



Articulation between health services and “indigenous medicine”: Anthropological reflections on policies and reality in Brazil

Articulación entre servicios de salud y “medicina indígena”: reflexiones antropológicas sobre la política y la realidad en Brasil

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ABSTRACT This paper contributes to the dialogue between the social sciences and social medicine in Latin America by exploring therapeutic pluralism in indigenous health policies and services in Brazil. It reviews recent anthropological research, concepts and current debates to critically examine Brazilian indigenous health policy and its concept of “differentiated care,” which proposes articulation between official health practices and indigenous therapies. A number of contradictions and tensions are present in the structural organizational of the indigenous health subsystem at the national level and in the daily practices of health teams at the local level. Guided by the hegemonic ideology of biomedicine, health professionals fail to recognize the dynamics and agency expressed in indigenous health practices.

KEY WORDS Health of Indigenous Peoples; Health Policy; Traditional Medicine; Anthropology; Brazil.

RESUMEN Este artículo contribuye al diálogo entre las ciencias sociales y la medicina social en América Latina a través de la exploración del pluralismo terapéutico en las políticas y servicios de salud indígena en Brasil. Revisa las investigaciones recientes en antropología, así como los conceptos y debates actuales, para examinar críticamente las políticas de salud indígena en Brasil y su concepto de “atención diferenciada”, que propone la articulación entre las prácticas oficiales de salud y las terapias indígenas. Varias contradicciones y tensiones están presentes entre la organización estructural del subsistema de salud indígena en el nivel nacional y las prácticas cotidianas de los equipos de salud en el nivel local. Guiados por la ideología hegemónica de la biomedicina, los profesionales de salud no reconocen las dinámicas y la agencia expresada en las prácticas indígenas de salud.

PALABRAS CLAVES Salud de Poblaciones Indígenas; Política de Salud; Medicina Tradicional; Antropología; Brasil.

INTRODUCTION

Since the Alma-Ata Declaration, a number of international documents have proclaimed the value of traditional knowledge in primary health services. Concomitantly, social medicine – called *collective health* in Brazil – has emerged in Latin America as a field differentiated from that of the public health characteristic of countries of the global north, going beyond the biological dimension of the disease process to focus on social conditions in the production of health. This health movement has been receptive to the contribution of the social sciences in understanding the health-disease process and in the organization of health services. In Brazil, many social scientists have been incorporated into collective health programs and conduct research that aims to contribute to the development and evaluation of health policies and services. This paper seeks to contribute to the dialogue between the social sciences and social medicine in Latin America by exploring therapeutic pluralism in indigenous health policies and services in Brazil, reviewing recent publications and current debates.

Most Latin American countries recognize the pluri-ethnic nature of the State and have established policies aimed at providing services in intercultural contexts that call for respect of and articulation with the traditional health practices that are present throughout the continent.⁽¹⁾ Brazilian indigenous health policy has been constructed under the concept of “differentiated care” and guided by the principles of universal access, community participation and articulation with the cultural traditions of the collectivities, respecting their practices and incorporating them, when possible, in the routine services offered by health centers.⁽²⁾ Although indigenous people comprise a relatively small proportion of the total Brazilian population (between 0.02% and 0.04%), their presence is prominent in the social imaginary as well as in public policies⁽³⁾ based on the constitutional guarantee of land, health and culture.

The First National Conference on the Protection of Indigenous Health, held in 1986, was part of a larger political process that culminated in the Constitution of 1988 with ample guarantees of citizen rights. In the health field, this process converged with the health reform that had as one of its principal results the creation of the Unified Health System (SUS) [*Sistema Único de Saúde*], in 1988. The SUS was conceived of and implemented as a social welfare policy with universal health coverage for the entire Brazilian population.⁽⁴⁾ After almost a decade of debates and various legal measures attempting to establish norms specifically for indigenous peoples, the Subsystem of Indigenous Health (SASI) [*Subsistema de Atenção à Saúde Indígena*] was instituted by Law 9836/99 and subsequently regulated by the National Policy for Health Care for Indigenous Peoples (PNASPI) [*Política Nacional de Atenção à Saúde dos Povos Indígena*] in 2002.

It is important to contextualize historically and politically the creation of the SASI, given that its proponent, Sérgio Arouca, who is a well-known advocate of the health reform, recognized the limitations of the universal policy of the SUS with respect to the particularities and necessities of indigenous minorities. Such recognition called for the institution of a specific policy and system that would not deprive indigenous peoples of the universal right to health, mandating the provision of a number initiatives in indigenous territories and promoting an extension of primary care without precedent in the history of interethnic relations in Brazil. It sought not only to guarantee the right to universal access to health services, putting indigenous peoples on equal footing with the rest of Brazil’s citizens, but also to provide culturally specific care sensitive to the local necessities of the numerous ethnic groups attended by the SASI.

The constitutional recognition that the violent history of interethnic contact generated social, economic, political and geographic marginalization of indigenous peoples, resulting in situations of vulnerability, justified one of the most inclusive social programs in Latin America in terms of coverage of services

and allocation of an important amount of resources dedicated to the betterment of indigenous peoples' health.⁽¹⁾ In addition to the charge of carrying out primary care in indigenous reserves, the SASI was given its own budget and a number of differentiated administrative and management strategies not established for other ethnic or racial minorities. It is important to point out this singularity of the subsystem management, given that in Brazil, federal levels of government are granted only regulatory and coordinating functions of health policy and not that of overseeing directly the provision of services, as occurs in the case of indigenous communities.⁽⁴⁾

As is common in other social policies in Brazil, there is a gap between the legal-political guarantee of a right and the results in the daily life of the country's citizens. Thus, for indigenous peoples, the existence of a special policy and subsystem of services has had little apparent impact on the improvement of health conditions.⁽⁵⁾ Their situation continues to be precarious, marked by the persistence of parasitic and infectious diseases that coexist with an accelerated nutritional and epidemiological transition in which new diseases emerge, including chronic syndromes, overweight and obesity, mental and behavioral disorders and external causes of illness and death.⁽⁶⁾ Historically high rates of malnutrition and infant mortality coexist with substance abuse, violent death and suicide, particularly among youth, and reflect structural violence, political subordination, economic exploitation, social discrimination, marginality and inadequate health care.⁽⁶⁾

Anthropologists have accompanied the construction of the indigenous health policy since the First National Conference in 1986, through political participation, collaboration with indigenous and ethnic organizations and research at the national and local levels.⁽⁷⁾ They have an important presence in local and national forums, councils, commissions and committees charged with the construction, administration and evaluation of services, even though their opinions, criticisms and suggestions often receive little consideration by governmental authorities.

There has been an increasing amount of research carried out regarding indigenous health. Recent reviews^(8,9) have demonstrated a substantial growth in research groups within collective health and social science graduate programs along with an increase in research and publications that address epidemiological, socio-cultural and political aspects of the topic. This extensive research is demonstrated by the annotated bibliography compiled by Buchillet.⁽¹⁰⁾ Important academic publishers, such as the Editora Fiocruz, Editora UFSC, EDUSP and others, publish specific books on the theme. In particular, Fiocruz's collection on Indigenous Peoples has increased the visibility of these works.^(11,12,13,14,15,16,17) The vitality of the field is also represented in the increasing number of authors and published articles in collective health, anthropological and social science journals in general.

THEMES AND CONCEPTS IN INDIGENOUS HEALTH POLICY

"Differentiated care" is central to Brazilian indigenous health policy. The discussion of "differentiation" refers to the foundations of public policy marked by a permanent tension between the abstraction of equality through universalized, standardized rights regulated by the State and the diversity of demands, desires and necessities voiced by individuals and social groups hoping that their singularities will be heard and respected and whose agency operates on the concrete level.⁽¹⁸⁾ It is within this sphere that Habermas places social movements, including those of ethnic minorities, which rise as central subjects and creators of citizenships that are manifested in daily life and not only as a legal abstraction.

The National Policy on Health Care for Indigenous Peoples does not precisely define the meaning of indigenous health, but correlates it with care that is respectful of indigenous knowledge and practices and that seeks an "articulation" capable of improving the health of these peoples.⁽²⁾ It recognizes that all indigenous societies "have their own

systems of interpretation, prevention and treatment of illness"⁽²⁾; it also underscores the importance of traditional medicine for community health care and recommends articulation with these systems of knowledge, "incorporating them, when possible, in the routines of work in health."⁽²⁾ The same document also affirms that primary care should be seen as a complement to and not a substitute for traditional practices.⁽²⁾ In other words, Brazilian legislation and regulatory documents call for articulation between official health practices and the diverse indigenous therapies in existence. This commitment to articulation between indigenous and official practices was reaffirmed in 2004 in Ordinance No. 70 "Directives for the Administrative Model of Indigenous Health" and in the VIGISUS II Project (2004-2008) regarding traditional medicine that sought to validate traditional knowledge and develop strategies for articulation between official and indigenous health systems.⁽¹⁹⁾ Despite their dialogic and participatory nature, these projects had little impact upon the actions of the larger subsystem. In addition, efforts to create regulatory legislation of alternative therapeutic practices and traditional medicine contradict the validation of traditional knowledge as legitimate.⁽²⁰⁾ In the case of the SASI, legislation is not clear regarding what constitutes "articulation" and how it could be carried out in the daily actions of primary care. In the terms of Habermas⁽¹⁸⁾ cited above, there is still little congruency between the abstract right guaranteed in the legislation and the therapeutic practices of the multi-professional teams that provide primary care in indigenous villages.

Although the recommendation to articulate different health traditions appears to suggest a greater concern for and fostering of the diversity of societies and indigenous cultures, a careful reading of the norms referring to "differentiation" evidences their vague character and the impossibility of putting them into practice as well as the lack of any contribution to advancement or innovation in the biomedical logic that organizes primary health care. It is important to underscore the absence in the SASI's principal documents of

the term "interculturality," one of the pillars of policies directed at ethnic minorities in a great part of the world. In spite of the polysemy of word in different contexts, it has operated as a directive for more horizontal interaction in mediations between the state and indigenous leaders.⁽²¹⁾ However, Brazilian health policy has passed over this relevant discussion present in the rest of the Latin American continent.

The omissions in the conception and administrative structure of the SASI have led various anthropologists to reflect critically on the concepts that orient it and the practices through which it is manifested. Among these, the works of several authors^(22,23,24,25,26,27,28,29,30,31,32) have questioned the meaning of indigenous health policy, its administrative practices and the quality of its primary care.

Many of these publications underscore the essentialist view of health authorities, one that promotes an understanding of culture as a fixed set of beliefs that *determine* action.⁽²³⁾ Such a rigid ideation has as its consequences the incapacity to recognize inter-societal differences, indigenous agency, the vitality of ethnohistory and the capacity to recreate and reinvent traditions. Cardoso⁽³⁰⁾ calls this static view "inclusive normatization," promoted by the subsystem that homogenizes administrative processes and the rendering of health services, refusing to recognize the inequalities to which indigenous people are submitted as well as the diversity of their ways of life.⁽³²⁾

Langdon⁽³³⁾ also criticizes the narrow view that the official system recognizes as traditional medicine, limiting it to a generic shamanism and/or the use of medicinal plants without taking into account the extreme variety of indigenous systems of care and healing.

Within this context, to proclaim differentiation, Brazilian health policy does not dialogue with the expectations and views of indigenous peoples; they are, in the end, negated or ignored by an official health system that limits itself to a vague ordering of administrative health routines. It is marked by a high degree of standardization of rigid

prescriptive technical norms, whose strictly biomedical character makes them impervious to local contexts and singularities.^(30,34,35)

The asymmetry of these relations is congruent with that which Pontes, Garnelo and Rego⁽³⁶⁾ call interaction between "moral strangers." Based on the propositions of Engelhardt Jr.,⁽³⁷⁾ the authors characterize the relations between indigenous people and health professionals as a situation in which the subjects do not share common values or moral authority. In the face of moral estrangement between subjects in interaction, the establishment of a consensus promoting the viability of adequate action would require true dialogue involving the participation of indigenous leaders and others in order to constitute a community of argumentation and communication. This in fact does not occur.⁽³⁶⁾ Thus, the action of the Brazilian State, as expressed in indigenous health policy and its regulatory documents, translates not into a discursive community, but into postcolonial asymmetry and the legal and moral subalternization of indigenous peoples. This asymmetry also finds translation at the technical level in the hegemony of the primary health care model developed in a mechanical and standardized form on indigenous reserves.

The examination of the concept of differentiated care and public policy has led to new orientations in research on race and ethnicity.⁽³⁸⁾ Others focus on specific questions of health service organization, such as the actions and training of professionals, including indigenous health agents,^(39,40,41,42,43,44) indigenous participation in councils for public accountability^(45,46,47,48) and the models of health care that are carried out in indigenous villages.^(36,43,49,50,51)

In this set of initiatives, special note should be given to the VIGISUS II Project mentioned above and associated with the area of traditional medicine.^(15,19,20) It supported a number of academic studies along with community action that stimulated, recorded and systematized experiences of validation and revitalization of traditional health practices. This experience represented the closest approximation to the concept of "articulation"

between official and native practices since the implantation of the SASI.^(15,19,52,53)

The production of ethnographies on the organization and daily provision of health care for indigenous communities has been a rich field for anthropological research in Brazil. As can be seen from the above discussion, this broad gamut of research, through local focus on villages, ethnic groups, specific diseases, biomedical practices, native systems of health practices and healing, among others, has provided a range of information on the functioning of the SASI and its organization in special indigenous health districts. These studies employ anthropological paradigms for the comprehension of health models and practices as well as the perspective of the actors in local contexts, seeking to understand how people organize and orient their practices with respect to the health problems they perceive, including those that do not correspond to biomedical nosology.

Dynamics and emergence of forms of self-care

Another set of studies focused more strictly on "ethnomedicine" or indigenous medicine, points out the dynamic and processual character of practices related to health care. Such studies are based on classical ethnographic methods, characterized by long periods of fieldwork and close relations with the subjects studied, and seek to understand the meanings and dynamics of self-care understood as the relation between action and structures of meaning that are involved in the production of health, following Menendez's⁽⁵⁴⁾ conception of self-care practices in its more ample sense. They describe and analyze the singularities, interactions, negotiations and existing conflicts in social processes, as well as the social construction of the body, personhood, identities and cosmopolitical dimensions that are directly related to the processes of biological and social reproduction of the group.

Such studies analyze "other" forms of knowledge that are revealed through the

ethnographic method and recognize the plurality of knowledge and rights as well as the right to such plurality,⁽⁵⁵⁾ raising questions related to indigenous cosmologies, shamanisms, relations with nature, practices of commensality, conviviality and sociality of daily life and reproductive processes that are crucial elements in the social and biological reproduction of any group. Of these numerous studies, the more recent include Pereira⁽⁵⁶⁾; Guimarães⁽⁵⁷⁾; Garneiro^(12,58); Biserra⁽⁵⁹⁾; Mendes dos Santos⁽⁶⁰⁾; Oliveira⁽⁶¹⁾; Silveira⁽⁶²⁾; Oliveira⁽⁶³⁾; Oliveira⁽⁶⁴⁾; Ávila⁽⁶⁵⁾; Scopel⁽⁶⁶⁾; Dias-Scopel⁽⁶⁷⁾; Scopel, Dias-Scopel and Wiik⁽⁶⁸⁾; and Pérez Gil⁽⁶⁹⁾.

Shamanism, a classic theme in anthropology, persists as a theme of interest, but with focus on the transformations of shamanic practices and their role in the affirmation of indigenous and cultural revitalization stimulated, at least in part, by the rise of public policies reaffirming cultural diversity. In addition to its role in relation to cosmopolitics and health, shamanism as an expression of traditional medicine constitutes a form of symbolic capital that expresses the affirmation of identity before the surrounding society.^(70,71,72,73) Langdon⁽⁷⁴⁾ argues that contemporary shamanisms must be understood as dialogic practices that emerge from the articulation with non-indigenous groups as well as with public policies, resulting in the appropriation of knowledge and objects from the hegemonic society, as seen in the case of the Guarani in Southern Brazil who adopted *ayahuasca* (*Banisteriopsis caapi*) in their ritual practices. With governmental resources and the health team's participation, a project was developed to reduce violence and alcohol abuse in the community. Incorporation of this Amazonian substance in their ritual practices resulted in the strengthening of the political and religious authority of the community's traditional leadership (*karaikuery*).⁽⁷⁵⁾ This is far from an isolated case, as recent studies have shown for the Huni Kuin (Cashinahua)⁽⁷⁶⁾ and other groups in Acre.

Studies of therapeutic pluralism have increasingly drawn from Menéndez's⁽⁷⁷⁾ approach, in particular the concept of self-care practices⁽⁵⁴⁾ in its more strict sense, in order

to research the variety of strategies used by patients and their families to prevent, treat, control, alleviate and or cure illnesses and other afflictions. The use of practices of self-care in the strict sense focuses on both representations of illness and practices. The studies recognize the autonomous character of these practices and their articulation with models of care, scientific or not. In addition, they show that experience with biomedical practices, particularly since the implantation of the SASI, has led to incorporation of these therapies and medications in indigenous therapeutic itineraries and self-care practices.

The dynamics of self-care practices are reflected in studies that focus on religious practices and conversion. Ghiggi Jr.⁽⁷⁸⁾ identified emergent healing practices in the evangelical churches on a Kaingang reserve and a network of native healers involving alliances with non-indigenous people that live outside it. On this same reserve, Oliveira⁽⁷⁹⁾ accompanied the Church of Health in the 1990s and its hybrid practices that represented "tradition" for the Kaingang leaders, despite the marked presence of biomedicine, popular Catholicism and spiritist practices. Other research⁽⁸⁰⁾ has registered significant interchange between the Kaingang and non-indigenous people with respect to alimentary habits and festive activities.

Analyses of therapeutic pluralism have been the object of diverse publications exploring self-care practices in contexts of "intermediality,"^(35,81,82) a concept that considers the articulation and appropriation of different knowledge traditions as marked by negotiations and relations of power that favor the development of new models of health care. Drawing from the concepts of intermediality and self-care practices, Scopel⁽⁶⁶⁾ and Dias-Scopel⁽⁶⁷⁾ explore the coexistence of diverse health care models among the Mundurucu people, as well as the political, economic and ideological aspects and strategies of power involved in health and illness knowledge and practices, independent of their origin. These concepts aid in the recognition of the mutual influence of contextual factors, the dynamics of Mundurucu choices, and the various models and

practices, hybrid and syncretic, that are present in daily life and in the processes of social and biological reproduction of the group.

The above studies demonstrate that it is necessary to go beyond the notion that different therapeutic traditions represent discrete systems with clear-cut frontiers between biomedical and indigenous practices. Research shows that there is a strong intertwining between diverse medical traditions in the daily practices of the patients and their families. This is contrary to the common sense opinion of many health professionals working with indigenous groups who perceive "culture," "beliefs" and "tradition" as static realities and thus interpret them as obstacles for the acceptance of biomedical services.^(83,84,85)

The hybrid medical practices documented in many of the above studies are evidence that contact zones between indigenous groups and biomedical practitioners^(81,82) are spaces of intermediality permeated by negotiations between political subjects endowed with social agency who, drawing from their experiences and necessities, adopt, appropriate, and articulate with all of the therapeutic options that are available. Pontes, Rego and Garnelo⁽⁸⁶⁾ reached a similar conclusion through research in the Alto Rio Negro region of Brazil, where the indigenous health agents are the central protagonists in articulation between native and biomedical therapeutic models, although such articulation is ignored, negated or refused by the non-indigenous health professionals whose strong adherence to biomedical principles impedes them from perceiving the breadth and fecundity of the self-care practices present in the villages.

A similar refusal to recognize self-care practices by health professionals is documented in research on indigenous patients with diabetes and hypertension or other conditions that are subjects of specific health programs. Portela Garcia⁽⁸⁷⁾ observed a great disparity between the perception of health professionals and Kaingang patients, who appropriated the programmatic care directed at them while simultaneously adopting other forms of self-care according to their necessities and desires for autonomy.

Other chronic problems identified as critical and urgent by officials and for which the anthropological approach has revealed a different perspective are "alcoholism" and mental illness, including suicide. Rejecting the label of alcoholism promoted by health officials, researchers have used the concept of "alcoholization" suggested by Menéndez⁽⁸⁸⁾ to analyze situations of alcohol consumption from the collective perspective, one that directs attention not only to the pathological but to the positive and ritual dimensions. The concept moves beyond individual and a-historical bodies and examines historical contexts and relations of the group with the larger society. Such studies do not lose sight of conflictive situations related to abuse of alcohol, but seek to understand how indigenous people perceive such risks and the strategies they develop to resolve them.^(16,78,89,90,91,92)

Other problems in mental health have been studied among indigenous peoples and, like alcohol abuse, demand complex explanations requiring a much more ample understanding than that which is found in biomedical manuals of diagnosis and treatment. Researchers point to the need for adequate knowledge of the social, economic and political relations behind the emergence of mental perturbations in indigenous communities and to the participatory character need to construct collective solutions and strategies to deal with them.^(19,91,93,94,95)

Other themes, such as research on nutritional status and food habits^(96,97,98) and the distribution and use of medications in indigenous reserves^(99,100,101) have a greater affinity with the field of collective health. However, they reflect the anthropological perspective and methodology in order to analyze indigenous agency and communication and relational asymmetries between health professionals and the indigenous communities, demonstrating the heterogeneity of perspectives and forces.

All of these studies point to the creative dynamics found in self-care practices, be they considered traditional or emergent forms. They challenge the dichotomy generally

established between indigenous and official models of care and make biomedical services also objects of ethnographic research on the local level, as is demonstrated in some of the aforementioned studies that examine how primary care is articulated with local knowledge and practices by the community members in situations of intermedicity. These study results converge to demonstrate that despite its hegemony and State support,⁽¹⁰²⁾ biomedicine does not supplant other forms of therapeutic practices. On the contrary, the continuing expansion of its services and medications coexists with the flourishing of popular and alternative healthcare models in Latin America and other parts of the world.

The research network in indigenous health

Collaboration between anthropologists and other researchers in the field of collective health is expressed in academic production as well as in engagement of researchers in favor of indigenous rights and the development of health policy. These researchers have a marked presence in forums, councils, commissions and local and national committees that are charged with public oversight, training of indigenous and non-indigenous health professionals, and monitoring and evaluating health services, in addition to serving as consultants for indigenous communities and associations. They have had an important role in the Intersectorial Commission on Indigenous Health that advises the National Health Council, on committees of the Department of Science and Technology of the Ministry of Health, and also in councils for the development of research in health that identifies priorities for financial support.⁽¹⁰³⁾

One manifestation of the relation between research and political engagement in defense of indigenous rights is the Indigenous Health Workgroup of the Brazilian Association in Collective Health (ABRASCO) [Associação Brasileira de Saúde Coletiva]. Founded in 2000 and composed of anthropologists and health professionals, including

the authors of this article, the workgroup maintains alliances with the Brazilian Association of Anthropology and the Brazilian Association of Population Studies in the form of academic events and publications. Members of the workgroup conducted the First National Survey on the Health and Nutrition of Indigenous Peoples, the broadest study on indigenous health that has been conducted in the country.^(104,105)

The National Council of Scientific and Technological Development (CNPq) [Conselho Nacional de Desenvolvimento Científico e Tecnológico] maintains a website where all active research groups in the country are registered. The consultation of this directory using the key word “indigenous health” identified 48 groups. Almost half (23) are associated with collective health institutions; anthropology follows in second place with six groups. An examination of the lines of research developed by these groups shows an interdisciplinary tendency, with the participation of researchers from different areas of health and the social sciences. These groups are also linked in research networks that often extend beyond Brazil. For instance, the National Institute of Science and Technology - Plural Brazil Institute (INCT-IBP) [Instituto Nacional de Ciência e Tecnologia - Instituto Brasil Plural] sponsors an important network linking researchers in anthropology, sociology and the health fields. Initially made up of the Social Anthropology graduate programs at the Universidade Federal de Santa Catarina and the Instituto Leônidas & Maria Deane, Fiocruz Amazônia, it has extended to other universities in Brazil and countries in the Americas, including Mexico, Colombia, Chile, Argentina, Venezuela and the United States. Researchers of this network study a number of different topics, one of the most important being that of indigenous health. In addition to collaboration in research, the network has hosted several colloquiums, round tables and panels at national and international conferences, two of which gave rise to published collections on indigenous health policies in Latin America⁽¹⁾ and on anthropology's contribution to public policy.⁽¹⁰⁶⁾

It is crucial to underscore the importance of multidisciplinary research networks in indigenous health for the identification, critical analysis and dissemination of theoretical frameworks and key concepts that guide the studies referenced throughout this article. Researchers are seeking the innovation and incorporation of analytical concepts appropriate to the Latin American context, such as "ethnoepidemiology,"⁽⁵⁵⁾ "socio-cultural epidemiology,"⁽¹⁰⁷⁾ and "self-care practices"^(54,108), that stimulate fruitful collaboration and dialogue within the anthropology of health in Latin America and its contributions to public policies from a comparative perspective.

FINAL CONSIDERATIONS

Through qualitative research strategies and with focus on the actors and their interactions, research studies in anthropology contribute to effectively fulfilling and putting into practice the principles of the SUS that aim to respect and articulate with the diversity of knowledge and practices. Focusing on the dynamics of therapeutic practices and the agency of actors makes it clear that therapeutic pluralism cannot be understood by referencing the generalizing dichotomies that put professionals in opposition with their patients or biomedical practices in opposition with traditional, indigenous or popular ones.

Local interactions and practices reflect more global contexts, revealing power relations in matters of life and death and in those that threaten the social fabric. Critical ethnographic analyses point out intersections and articulations between factors of the macro-structural order and the forms through which

health and illness are dealt with locally. In this way, the analyses produced by the anthropological approach explore the specificities of particular medical systems as regional, national and global processes that transcend the local context, contributing also to public policy and to the collectivities that are attended by health services.

Brazilian legislation proclaims respect for its indigenous peoples and validation of their knowledge and health practices. However, the exercise of respect for the indigenous people in health interventions does not imply simply "tolerance" for the other, but demands the establishment of a true dialogue among the multidisciplinary health team, the patients and the indigenous community as a whole. The presuppositions associated with such a dialogue are not favorable, given that medical encounters occur in social contexts marked by inequalities and economic and social hierarchies. The debate undertaken by the network of researchers in indigenous health on the integration or articulation of traditional medical practices in primary care points to even greater complexity and difficulty. Any dialogue between such diverse systems of knowledge and practices involves communication between markedly different epistemologies and requires a disposition for placing one's own point of view in perspective. In other words, the re-dimensioning of the premises and practices of primary health care in indigenous villages in coexistence with traditional knowledge would require that health professionals, scientists and indigenous people take seriously the perspective of the other, in order to recognize that there are various ways to know the nature of the world.⁽¹⁰⁹⁾

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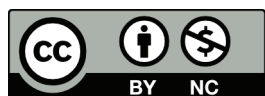
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