Social control in the Indigenous Health Care Subsystem: a silenced structure

Controle social no Subsistema de Atenção à Saúde Indígena: uma estrutura silenciada

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Abstract

In Brazil, one of the fundamental principles of the Brazilian National Health System is social participation. Through mobilization, indigenous peoples secured the publication of the law establishing the Indigenous Health Subsystem in 1999, structured in 34 Special Indigenous Health Districts. From the beginning, participation instances were organized: Local Councils, District Councils of Indigenous Health (Condisi) and the Condisi Presidents Forum (FPCondisi) This study aims to understand the formal structure and effective configuration of the social participation space of indigenous people in the construction of a differentiated health policy. A qualitative methodology was used with several sources and materials, with documentary analysis of minutes of Condisi Litoral Sul and FPCondisi meetings, legislation and with in-depth interviews with indigenous people and indigenists. The results showed that there are several ways for indigenous people to participate in health policy. It is possible to state that most of the interviewees recognizes Condisi as a space for dialogue between indigenous people and the government, but they also point out the limits of the effectiveness of this and other instances of social control. The silencing of indigenous agendas in formal participation spaces makes these people seek for other ways to lead the construction of a differentiated health policy.

Keywords: Health of Indigenous Peoples; Social Participation; District Councils for Indigenous Health; Condisi Presidents Forum; Health Councils.

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Resumo

No Brasil, um dos princípios fundamentais do Sistema Único de Saúde é a participação social. Por meio de muita mobilização, os povos originários garantiram a publicação da lei que estabelece o Subsistema de Atenção à Saúde Indígena em 1999, estruturado em 34 Distritos Sanitários Especiais Indígenas. Desde o início foram organizadas instâncias de participação: os Conselhos Locais, os Conselhos Distritais de Saúde Indígena (Condisi) e o Fórum de Presidentes de Condisi (FPCondisi). Este estudo tem como objetivo compreender a estrutura formal e a efetiva configuração do espaço de participação social dos povos indígenas na construção de uma política de saúde diferenciada. Foi utilizada metodologia qualitativa com diversas fontes e materiais, com análise documental de atas de reuniões do Condisi Litoral Sul e do FPCondisi, legislação e com entrevistas em profundidade com indígenas e indigenistas. Os resultados demonstram que há vários caminhos de participação dos indígenas na política de saúde. É possível afirmar que a maioria dos entrevistados reconhece o Condisi como espaço de diálogo entre indígenas e governo, mas também apontam falta de resolubilidade desta e demais instâncias de controle social. O silenciamento das pautas indígenas nos espaços de participação formal faz com que esses povos busquem outras formas de protagonizar a construção de uma política de saúde diferenciada.
Palavras-chave: Saúde Indígena; Participação Social; Conselho Distrital de Saúde Indígena; Fórum de Presidentes de Condisi; Conselhos de Saúde.

Introduction

Brazil's Constitution of 1988 establishes a Democratic State based on the Rule of Law, with social welfare as a central objective of the political and social organization of the country. The Magna Carta established several devices for the social control of the State by "organized civil society", instituting a new understanding of the relationship of people with the State, with citizenship status, identity carriers and right holders (Mattos; Baptista, 2015). Thus, citizens are configured as actors who relate to and participate in the State.

The discussion on social participation is present, at least, in the entire history of the Republic in Brazil. According to Valla (1998, p. 9), it is understood as "multiple actions that different social forces develop to influence the formulation, enactment, monitoring and evaluation of public policies and/or basic services in the social area."

Mattos and Baptista (2015, p. 97) define public polices as "government responses to demands, problems and conflicts that arise from a social group, being the product of negotiations between different interests, mediated by technical rationality, aiming at maintaining a social order." The field of production of these policies has intense disputes, and the participation of citizens is a key feature of this process.

Menéndez (2009) highlights that social participation is recognized in the Alma-Ata Conference as one of the basic activities that support primary health care policy. The author offers a broad understanding of the topic, identifying 11 main activities in the health-disease-care process that range from the construction of domestic gardens to the support to the organization and functioning of Local Health Systems.

In Brazil, the health area was a pioneer in bringing social participation to the discussion of public policies. The topic was discussed at the 8th National Health Conference and formalized by Law no. 8.142/1990 in order to ensure that the organized sectors of society are involved in the formulation, monitoring of the implementation, allocation of resources and evaluation of policies (Correia, 2000). To this end, health councils were

instituted in each sphere of the government to discuss and deliberate on health policy, establishing that a Health Conference would be held every four years to assess the situation of the sector and propose guidelines.

Social participation in health policy represents the recognition of diversity and, often, the conflicting interests of society, opening channels to discuss them in order to be negotiated or to compose adequate solutions to the problems discussed (Nunes et al., 2018). However, some authors argue that this institutionalization, over time, was imposing a structure on the social control of the Brazilian National Health System (SUS) which shaped its room for maneuver to conform to the logic of the State (Bravo; Correia, 2012).

Indigenous peoples constitute a social force in this field of dispute to influence public policies, especially in the wake of the Federal Constitution. Over the centuries in which they were subjected to a State and a government that are not part of their mode of organization, these peoples have led the struggle for overcoming the "supervisory power" exercised by the State. The indigenous in movement, through the People's Union of Indigenous Nations, secured the incorporation of their rights in the Constitution, which, in Chapter VIII ("On Indigenous") recognizes that they are Brazilian citizens, entitled to their way of life and to take over traditional lands. This amounts to a legally sanctioned break with the policy based on a linear conception of human evolution and integration in the national community under supervision of the State (Munduruku, 2012; Souza Lima, 2015).

In the 1990s, indigenous social organizations were established, with a key role in the fight for the recognition of their constitutional rights, influencing the organization of the policy of land demarcation, education and health (Paula; Vianna, 2011; Souza Lima, 2015). With the organization of the two National Indigenous Health Conferences in 1986 and 1993, and with the indigenous representation actively occupying and disputing these spaces, the fundamental guidelines of the Indigenous Health Care Subsystem (Sasi) were elaborated. After many articulations at the National Congress, the Sasi was approved and published by Law No. 9,836/1999 (Arouca Law), recognizing that the ways of life of indigenous people are distinct and, therefore, require differentiated care.

The Sasi, under centralized management of the federal government, has as its main objective to ensure primary care in indigenous villages, considering and articulating the integrality of care and respecting the cultural, social and epidemiological needs of each people. During the first 11 years, management was attributed to the National Health Foundation (Funasa); in 2010, after complaints and claims by indigenous peoples, the Special Department of Indigenous Health (Sesai) was created in the structure of the Ministry of Health, and is the current administering body for indigenous health.

The creation of Sasi triggered a process of district formation, as decided in the 2nd National Indigenous Health Conference, which culminated in 34 Indigenous Special Health Districts (Dsei). These were structured according to the diversity displayed by indigenous cultural, contact and political organization, without considering the limits between municipalities and states. The organization of Dsei includes structures and professionals to assist indigenous peoples – Polo Base, Indigenous Health Support and Multidisciplinary Indigenous Health Team (EMSI) – and social participation bodies to work with administration in proposing actions, planning, monitoring and evaluation – Local Councils of Indigenous Health (CLSI) and District Council of Indigenous Health (Condisi). In 2006, the Condisi Presidents' Forum (FPCondisi) was created at the national level (Cardoso, 2015; Garnelo, 2004).

The production of public policies, however, does not end with the publication of the norm. The latter was followed by a struggle for its actual creation and implementation. The 2016 United Nations report points to the stagnation of indigenist policies (Tauli Corpuz, 2016). The disputes to implement these policies require a continuous action of indigenous peoples, with mobilizations and confrontations of governments and parliamentary proposals that hurt their constitutional rights, reaffirming the abyssal exclusion of these people and the internal colonialism that persists in the country (Casanova, 2006; Santos, 2018).

Based on the epistemologies of the South, Santos (2018) discusses abyssal exclusion, which is the result of recognizing a single possibility of knowledge, time and way of life – abyssal thought –, which systematically produces the absence of all groups that challenge these monocultures. Thus, indigenous peoples struggle to overcome the abyssal exclusion to which they are subjected. The responses that emerge from these struggles strengthen cognitive justice, which, in this case, involves the recognition of the rights of indigenous peoples to construct their own histories, their ways of organizing collective life and participation, in addition to recognizing their knowledge and practices relative to health and healing beyond a local knowledge.

The Sasi was conquered with the proposal of being differentiated and respecting the cultural characteristics of the diverse indigenous peoples. The existence of negotiation forums between indigenous people, health professionals and administration is important to allow the emergence of the needs of peoples, their medicines and debates on the possibilities and limits of articulation with biomedicine. In this sense, understanding the formal structure organized at the national level, as established by laws no. 8,142/1990 and Arouca (Brasil, 1999), and the effective configuration of a space for social participation of indigenous peoples with the implementation of Sasi from 1999 is crucial to create possibilities for the construction and implementation of a differentiated health policy.

Methodology

The research used qualitative methodology with documentary analysis and in-depth interviews (Minayo, 2013; Sá-Silva; Almeida; Guindani, 2009). We analyzed the SUS and Sasi legislation related to the topic of social participation (Chart 1), 29 minutes of FPCondisi meetings held between 2011 and 2017 – the period during which the management of Sasi was under the responsibility of Sesai – and 40 minutes of Condisi meetings of the Dsei Litoral Sul conducted between 2000 and 2017. This Dsei was chosen due to the possibility of access and proximity with the interviewer, who was a member of the council from 2009 to 2013, an experience that contributed to understanding and analyzing the material.

The interviews were performed in the first half of 2017 with 11 indigenous people and four indigenists chosen from a set of key informants who acted in the process of construction of indigenous health policy and participated in the social control bodies of the Sasi. In order to allow a reflection on indigenous participation at national level, the interviewees represent all regions of the country (Chart 2).

After exhaustive reading of all the material, it was possible to identify and analyze the issues pointed out here. Although this article does not highlight the statements of all the interviewees, all of them brought reflections on the participation of indigenous peoples in the National Policy for Health Care of Indigenous Peoples (Pnaspi) based on diverse knowledges, without putting them in conflict, recognizing the specific context of speech of each one.

Chart 1 – Legal texts on social participation in health

Author	Text type	No.	Date of signature	Description of the norm	Current situation
MS/MO	Ordinance	254	01/31/2002	Approves the National Policy for Health Care of Indigenous Peoples.	Revoked by Consolidation No. 2/2017
MS/MO	Ordinance	644	03/27/2006	Establishes the Permanent Forum of Presidents of the District Councils of Indigenous Health.	Revoked by Consolidation No. 4/2017
MS/MO	Ordinance	755	04/18/2012	Discusses the organization of social control in the Indigenous Health Care Subsystem.	Revoked by Consolidation No. 4/2017

MS/MO: Ministry of Health, Minister's Office.

Chart 2 – Ratio of respondents

Identification	State of origin	Performance in social control	Profession
Indigenist 1	–	Participated	Doctor
Indigenist 2	–	Participated	Doctor and anthropologist
Indigenist 3	–	Participated	Doctor
Indigenist 4	–	Participated	Doctor
Guarani/RS	Rio Grande do Sul	District councilor	Nurse
Guarani/RJ	Rio de Janeiro	District councilor	Driver
Guajajara/MA	Maranhão	–	Social worker
Tucano/AM	Amazonas	–	Culture agent and former UNI coordinator
Taurepang/RR	Roraima	–	Teacher
Tremembé/CE	Ceará	District councilor	Indigenous health agent
Guarani/SP	São Paulo	District councilor	–
Krenak/MG	Minas Gerais	Participated	Former UNI coordinator
Xavante/MT	Mato Grosso	–	–
Baré/AM	Amazonas	–	–
Kayapó/MT	Mato Grosso	–	–

UNI: Union of Indigenous Nations.

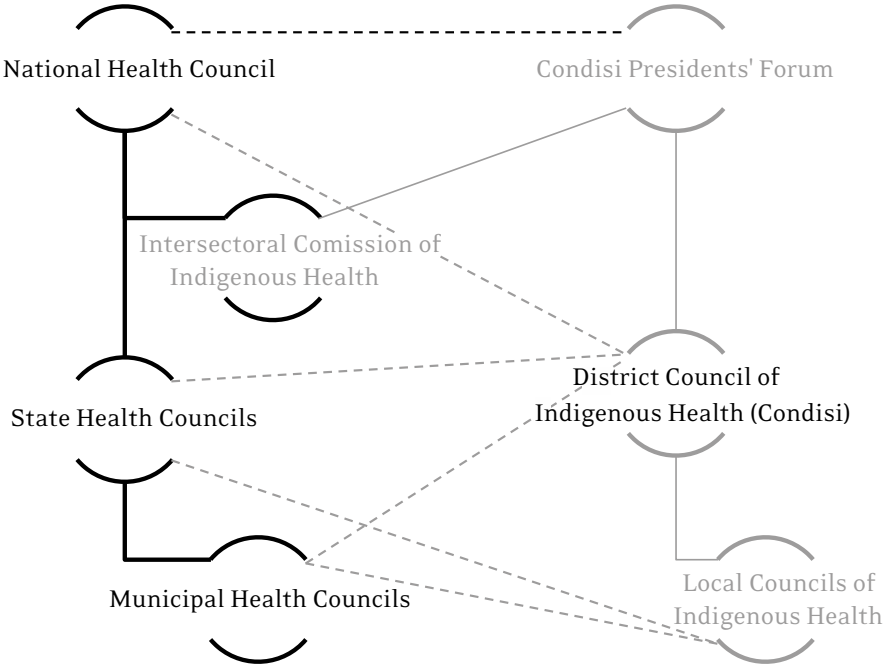
The research followed the recommendation of the National Research Ethics Committee, being approved by Opinion No. 1,766,478. Considering the characteristics of the interviewees, this study chose not to identify the indigenists and to identify the indigenous participants by ethnicity and acronym of the state of origin (Chart 2).

Results and discussion

The interviews and legislation analyzed show that the structures of social control trace two paths of participation of indigenous peoples in health policies, with little interaction between them in the national sphere and no articulation at the level of states and municipalities, thus displaying parallel features in the structure of social control (Figure 1).

Social control in the Sasi was shaped according to Law no. 8,142/1990 and the deliberations of the National Health Council (CNS). Its organization is determined by Ordinance No. 755/2012, published under the administration of Sesai and regulating the structures of CLSI, Condisi and FPCondisi mentioned in Pnaspi (Ordinance No. 254/2002) and in Ordinance No. 644/2006 (Brasil, 2006, 2012; Funasa, 2002). However, the relation between the institutions is not standardized, and the articulations are in construction. The discussion on the role of CLSI, Condisi and FPCondisi appears frequently in the analyzed minutes. The same happens with the debates regarding the relations between these instances, between them and the administration, at the local, district or federal level, and at the CNS and Intersectoral Commission on Indigenous Health (Cisi).

Figure 1 – Representation of existing relations between institutions of social control and those that need to be strengthened



Continuous lines: existing relations between institutions of social control; segmented lines: relations that need to be strengthened; nomenclatures in black: deliberative bodies; nomenclatures in gray: advisory bodies.

The FPCondisi, with a permanent and consultative character, has the competence to participate in the formulation of, and follow the Pnaspi, as well as to strengthen and articulate social control. Among the statements of the interviewees, there are criticisms of this instance, which, in the perception of indigenists, creates distance from the discussions at the grassroots:

> *Subsequently, Funasa constituted this Condisi Forum* [...] *It is a political autonomy that is much closer to Brazilian central governments then to the needs, priorities of the villages.* (Indigenist 2)

Ferreira (2012) points out that the FPCondisi emerged because of a demand of the Condisi presidents due to the lack of autonomy of Dsei in the administration of the territories. Despite being an advisory body, the Forum has an important influence on government decisions. This space was affected by Presidential Decree No. 9,759/2019 (Brasil, 2019), which extinguishes and limits the existence of collegiates in federal management. Thus, although the interviews indicated that the FPCondisi occupied a central role in the articulation with the Sesai, maintaining the core of the discussion in the national administration of Sasi and distancing villages from this debate, its extinction further hinders indigenous participation in the national policy debate.

CLSI, considered as a space of exercise of indigenous decision-making power, were thought as the center of the Subsystem. They would be the non-deliberative bodies of real influence of indigenous leaders, where the policy should be planned. It was hoped that the construction of Sasi would be collective, which did not happen.

> *A myriad of local councils was predicted in which the village leadership that, in fact, had power and influence at the local level, could exercise decision-making, better understand the planning processes and define more clearly the need for health. These Local Councils* [...] *were not implemented in practice in the way they should be.* (Indigenist 2)

The Condisi, which are the deliberative instances of Sasi, were also established, as well as the municipal and state health councils, and generated contradictory positions among the interviewees:

> *Look, there is a side that is very good, but there is another side* [...] [because] *they created this barrier so that the indigenous peoples would not achieve their goal directly in Brasília.* [...] *It is hard to get an answer to what we have been discussing for years with the District Council.* (Guarani/RJ)

The formalization of the CLSI spaces by Ordinance No. 755/2012 (Brasil, 2012) brought as a consequence the bureaucracy of non-indigenous administration. By stipulating that CLSI members must be elected, participation of the entire community is hindered, and the frequency of the meetings is not guaranteed. The minutes of the Condisi Litoral Sul constantly reaffirm the importance of CLSI meetings and request support from the Dsei to ensure this space. They point out that, often, these meetings do not occur due to lack of resources for transportation and food for members.

For indigenous peoples, who are collective subjects who build agendas and decisions in moments of conversation, it is possible to understand the importance of Condisi and CLSI as an environment for meetings and articulation between villages. In several interviews, these are described as spaces where they may "find relatives" and "gather everyone." When the administration denies this perspective, it does not recognize the differentiated way of indigenous participation provided for in the Federal Constitution (Brasil, 1988), in Convention No. 169 (OIT, 2011) and in the Arouca Law (Brasil, 1999), thus breaking with the collective responsibility for the health of indigenous peoples.

The very publication of Ordinance No. 755/2012 (Brasil, 2012), in April of that year, violates the principle of indigenous participation, since it was elaborated without hearing and collaborating with the major stakeholders, the indigenous peoples. The minute of the 3rd Extraordinary Meeting of the FPCondisi, which took place in May 2012, questioned the "new ordinance of social control," but only in the 4th Extraordinary FPCondisi Meeting, in July 2012, was the Ordinance shown in slides and the doubts of the Condisi presidents were clarified. However, before the publication of the Ordinance, the minutes of the FPCondisi meeting do not indicate debate on its content, and the minutes of the Condisi Litoral Sul do not include any reference to the topic.

Silenced paths: bureaucratic and conflicted spaces

The minutes analyzed highlight the divergent positions on the organization of different spaces of social control and the protagonists of some decisions. As FPCondisi was an advisory body of Sesai, the responsibility of deliberating on the policies to be developed by the Ministry of Health rests with the CNS. The FPCondisi minutes depict divergences between these bodies regarding, for example, the structuring of the National Institute of Indigenous Health (Insi), proposed by the Ministry of Health to carry out health actions in indigenous territories.

This discussion reinforces the conflict and lack of articulation between FPCondisi and CNS. In the history of health policy for indigenous peoples, it is important to highlight that the articulation between indigenous movements and CNS began with the creation of Cisi, a permanent advisory commission, in 1993. It was within this space, with indigenous representation, that the debate took place to provide guidelines for the CNS. However, the interviews point to a weakening in Cisi as the Sasi administration declares the FPCondisi as the highest body of social control:

> [the administration body] *published a manual entitled Social Control in the Indigenous Health System and placed the maximum instance of social control in the subsystem, the FPCondisi. I thought that the National Health Council was the maximum instance of social control in Sasi, which had indigenous representation and Cisi as advisor.* (Indigenist 3)

The fragility of the discussion in Cisi may have influenced the power of articulation with CNS. It is important to highlight, however, that the proposal of the Insi, a private institute under public law is opposed to the logic advocated for SUS, which finds

in CNS a strong ally in its defense. Another point that may have influenced the position of CNS was the criticism of indigenous and indigenist associations regarding the swiftness with which the agenda was discussed in the Condisi, failing to provide time to mature the discussions, as described in the minutes.

Results show that the main disputes regarding the deliberations on indigenous health policy occurred at the federal level. This fact may be related to the lack of dialogue between CLSI, Condisi, municipal and state health councils. With federal administration and a territorial organization that breaks with the geopolitics of the Brazilian State, the logic of discussion at the municipal and state level may make little to no sense for indigenous peoples in movement. Studies show that the indigenous health agenda gained greater prominence in CNS, without, however, reflecting an improvement in the health condition of these peoples, with persistent indicators far below the national ones (Teixeira; Simas; Costa, 2013) and does not signal the necessary articulation of the discussions of the CNS with FPCondisi, Condisi and CLSI.

The organization of the Sasi councils was a prominent theme in all the interviews, even if the interviewer did not mention it as a topic of interest. According to one of the interviewees, as the CLSI was not implemented as planned, it led to a change in the performance of Condisi, which took up a more bureaucratic function, compromising their role in the discussion of indigenous health policy:

> *So, the Condisi ended up becoming a bureaucratic space, with a representativeness that does not adhere to the groups they should represent; they are very much driven to endorse plans, to approve accountability.* (Indigenist 2)

When analyzing indigenous participation in the 20th and 21st century, Souza Lima (2015, p. 444) states that

> the sense of participation was gradually changing. With an eminently political character and marked by the search for autonomy in the dialogue with government agencies, indigenous participation was present with a more technical, bureaucratic and sometimes figurative character.

This bureaucratization of social control became more apparent over time, as the minutes point out. The discussion of the internal rules, with regard to the need to standardize the Condisi, is very intense in the first meetings of the Forum and, consequently, several minutes of the Condisi Litoral Sul address its reformulation. This discussion brings to the meetings an increasing concern with following these regulations, giving the impression that not following them would delegitimize deliberations.

In this space dominated by the operationalization of the State, the profile of the councilors who manage to occupy it does not always reflect the characteristics of the sages of the villages. Souza Lima (2015) states that "participating" requires indigenous peoples to have resources and knowledge – to use e-mails and travel by plane, for example – and to learn proper etiquette for participatory forums – respecting the established time for speech and the rules themselves. This bureaucratization generates questions regarding the representativeness of the councilors, which is common in the SUS:

> *This is the problem of the representativeness model that was adopted in the SUS. So, you end up generating a set of leaders that have their legitimacy, no doubt, but they are much more sensitive to the needs of power* [...]. *There are some council representatives who are extremely motivated, mobilized people; now, the concrete result is that the Condisi has not been able to effectively influence the political instance.* (Indigenist 2)

Although it provides an opening for dialogue, this space reaffirms the colonial logic as it is structured from rules at a distance from indigenous conceptions. The hegemony of managerial discussions and topics related to biomedical knowledge reinforces the limits of this space of participation in the construction of public policies with indigenous protagonism.

Krenak/MG restates the need, posed by Souza Lima (2015), to acquire resources and knowledge in this perspective of participation by bringing to this debate two challenges that affect the performance of councilors: the need for logistical organization to ensure the presence of indigenous people and the asymmetry between the segments of the council.

The preparation of an environment to be heard begins far back [...]. *We know that there are some places* [in] *which a councilor travels five days to be there on the day of the meeting. If they are told that they should come in that same week, they won't come.*

[...]

There is the patient, the administrator. [...] *in order to organize the system, they create these categories,* [but] *they move away the collectives that will need to integrate later to do something together instead of bringing them closer, because they already started with installed inequalities.* (Krenak/MG)

These points show the importance of planning the meeting so that logistical issues do not prevent participation. Planning becomes even more important when the meetings take place in urban centers, which brings other needs regarding the availability of financial resources and scheduling, consequently establishing prerequisites for participation.

The Condisi and FPCondisi minutes demonstrate frequent changes in scheduling and absence of councilors who did not receive tickets and/or accommodations. Justifying themselves with lack of time to organize the meeting and provide resources, or even with other activities in which they are involved, administrators change these dates without considering the other political and life activities of the councilors. Thus, power relations are established, which, by not providing an adequate environment for the participation of indigenous people, require them to be present, to discuss and to vote based on the logic, availability and interest of State agendas. This perspective echoes the second point made by Krenak/MG regarding the existing inequality between the representatives of the segments of administrators, workers and patients. Thus, it can be understood that the organization of the Council has not been up to the task of ensuring indigenous participation in the management of the subsystem.

In this context of a structure imposed by the State, following the same format of social control of the SUS, with no respect for the specificities of indigenous populations, as already highlighted by Crux and Coelho (2012), distinct views are perceived among indigenous interviewees. Even if they criticize its functioning, those who participate in the instances as councilors or who are EMSI professionals recognize the importance of this space as a place where indigenous health policy is discussed.

We, as presidents of Condisi, are really the link of the grassroots with administration here. [...] *this conversation is working.* (Tremembé/CE)

Cecilio, Carapinheiro and Andreazza (2014, p. 18) highlight the position of representants of social control in the SUS who present themselves "more as experts than as lay people," because they dominate elements of the public machine, which provides another way of reflecting on this space, closer to the evaluation of administrators. However, indigenous people who do not act in these spaces consider them as places to legitimize government decisions and that do not represent the needs of the community.

The councilors, they dance to the music of the organization called Sesai. They are much more defending the Sesai than the very right to health that indigenous peoples have. I see it like this, without much action, without council autonomy, inside my region. (Taurepang/RR)

The considerations of Ferreira (2012), by stating that, in practice, the participation of the community does not happen in Condisi spaces, and drawing attention to the need to prevent these important spaces from becoming only places of legitimation of the actions of the State, corroborate the positions of the interviewees. The perception of participants of this research is clear regarding the limited space for indigenous voice and agendas that represent the communities in this organization, questioning the co-optation of the debate by the State.

The material analyzed and the interviews show that the specific needs of indigenous peoples have little room for discussion in the Condisi. Langdon & Diehl (2007) have highlighted the bureaucratic and institutionalized structure of these forums, which hinders the participation of the indigenous community, observing that differentiated care,

the main mission of the Sasi, is not discussed in the meetings, a situation that persists even today. The minutes do not portray the discussion on how assistance in the villages should be organized and how to articulate the participation of *pajés*, midwives and indigenous medications in EMSI. The valorization of these medicines is pointed out as necessary in several meetings, but it fails to resonate with administration. Something similar happens to references to the needs of each Polo Base in Condisi and of each Condisi in the Forum, which appear on record when different participants expose the reality of their conditions, but do not unfold in any in-depth discussion.

Thus, the Condisi meeting is a moment of intense dispute over the agenda with the Dsei coordinator, often emptying the plenary and favoring individualized discussion of local needs, and thus demonstrating the fragility and absence of autonomy of the Polo Base. At the federal level, the dispute over the agenda with the secretary of Sesai and the heads of department reinforces the limits of the autonomy of administration of the Dsei themselves, already pointed out by Cardoso (2015) as an important challenge for Sasi.

Another relevant point that corroborates this limited response to indigenous needs is found in the Condisi minutes, which always mention the referral of several documents to the competent bodies, often Sesai itself, and begin with the statement that "there was no response to the referrals sent." In the same sense, most of the indigenous peoples, mainly from the South and Southeast regions, also report in the interviews the lack of return and commitment of administration in the joint debate of the proposed agendas:

> *the District Council deliberates many things, but often we are not heard, and this ends up weakening the grassroots at the villages.* (Guarani/RS)

This report highlights a frequent concern found in the minutes: the demands of the grassroots. Councilors show great respect for what the community demands. Thus, even if there is less involvement with their territories, the defense of the agendas of the village and the attempt to get an effective return are present in their daily lives. Currently, the problem is outsourced to these councilors, and the very perspective that they are closer to administration contributes to this construction of the imaginary, in which the responsibility is divided between government and councilors, with greater weight on the latter. The villages, when they do not see their needs met, emphatically demand them from councilors: *if it doesn't work, screw the councilors, not the State* (Indigenist 1). Thus, the structure of social control does not accommodate the indigenous way of doing politics, silencing this participation.

The interviewees who work in social control report another problem that affects this relation with their communities: time. With administration demands to be discussed within a short term, there is no time to debate with the grassroots:

> *This isn't quite the truth, we don't have time* [...] *Then we end up always quoting the ILO* [International Labour Organization, referring to its convention No. 169]*, which ensures prior consultation, but we end up not doing this prior consultation as it should be, because the consultation was supposed to be detailed, to go to the grassroots, to go to the village and talked about, and sometimes we don't have time, because everything has a limited deadline.* (Tremembé/CE)

> *No. We have this issue, we have freedom to discuss, but often we don't have time.* [...] *This ends up reflecting in the bases and the indigenous people themselves begin to argue with each other.* (Guarani/RS)

It is necessary to underline that the structures of these bodies follow the non-indigenous logic of exercising power, which is not only expressed in the organization and rules of operation of the council, but also in the time frames for institutional response required of these forums. Thus, deliberation over these agendas are carried out without ensuring that the indigenous peoples understand what is at stake in order to effectively participate in decision-making:

> *The Condisi is an instance that does not follow the indigenous logic of exercising political power, it is a blank instance in which, depending on the situation, people are either coerced or invited to endorse*

decisions that may cause severe damage, and they are vulnerable there, because, after all, it is a space in which control is given by the State [...]. *This is not something that only happens in the indigenous world, this happens in the SUS as a whole.* (Indigenist 2)

One constant thing that I noticed was that budgets were made a priori, they were submitted for approval and were made in such specialized language that most councilors couldn't read the spreadsheets, but they were encouraged and sometimes even convinced that they had to approve it right away because, otherwise, our region was going to be outside this budget. (Krenak/MG)

Finally, we reaffirm that indigenous participation in administration is crossed not only by the difficulty of intercultural dialogue, but also by the inflexibility of the administration in dealing with this population in a way that takes their difference into account (Teixeira; Simas; Costa, 2013). Although the Sasi exists, which proposes to be differentiated, in the functioning of social control this differentiation is not noticed. The State, which historically exerts power over indigenous peoples in an authoritarian manner, has not respected the traditional ways of political organization of this population, reaffirming the violent and colonial character of the Brazilian political elite (Souza Lima, 2015).

Thus, the organization of these spaces and the silencing of indigenous agendas are at stake. The laws and acts of government emanating from the State are not based on the indigenous logic of organization. In the long history of a colonization that has not yet ended, indigenous peoples are faced with the paradox that, in order to be recognized by the State, they need to approach the State and integrate themselves into their organizational logic. The question thus arises: how to ensure indigenous participation in spaces created with another rationality, an abyssal rationality (Santos, 2009), transforming them into spaces that challenge it?

The importance of SUS and Subsystem participation forums is undeniable. The data brought here, however, provide evidence to sustain the proposition that, over time, their increasing bureaucratization limited and conditioned the possibility of participation of indigenous peoples. They are spaces that, currently, have as its main goal to promote compliance with the legal obligations established in SUS regulations. They are thus regarded by the indigenous community as a space for legitimizing government proposals, opening up conflicts among indigenous peoples who demand that the actions of councilors be effective.

Breaking the silence: indigenous peoples moving through cracks of dialogue with the State

With increasingly structured and limited spaces silencing indigenous claims, other forms of participation gain momentum, such as the organization of the Acampamento Terra Livre and the invasions of Dsei and Sesai headquarters. In recent years, important movements with actions on social networks and a range of media have occurred to defend the financial autonomy of the Dsei, such as #OcupaSesai, and the permanence of the Sasi administration at the federal level in a specific department, the Sesai, with #NÃOAMUNICIPALIZAÇÃO (no to municipalization).[1]

Some indigenous people understand that these are not the most appropriate forms of claim, but when a space is silenced, these peoples in movement seek other ways to open up spaces for negotiation with the State. These movements are strengthened by the need to negotiate demands which, due to the silencing of social control environments and changes in the characteristics of participation, take the form of as "retail" demands and draw on "pressure", in ways that are closer to local, everyday life:

Then, we began somehow to rebel against the situation. When the District saw [...] *that the situation crossed the line, they mobilized themselves; the head of sanitation came* [...], *now the District coordinator comes to try to dialogue with the municipality, but this soon goes away; suddenly, if we can't keep the pressure, this is lost.* (Guarani/SP)

1 APIB - ARTICULATION OF THE INDIGENOUS PEOPLES OF BRAZIL. c2019. Available from: <https://apiboficial.org/>. Access on: May 18, 2019.

We only have a voice when we find some irregularity, then the indigenous peoples not only ensure their legitimacy, but also, in a form of pressure, that the body will fulfill its role. (Taurepang/RR)

It is possible to recognize that, considering the silencing of social control structures, the other forms of creating visibility for the demands of indigenous territories are those that open up spaces for some kind of response. As the internet is gaining room in the lives of all people, indigenous peoples are also appropriating and occupying it, transforming it into an environment for mobilization.

According to Krenak (2015), when he states that a movement is something with power, the results suggest that, despite mobilizations of a more limited scope, with more local demands, indigenous peoples seek different alternatives to protest. These movements seek to overcome the continued production of invisibility and the absence of recognition by the State of the several ways of life and needs of indigenous peoples. The permanent struggle to overcome this invisibility results in temporary and repeated displacements of this form of abyssal exclusion (Santos, 2009), with the emergence, even if through particular or localized instances, indigenous alternatives for the production of life and health care.

Final remarks

How to contribute to the amplification of indigenous voices that participate in spaces of social control? The answer involves, among other actions and initiatives, changing the existing forums, so that they are not reduced to spaces of discussion and legitimization of proposals elaborated by the administration or those few participants who, dominating the rules that organize these spaces, are able to identify and widen the gaps that allow some opening for dialogue.

The challenge to overcome the process of silencing indigenous participation is about how to engage with hierarchies between administrators, workers and patients, and between the knowledges and languages present in existing forums. The answer to this challenge involves, among other conditions, overcoming conflicts on the roles of the several instances, especially at federal level, strengthening each of them in order to promote and ensure social participation in indigenous health policies.

In the current political context, this silencing process is intensified. The 6th National Conference of Indigenous Health, called for 2019, has not yet taken place. The Sasi administration is limiting the number of Condisi meetings, and the existence of the FPCondisi is being discussed in Court due to Presidential Decree No. 9.759/2019 (Brasil, 2019), which extinguished forums and councils not provided for in law. In contrast to the current scenario of silencing, indigenous peoples move and occupy social networks, the Esplanade of Ministries, the Plenary of the Congress and administration spaces. These potent movements seek to overcome the barriers to the incorporation of their demands and to ensure their indigenous and constitutional rights by the State.

Given this scenario, it is fundamental to reaffirm the importance of indigenous participation to ensure and maintain their constitutional rights. We highlight here the guarantee of organization and functioning of Sasi as established in the Arouca Law and Pnaspi, with recognition of the protagonism of indigenous peoples in the spaces of social control and construction of the subsystem. Thus, it will be possible to re-establish its original role: to discuss a differentiated model of health care in indigenous territories. Public policies of social protection and care cannot be produced without legitimizing the participation of its protagonists.

References

BRASIL. Constituição da República Federativa do Brasil de 1988. *Diário Oficial da União*, Brasília, DF, 5 nov. 1988. Disponível em: <https://bit.ly/3iHvibW>. Acesso em: 14 set. 2017.

BRASIL. Lei nº 8.142, de 28 de dezembro de 1990. Dispõe sobre a participação da comunidade na gestão do Sistema Único de Saúde (SUS) e sobre as transferências intergovernamentais de recursos financeiros na área da saúde e dá outras providências. *Diário Oficial da União*, Brasília, DF, 31 dez. 1990.

BRASIL. Lei nº 9.836, de 23 de setembro de 1999. Acrescenta dispositivos à Lei nº 8.080, de 19 de setembro de 1990, que "dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências", instituindo o Subsistema de Atenção à Saúde Indígena. *Diário Oficial da União*, Brasília, DF, 24 set. 1999.

BRASIL. Ministério da Saúde. Gabinete do Ministro. Portaria nº 644, de 27 de março de 2006. Institui o Fórum Permanente de Presidentes dos Conselhos Distritais de Saúde Indígena. *Diário Oficial da União*, Brasília, DF, 29 mar. 2006.

BRASIL. Ministério da Saúde. Gabinete do Ministro. Portaria nº 755, de 18 de abril de 2012. Dispõe sobre a organização do controle social no Subsistema de Atenção à Saúde Indígena. *Diário Oficial da União*, Brasília, DF, 20 abr. 2012.

BRASIL. Ministério da Saúde. Gabinete do Ministro. Portaria de Consolidação nº 2, de 28 de setembro de 2017. Consolidação das normas sobre as políticas nacionais de saúde do Sistema Único de Saúde. *Diário Oficial da União*, Brasília, DF, 3 out. 2017a.

BRASIL. Ministério da Saúde. Gabinete do Ministro. Portaria de Consolidação nº 4, de 28 de setembro de 2017. Consolidação das normas sobre os sistemas e os subsistemas do Sistema Único de Saúde. *Diário Oficial da União*, Brasília, DF, 3 out. 2017b.

BRASIL. Decreto Presidencial nº 9.759, de 11 de abril de 2019. Extingue e estabelece diretrizes, regras e limitações para colegiados da administração pública federal. *Diário Oficial da União*, Brasília, DF, 11 abr. 2019.

BRAVO, M. I. S.; CORREIA, M. V. C. Desafios do controle social na atualidade. *Serviço Social & Sociedade*, São Paulo, n. 109, p. 126-150, 2012.

CARDOSO, M. D. Políticas de saúde no Brasil: do modelo assistencial à representação política. In: LANGDON, E. J.; CARDOSO, M. D. (Org.). *Saúde indígena*: políticas comparadas na América Latina. Florianópolis: UFSC, 2015. p. 83-106.

CASANOVA, P. G. Colonialismo interno (una redefinición). In: BORON, A. A. et al. (Org.). *La teoría marxista hoy*: problemas y perspectivas. Buenos Aires: Clacso, 2006. p. 409-434.

CECILIO, L. C. O.; CARAPINHEIRO, G.; ANDREAZZA, R. *Os mapas do cuidado*: o agir leigo na saúde. São Paulo: Hucitec, 2014.

CORREIA, M. V. C. *Que controle social?* Os conselhos de saúde como instrumento. Rio de Janeiro: Fiocruz, 2000.

CRUZ, K. R.; COELHO, E. M. B. A saúde indigenista e os desafios da particip(ação) indígena. *Saúde e Sociedade*, São Paulo, v. 21, p. 185-198, 2012. Suplemento 1.

FERREIRA, L. B. *O controle social no subsistema de atenção indígena*: uma reflexão bioética. 2012. Tese (Doutorado em Bioética) – Universidade de Brasília, Brasília, DF, 2012.

FUNASA – FUNDAÇÃO NACIONAL DE SAÚDE. *Política nacional de atenção à saúde dos povos indígenas*. 2. ed. Brasília, DF, 2002. Disponível em: <https://bit.ly/3iqvzA2>. Acesso em: 14 set. 2020.

GARNELO, L. *Política de saúde dos povos indígenas no Brasil*: análise situacional do período de 1990 a 2004. Porto Velho: Universidade Federal de Rondônia, 2004. (Documento de Trabalho n. 9). Disponível em: <https://bit.ly/30EaUBC>. Aceso em: 13 dez. 2017.

KRENAK, A. *Encontros*. Rio de Janeiro: Azougue, 2015.

LANGDON, E. J.; DIEHL, E. E. Participação e autonomia nos espaços interculturais de saúde indígena: reflexões a partir do sul do Brasil. *Saúde e Sociedade*, São Paulo, v. 16, n. 2, p. 19-36, 2007.

MATTOS, R. A.; BAPTISTA, T. W. F. Sobre política (ou o que achamos pertinente refletir para analisar políticas). In: MATTOS, R. A.; BAPTISTA, T. W. F. (Org.). *Caminhos para análise das políticas de saúde.* Porto Alegre: Rede Unida, 2015. p. 83-152.

MENÉNDEZ, E. L. *Sujeitos, saberes e estruturas*: uma introdução ao enfoque relacional no estudo da saúde coletiva. São Paulo: Hucitec, 2009.

MINAYO, M. C. S. *O desafio do conhecimento*: pesquisa qualitativa em saúde. São Paulo: Hucitec, 2013.

MUNDURUKU, D. *O caráter educativo do movimento indígena brasileiro (1970-1990)*. São Paulo: Paulinas, 2012.

NUNES, J. A. et al. A emergência do sujeito participativo: interseções entre ciência, política e ontologia. *Sociologias*, Porto Alegre, v. 20, n. 48, p. 162-187, 2018.

OIT – ORGANIZAÇÃO INTERNACIONAL DO TRABALHO. *Convenção nº 169 sobre povos indígenas e tribais e resolução referente à ação da OIT*. Brasília, DF, 2011.

PAULA, L. R.; VIANNA, F. L. B. *Mapeando políticas públicas para povos indígenas*. Rio de Janeiro: Laced/UFRJ, 2011.

SANTOS, B. S. Para além do pensamento abissal: das linhas globais a uma ecologia de saberes. In: SANTOS, B. S.; MENESES, M. P. *Epistemologias do Sul*. Coimbra: Almedina, 2009. p. 23-72.

SANTOS, B. S. *O fim do império cognitivo*: a afirmação das epistemologias do Sul. Coimbra: Almedina, 2018.

SÁ-SILVA, J. R.; ALMEIDA, C. D.; GUINDANI, J. F. Pesquisa documental: pistas teóricas e metodológicas. *Revista Brasileira de História & Ciências Sociais*, Santa Vitória do Palmar, v. 1, n. 1, 2009.

SOUZA LIMA, A. C. Sobre tutela e participação: povos indígenas e formas de governo no Brasil, séculos XX/XXI. *Mana*, Rio de Janeiro, v. 21, n. 2, p. 425-457, 2015.

TAULI CORPUZ, V. *Declaração de fim de missão*. Genebra: Conselho de Direitos Humanos das Nações Unidas, 2016. Disponível em: <https://bit.ly/35GIrhR>. Acesso em: 15 fev. 2017.

TEIXEIRA, C. C.; SIMAS, D. H.; COSTA, N. M. A. C. Controle social na saúde indígena: limites e possibilidades da democracia direta. *Revista Tempus*, Brasília, DF, v. 7, n. 4, p. 97-115, 2013.

VALLA, V. V. Sobre participação popular: uma questão de perspectiva. *Caderno de Saúde Pública*, Rio de Janeiro, v. 14, p. 7-18, 1998. Suplemento 2.

Authors' contribution

Scalco conceived the study and collected the data. Louvison collaborated in the study design. All authors contributed to data analysis and writing of the article.

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