conflict of interest (Langdon and Diehl 2007). Depending upon the DSEI, frequency of District health council meetings varies tremendously. In some cases, the meetings are held only every few years, a serious obstacle to the principles of social control that call for community participation in the planning, execution and evaluation process (Langdon & Diehl 2007).

An early evaluation of the subsystem made in 2003 (Garnelo et al. 2003, Garnelo & Brandão 2003) indicated that it resulted in a significant increase in access to primary attention in Indian communities. However, bureaucratic and organizational problems continue to cause inefficient services and the inability to resolve many health problems, both those of a chronic nature as well as emergency situations. More recent studies show that the problems of organization and efficiency evident in the 1990s have continued, including the lack of clear delegation of the responsibilities of institutions and health programs charged with services (FUNASA, FUNAI, municipal and state departments of health, universities, and NGOs). The distribution of medications, administered by the Department of Indian Health at the national level, does not correspond necessarily to local needs, and more adequate distribution is a continuing demand by both local health professionals and Indians. The network of primary health services with secondary and specialized health services outside Indian Areas continues to be problematic, and the hospitals and other services that receive funding to attend Indian patients are not held accountable. Collection of accurate epidemiological data continues to be a difficulty, and the system that has been implemented does not interact with other national health databases. Finally, financial accountability has been problematic for both the municipalities and NGOs receiving funds.

After a decade, the status of this subsystem of differentiated attention based on the organization of Special Indian Health Districts separate from the Unified National System of Health continues to be challenged. The original demand for a system of Indian health responsible directly to the Ministry of Health was seen as a strategy of inclusion and guarantee of universal access. As it resulted, primary attention became the responsibility of the Department of Indian Health within the National Foundation of Health, which has a number of other responsibilities and preoccupations with non-Indian health on its agenda. Separation and autonomy from the municipally based system has not been possible, nor do many politicians consider a subsystem compatible with the principles of the National Unified System of Health. Indian communities tend to suffer marginalization and exclusion in the face of local and regional political processes, but an increasing number of municipalities are receiving funding for the provision of primary health teams (rather than NGOs), in spite of criticisms regarding improper use of funds. Those in favor of a subsystem fear the "municipalization" of Indian health and its consequences. Others argue that the Unified National Health System is universal, designed to attend all members included in the democratic society, and thus a separate subsystem privileging special populations should not exist. It is not clear how this debate over the provision of primary attention to Indian Areas will be resolved. Early in 2010, the position of Secretary of Indian Health, directly responsible to the Minister of Health, was created, but the implications of this change are unclear at this time.

Differentiated Attention as Inclusion of Cultural Health Practices

As a final part of this paper, I focus on relation between inclusion and the Brazilian notion of differentiated attention as it pertains to the multicultural dimension of Indian health services. Since the first discussions in the 1980s, the notion of differentiated attention has referred to inclusion in two ways – (1) differentiated subsystem of health that guarantees universal access and social control and (2) differentiated medical attention that guarantees the group's right to its cultural particularities. In 2000, a document dedicated to the formulation of national policy under the newly created subsystem affirmed this latter form of differentiated attention to be the recognition of "the efficacy" of indigenous medicine and "the right of these peoples to their culture" (Brasil 2002:13). The same document states,

> The principle that permeates all the directives of the National Policy of Health Attention for Indian Peoples is respect for the conceptions, values and practices relative to the processes of health and illness belonging to each indigenous society and their diverse specialists (Brasil 2002:18).

In another part, the document characterizes traditional indigenous health systems:

> (…) as based on a holistic approach to health, whose principle is the harmony of individuals, families and communities with the universe that surrounds them. Curing practices respond to each indigenous community's internal logic and are the product of the particular relation with the spiritual world and the beings in the environment in which they live. These practices and conceptions are, generally, health resources of empirical and symbolic efficacy, in accord with the most recent definition of health by the World Health Organization (Brasil 2002:17).

Three directives for the practice of differentiated attention are outlined: training of human resources for work in intercultural contexts, articulation with traditional indigenous health systems, and training of Indian Health Agents in order to stimulate the Indian peoples appropriation of the knowledge and techniques of western medicine, "not as a substitution, but as an addition to the collection of their own therapies and other cultural practices, whether they be traditional or not" (Brasil 2002:16).

Although the document emphasizes the importance of Indian traditional practices and their maintenance in the face of biomedical health services, the theme was given minimal attention during the first years of the Indian health subsystem (Garnelo et al. 2003). In a meeting for the preparation of the III National Conference on Indian Health, the Director of the Department of Indian Health affirmed to me that this was not the primary preoccupation of the Indians.[11] The Department of Indian Health at the national level did not orient health professionals at the District or local level to reflect upon clinical practice and delivery of primary attention. Some health teams implemented efforts to provide differentiated attention in this sense[12], but this has not been the case for the majority, and after a decade, it is possible to affirm that clinical practices in Indian communities do not differ in nature from those in non-Indian communities.

In 2004, with the change of the Director of the Department of Indian Health, renewed discussion was made with regard to the relation between primary health services and traditional practices. In an Ordinance issued by the Minister of Health, two paragraphs refer to inclusion of traditional medicine, but in slightly different concepts. One recommends *articulation* between the official services and Indian Medicine. The other calls for *integration* of the two practices. It instructs the medical professionals

> To respect the cultures and values of each ethnic group, as well as ***integrate*** the actions of traditional medicine with health practices adopted by the Indian communities
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> To ***articulate*** Indian Health practices with traditional medicine, respecting the characteristics of Indigenous cultures.
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> (Portaria No. 70, de 20/01/2004)

In 2005, a project entitled "Innovative Interventions in Indian Health – Traditional Medicine" was financed by the World Bank and administered by a sector different than the Department of Indian Health but part of FUNASA. This program has conducted a number of projects throughout the

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[11] This view is supported by several studies that show the conquest of equal access to health services and medications as the primary goal and perceived benefit of the subsystem (Cardoso 2001; Garnelo and Wright 2001; Portela 2010).

[12] See Langdon and Garnelo (2004) for a reflection on a number of examples.

country with Indian communities on traditional birthing systems and medicinal plants (Ferreira and Orsório 2007). They have been innovative in the sense that they join research with active community participation (a methodology called *pesquisação* in Portuguese) for the development of "traditional medicine projects", a context in which "tradition" was explicitly recognized by the coordinator as emergent and a result of the dialogue between the various actors (Ferreira 2010). This project, affecting a limited number of Indian communities, is one of the few directives by the Department of Indian Health at the national level for differentiated attention conceived of as attention that respects and articulates with different indigenous health practices.

Although this project recognizes the dynamics of health practices in Indian communities and does not regard traditional medicine as a set of fixed customs or beliefs that represent survivals from the past, most health professionals working in the subsystem do not share such a vision. This is true of both those in health fields as well as the Indian Agents of Health. Few members of the multidisciplinary health teams offering health services in Indian Areas have received training that addresses this issue. It has not been a preoccupation of the training courses that have been offered; most focus on technical aspects of health care problems. In addition, the high turnover of health team members has contributed to a lack of preparation for working with culturally differentiated Indian communities. For the most part, health services are delivered with no consideration for the social or cultural practices of the specific group, and "culture" is conceived as an obstacle to full acceptance or compliance of biomedical therapies.

Inclusion of "traditional practices" in differentiated attention faces conceptual problems that have not been addressed. Without adequate preparation of the health teams nor orientation guiding a reflection about the cultural aspects of differentiated attention, the professionals that work with Indian groups continue to hold misconceptions about the nature of Indigenous health practices and behavior, a situation not unlike other parts of the world (Yoder 1997). Culture is seen as static, homogeneous and normative. Culture is conceived to be a complex of beliefs that control both behavior and perception. One consequence of this normative and static view of culture is the idea that the Indians are locked into their beliefs, failing to recognize the benefits or rationality of other practices. Culture is seen as an obstacle for the adoption of "rational" healthy behavior. Brazilian public health workers blame Indian culture as the cause of what they consider to be the Indians' incapacity to understand modern hygienic principles or the directives of the health professionals.

Another misconception that plagues the notion of differentiated attention as *inclusion* of native practices and culture is the perspective that Indigenous medical knowledge and practices are based on magical notions of the universe. Early pioneers in medical anthropology argued that the differences between primitive and scientific medicine are so great that transformation from primitive thought (magical) to the scientific (scientific) is impossible. Despite the efforts of anthropologists to change such misconceptions (Menéndez 2003), the notion that there is a radical discontinuity and opposition between the rationalities of the two systems is still current among most health professionals.

The impact of such a view has resulted in inequalities and hierarchical ranking of medical practices according to the scientific vision of efficacy. As a consequence, traditional medical practices validated by biomedicine are those that should be encouraged and those that do not pass such a scientific proof should be excluded. This vision is evidence of the developmental view that establishes biomedical hegemony over traditional practices (Frankenberg 1980) and that is seen among many who advocate the collaboration between traditional and scientific medicines:

> Traditional medicine comprises those practices based on beliefs that were in existence, often for hundreds of years, before the development and spread of modern scientific medicine and which are still in use today. ... Generally speaking, however, traditional medicine has been separated from the mainstream of modern medicine. A basic approach, therefore, has been to promote the bringing together of modern scientific medicine *with the proven useful traditional practices* within the framework of the local health care system (Akerele 1987:177-178. Italics added by me).

Such a view was expressed in the herbal medicine projects of the Traditional Medicine project initiated in 2005. Calling upon the principles outlined in the National Policy of Medications and Pharmaceutical Assistance, pharmacists confronted the Indian participants and insisted that only substances with rationally approved efficacy could be developed (Santos 2007; Ferreira 2007). Their argument underscores the contradiction implicit between the hegemony of science contained in the National Policy of Medications and Pharmaceutical Assistance legislation and the principle of inclusion and respect present in the National Policy for Health Attention for Indian Populations.

Anthropological research has demonstrated that it is simplistic to view biomedical services and Indian medicine operating in a social field in which the Indian chooses one or the other depending upon his perception as to which is more efficacious (a benefit-cost model). In everyday practice, the dynamics of therapeutic choice and health practices is far more complex than the rationality implicit in this model (Buchillet 1991, Menéndez 2003). Moreover, practices of health attention do not fit clear-cut categories of traditional versus biomedical practices. Biomedical resources are present in the form of the health post, the multidisciplinary health team, the distribution of medications and the local private pharmacies. Besides these, there are a number of modalities of therapy used that are part of the popular medical system of the surrounding non-Indian populations. These range from the use of plants and bottled concoctions and auto-medication to the use of healing specialists and rituals that are found in popular Catholicism, evangelical cults and Afro-Brazilian religions.

Research has demonstrated that the frontiers between official health services and the local practices, be they of indigenous origin or not, are not well defined, nor are they impermeable in the practice of daily life. Curing practices do not conform to mutually exclusive categories marking a simple opposition between ethnomedicine and biomedicine. Moreover, perceptions and acceptance of biomedical practices are not uniform or homogenous in any one group. Instead, members of a community hold different ideas, which can appear to be contradictory even within the same individual depending upon the particular context. Recognition of this situation of heterogeneity has implications for the kinds of information about the native culture that is relevant for medical professionals. These are issues that have yet to be addressed by Indian health policy.

Final commentaries

Inclusion of Indian peoples in Brazilian health services has become operational through the subsystem of differentiated attention based on Special Indian Health Districts. The implantation of the subsystem of Indian health in 1999, along with considerable increase in financial resources, has made important strides in the expansion of health services in order to include the indigenous peoples and guarantee them the right to health. The second aspect of inclusion, that which calls for the respect of native cultures and articulates with traditional health practices, has been less successful. As discussed above, most health professionals working in Indian health have not received the proper training that prepares them for work in ethnically differentiated communities. However, this article argues that the greater problem facing inclusion of, or articulation with, indigenous health practices stems from the complexities and contradictions of the hierarchies of knowledge implicit in the goal of improving health conditions of a community through the expansion of biomedical services while attempting to incorporate or collaborate with the group's existing health practices, most often expressed as traditional, indigenous or cultural. As long as biomedical science maintains the hegemonic position of validating the practices that should be implemented, inherent inequality between scientific and community practices exists. Cultural practices are relegated to a secondary position, one in which they are viewed as inherently static, magical and rationally ineffective. Consequently, if articulation or incorporation of these practices in biomedical service is viewed as an aspect of inclusion, most health professionals believe that the practices to be incorporated must be subject to selection according to their scientific efficacy.

Bonfil (1966) expressed decades ago that a conservative view permeates health projects that conceives of culture as an obstacle to progress and ignores the greater political implications of health programs in the third world. Despite an enlightened National Policy of Indian Health, which consciously recognizes the validity and importance of native health practices, the developmental perspective, as characterized by Bonfil, Frankenberg and others, continues unconsciously to guide the majority of the health professionals working with Indian communities in Brazil. The well-intentioned principles outlined in the National Policy for Indian Health Attention have not become a reality.

Brazil is a long way from fully implementing an effective system of differentiated health attention for Indian populations, although they have benefited from increased services as a result of considerable financial support. Bureaucratic and organizational problems continue. "Differentiated attention" is yet to be constructed as a working concept for local services. Attempts to develop culturally adequate attention are isolated and receive little support at the national level. Those involved in the provision of services, particularly the FUNASA workers and the health teams, must be fully committed to offering differentiated health care and respecting the communities with whom they work. As of yet, this commitment has not been fully evident at the national, district or local level of health services.

Finally the dynamics and heterogeneity of the local situations of intermedicality (Greene 1998) deny simplistic solutions for the satisfaction for the call for inclusion of traditional health practices. Traditional medicine and biomedicine are not two systems in opposition. The success of health programs depends far more upon external and internal political factors than upon the scientific value of biomedicine. Health is as much political as it is clinical. There is a need for an understanding as to how the national political decisions, bureaucratic structures and local decision making processes affect the outcome of the efficacy of daily clinical practice.

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