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First Indigenous Health Forum: Construction and spreading of the Indigenous Health Agenda in the 1990s

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Abstract *The Indigenous Health Conferences (IHC) have been the political spaces for expressing and consolidating ideas and proposals. However, in 1993, the "First Indigenous Health Forum" was held a few months before the second IHC. With a historical approach, this paper aimed to understand the organization and impacts of this Forum in the construction of Brazilian Indigenous Health policies during the 1990s. We analyzed an unpublished set of documents organized as a Dossier by Dr. István Varga and deposited in the University of São Paulo's library. We discuss that a strong connection with the First Indigenous Health Forum was established between the first and second IHC. The argumentative structures and proposals formulated in the First Indigenous Health Forum were reinforced during the subsequent events culminating in the Second IHC.*

Key words *Health of Indigenous Populations, Social Control, Social Participation, Health Conferences*

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Introduction

The 1988 Brazilian Constitution (CF88) paved the way for realizing social aspirations that had developed in Brazilian society in previous decades. The literature indicates CF88's relevance for Indigenous rights. Cardoso[1] reinforces that, in the case of Indigenous Health, the CF88 opened space for developing a differentiated subsystem dedicated to serving Indigenous populations.

Indigenous peoples thus began to demand the institutionalization of respect for their sociocultural and linguistic diversity in health services. Furthermore, the premise of Indigenous people's active participation in healthcare management was assumed[2].

On the other hand, the Indigenous Healthcare Subsystem (SasiSUS) has faced many challenges in responding to the demands of the diverse realities in which these peoples live since its institutionalization in 1999, and it can be argued that it occupies a peripheral place within the Unified Health System (SUS)[3]. The trajectory of the current Indigenous health policy is marked by social struggles driven by the Indigenous social movement, Indigenous, and the health movement itself, in an articulation produced throughout the 1970s and 1980s[4]. Based on historical research, the collection *Policies Before the Indigenous Health Policy*[5] systematizes the political and social arrangements that contributed to formulating and establishing what we know today as SasiSUS.

Santos *et al.*[6] emphasize that, after two decades of implementation, it is essential to recognize SASI-SUS advances in financing, service extension, and Indigenous participation in social control. On the other hand, these authors point out many other persistent challenges, such as the low quality of services provided at the local level, the challenges of qualifying professionals, and the lack of basic sanitation in Indigenous communities.

Analyzing the history behind this policy contributes to understanding the contradictions and disputes that founded the field of Indigenous Health itself. The construction of health policy is a conflicting process that involves a set of divergent forces[3]. Tensions, advances, and setbacks[6] have marked the trajectory of Brazilian Indigenous Health policies. Among the milestones and historical background recurrently analyzed in Indigenous Health are the First National Conference on the Protection of Indigenous Health (CNPSI) in November 1986 and the Second National Health Conference for Indigenous Peoples (CNSPI) in October 1993. However, we only found in Diehl[7] an analysis of the repercussions of the First Indigenous Health Forum held on April 22-26, 1993 – an event organized by the National Health Foundation (FUNASA) and FUNAI –, with a lack of a more in-depth analysis in the literature of the role of this Forum in the development of the Indigenous Health policy and which, from the methodological perspective adopted, fundamentally contributed to consolidating the main theses presented in the First CNPSI and to the proposals of the Second CNSPI. Not even the PNASPI (2002) in the "background" section mentions the existence of the First Forum.

About a Dossier on a Library Shelf

In 2001, István Van Deursen Varga, currently a professor at the Federal University of Maranhão, deposited a set of documents in the Public Health Library of the University of São Paulo (USP) that were relevant to understanding the context that preceded the Second CNSPI. These documents, herein referred to as the "Varga Dossier", are related to the First Indigenous Health Forum and the preparatory conferences for the Second CNSPI. Also, Varga includes a report describing his impressions of this period in the Dossier. The collection had been compiled throughout 1993 when Varga conducted his activities at FUNASA's Indigenous Health Coordination Office (COSAI/FUNASA).

We opted for the word "Dossier" to stress that it is a collection of documents related to a historical process. The Dossier is 296 pages long and consists of 32 documents, including material on regional and state health conferences, motions, and reports on Varga's activities. Since it was deposited approximately two decades ago, the volume was not withdrawn through loan until 2018, when it was located by one of the participants in the research "Health of Indigenous Peoples in Brazil: Historical, Sociocultural and Political Perspectives" and incorporated into the documentary collection of this project and made available in the Virtual Library on the Health of Indigenous Peoples. The "Varga Dossier" was organized by a character involved in the central dynamics related to Indigenous peoples' health public policies in the 1990s and whose analysis potentially sheds light on the understanding of the transformation process in Brazilian Indigenous Health.

Varga is a doctor who graduated from the then São Paulo Medical School (EPM). While

still in his early years of medical school, he made his first trip to the Xingu region. This event would mark the beginning of his relationship with Indigenous peoples, as he recounted in an interview. He worked at the São Paulo State Health Secretariat and created an Indigenous Health working group there. In 1993, Varga was invited to join COSAI/FUNASA in Brasília and was Executive Coordinator of the First National Forum on Indigenous Health and the Second CNSPI.

The decision to forward the Dossier to the USP Library occurred after Varga was surprised – as he indicated – in 2000 with the demand of "an employee of FUNASA's Indigenous Health Department requesting him to send this Documentation to Brasília for the preparation of a report of both events, as part of the work of organizing the III National Indigenous Health Conference"[8]. Varga questioned the fact that FUNASA itself did not have such documents, since copies of them were also sent to COSAI/FUNASA when they were produced. "The person who sent me this request said that she had looked for them in all the archives without success"[8]. This situation illustrates the little attention to institutional memory and public policies, and we would have fewer elements to know this story if it were not for the hands of an agent who took the initiative to save some public documents.

This article aims to understand the role of the First Indigenous Health Forum in shaping health policies for Brazilian Indigenous peoples. The analysis sought to compare documents in the Dossier with a set of interviews that make up the collection of the project "Health of Indigenous Peoples in Brazil: Historical, Sociocultural and Political Perspectives" (CONEP Opinion No. CAAE 61230416.6.0000.5240) with the literature.

From a methodological viewpoint, we rely on the formulations proposed by Bourdieu[9] to analyze policies, in particular, the search for understanding the specific interests of social agents, their priorities and interactions, and the identification of the ideas and argumentative elements at the policy's genesis. Bourdieu's reading indicates

The concept of agent does not reveal a human action free from contingencies since it is influenced by the 'structured structure' of the field, by its regularities and logic and its sense of play. The agent is the one who acts and fights within a field of interests, having in his action principles and inculcations of these logics that are immanent to him, produced in the encounter of the individual histories of the agents with the collective history of the field[9] (p.29).

The Bourdieusian socio-historical approach allows us to understand the dynamics that underpin the processes of constructing public policies. Thus, from this methodological perspective, understanding the genesis of a health policy is not limited to merely finding out who the agents were or narrating the description of the chronology of the facts; in a more comprehensive and integrated way, it implies, especially, understanding the interests involved and the circumstances that made its emergence possible in a specific historical context[9]. "This understanding requires analyzing the structure and dynamics of a space of relationships between social agents [...] who share interests regarding the Policy's object"[9] (p.22).

The analysis undertaken here focused on the 32 documents that make up the Dossier and was guided by the historical memory of the interview conducted with Varga. The entire process of historical reconstruction presented here was conducted in dialogue with central authors in Indigenous Health, such as Cardoso[1], Langdon[2], Garnelo[3,10], Santos *et al.*[6], Diehl[7], Pontes[11], and Verani[12].

The 1990s: Transitions, contradictions, and tensions

In 2002, the PNASPI was launched as an integral part of the SUS. As highlighted by Mendes *et al.*[13], this political strategy was developed with the premise that its implementation would align with the fundamental principles of the SUS, which emphasize decentralized actions and resources and promote universality, comprehensiveness, equity, and social participation. In this context, PNASPI also underscores the importance of meaningfully considering issues related to the cultural, ethnic, geographic, epidemiological, historical, and political diversity of Indigenous peoples.

The adoption of such a policy, however, is part of a set of profound transformations within the Brazilian State that unfolded as a result of the CF88. Firstly, we emphasize that with the CF88, "a 'legal' end was thus put to the tutelary regime"[14] (p.440). "Before the reformulation of the Brazilian Constitution in 1988, Indigenous peoples were protected by the State. Deprived of rights, the expected trajectory was progressive assimilation by the rest of the Brazilian population"[10] (p.1). Scalco *et al.*[15] highlight that the Indigenous movement managed to secure the Popular Amendment promoted by the Union of Indigenous Nations (UNI) in the Constitution.

Chapter VIII of the Constitution, entitled "About the Indigenous people", unequivocally recognizes the status of Indigenous peoples as Brazilian citizens. The CF88 paved the way for implementing health policy strategies targeted explicitly at such groups[16], affirming the right to social participation as a principle of State action.

Despite constructing Article 196 of the 1988 Federal Constitution, the SUS did not find sufficient institutional and financial support for its materialization. The 1990s saw the end of INAMPS, the birth of decentralization, the transformation in the logic of health financing, and the creation of dozens of public policies. This decade was responsible for the beginning of the change in the logic of the old healthcare attention model, including in Indigenous health actions. The erosion of this model shook FUNAI's foundations, which, according to Santilli, was a "living dead that will continue to hover over the Indigenous policy until there are consistent alternatives to this model"[17] (p.48).

We should highlight that, within the profound transformations in Indigenous Health in the 1990s, the idea of an Indigenous Health District emerged from formulating the Brazilian health reform itself, but in contrast to the predominant perspective of health municipalization[11]. However, the transformation of this model had already been considered in the 1980s, among other spaces, within the very FUNAI, which even held some events to formulate guidelines to restructure care provided to Indigenous communities[4]. Relevant argumentative elements that would be affirmed in subsequent years, such as in the 1990s, already appeared in the reports of these events. One of these, for example, highlighted 1) Indigenous participation as the basis of policy; 2) The need for recognition of Indigenous medicines; 3) The defense of access to all healthcare levels of the health system; and 4) The qualification of health workers in anthropological knowledge to work in the territories.

However, the healthcare model implemented by FUNAI was eminently campaign-based, curativist, and privatist, aligned with the models that had predominated for decades in the work of the Indigenous Protection Service (SPI)[4] (p.149). Furthermore, based on constitutional principles, the approval of Law No. 8,080/1990, and the demands of the Indigenous movements, the implementation of the Indigenous Health Policy should necessarily cease to be part of FUNAI's attributions and become part of the Ministry of Health (MS) actions. In this regard, the 1999 Arouca Law expresses and institutionally consolidates a broad understanding that emerged from the conflict and institutional contradictions between the MS, through FUNASA, and the Ministry of Justice, through FUNAI, a process known as the "long Indigenous Health Reform"[18]. The establishment of the PNASPI should not be understood as a static moment in the timeline of policy creation, but considering its temporal depth, the complexity of the social and institutional actors involved, including the social movement and the articulations with the health movement, among other dimensions.

FUNAI - FUNASA tensions

The 1990s were marked by conflict between FUNAI and FUNASA over Indigenous Health[10]. FUNAI emerged from the extinction of the SPI in 1967, and FUNASA emerged from the 1991 merger of the Public Health Services Foundation (FSESP) and the Superintendence of Public Health Campaigns (SUCAM). The 1990s brought several transformations that put these two institutions in a situation of conflict and dispute over the operationalization of healthcare for Indigenous peoples.

The imbroglio became particularly evident after the publication of Decree No. 23 of February 4, 1991, which established the conditions for providing healthcare to Indigenous populations. This decree removed FUNAI from its role in the health issue and transferred it to FUNASA, even creating a hierarchy between them. This regulation lasted three years and was replaced by Decree No. 1,141 of May 19, 1994. In the context of Decree No. 23, "the Indigenous Health Coordination (COSAI) was created within the Ministry of Health, subordinated to FUNASA's Operations Department (DEOPE), with the responsibility of implementing the new Indigenous healthcare model"[19].

As a result of this conflict, an already weakened care system aimed at Indigenous populations was fragmented. This refers back to the paradigm that existed before the creation of the SUS, in which curative-related responsibilities were delegated to FUNAI while preventive measures were under the purview of the Ministry of Health[18]. Furthermore, one of the sections of the Forum's report evidences the context of Decree No. 23 and its repercussions for the organization of the Indigenous Health policy.

This caused an almost total strangulation of the bureaucratic and operational channels that

should bring healthcare to the villages. It is impossible to calculate the real consequences of this situation today, but it is easy to see the countless deaths and the physical disappearance of Indigenous communities[8].

The swinging responsibilities, lack of dialogue and planning, and differences in the capacities of action between FUNASA and FUNAI, combined with the lack of resources, led to a greater fragility in coordinating initiatives targeting Indigenous Health[7]. This conflict strongly marked the trajectory of this area in Brazil. Tensions between the two entities increased during the 1990-1999 period, culminating in the revocation of Decree No. 23 and the subsequent adoption of Decree No. 1,141. This latter act restored responsibility for healthcare for Indigenous peoples to FUNAI. However, another government document (Normative Resolution No. 001/1994) maintained the relationship between the Ministry of Health and Indigenous Health, confirming its responsibility for implementing preventive measures in the communities[3].

FUNAI's work was characterized by the emergency nature of its interventions, generally marked by specific and isolated actions permeated by a "catastrophism" bias[12]. Also, FUNAI faced a budget allocation that reflected the low social stimulus directed at Indigenous peoples, especially after its incorporation into the Ministry of Justice, in which it was not seen as one of the priority areas.

Besides the general lack of prestige, Santilli argues that the institution had problems regarding its technical capacity to propose budgets, "Not even God would approve FUNAI's budget proposal if he analyzed it for a second. [...] We can derive from this that one can get an idea of the institution's credibility in the upper echelons of government"[17] (p.40).

Verani[12] highlights that the transfer of responsibility for Indigenous Health to the Ministry of Health, even in a context of discredit, brought a considerable injection of resources and technical and human capacities due to the commitment of resources from the Ministry of Health and funding from international organizations.

The dispute between FUNAI and FUNASA continued until the late 1990s, ending only with the enactment of the Arouca Law (No. 9,836) in 1999. It is essential to revisit the argument developed in the previous section and understand that the conflict in question became a central element in developing the incipient Indigenous Health Policy[11]. Within this conflict, stakeholders committed to transforming the field were mobilized and the main ideas and arguments disseminated throughout the decade were developed. This was the "space of possibilities"[9] from which, to a large extent, the Indigenous Health Policy emerged.

The new COSAI coordination organized the First National Forum on Indigenous Health in 1993 in this conflicting context. Varga affirms that the context of the intense dispute between FUNASA and FUNAI is the "main cause of inaction, duplicated actions, wasted resources, and the ever-widespread serious health situation of Indigenous peoples in the country" where "the Indigenous have been the greatest losers"[8]. Thus, the Forum aimed to "establish a cooperation plan between FUNASA and FUNAI in Indigenous Health and define the guidelines for the action plan of the new COSAI team". In this way, the Forum aimed to establish a collaboration plan between FUNASA and FUNAI and outline the guidelines to be adopted by the action plan of the newly installed COSAI team, which began its activities in March 1993.

The First Indigenous Health Forum

We understand that the First Indigenous Health Forum, whose structure and functioning will be discussed later, can be interpreted as an attempt to build a space for mediation (especially of conflicts) between a public policy in erosion (that of FUNAI) and another in emergence (Indigenous Health as a SUS subsystem, then under the responsibility of FUNASA).

We emphasize that the First CNPSI of 1986 already called for Indigenous participation in all decision-making bodies in its final report and creating an agency linked to the Ministry of Health to integrate the specific Indigenous Health system into the national system. These two central points guided the political actions of the new COSAI coordination. Arouca himself recognized that "the First CNPSI aimed to contribute to the Indigenous perspective in health reform, which shows a close connection between this reform and the debates on a new health policy for Indigenous peoples"[20] (p.5). The second CNSPI was held seven years after the first and aimed to define the principles and guidelines of the "Differentiated Indigenous Health Care Model".

Thus, we can state that the First CNPSI report focuses on "doctrinal principles", outlining the foundations that would support future perspectives regarding the provision of healthcare for Indigenous populations. In contrast, the

report of the Second CNSPI presents strategic formulations aimed at implementing this proposed health system. The First CNPSI recorded a demand that the management of Indigenous healthcare be linked to the MS[13].

The First Indigenous Health Forum and several regional and state preparatory conferences for the Second CNSPI were held between one conference and another. The fact is that "in Indigenous Health, the legal frameworks made little progress during the 1980s and 1990s, and the specific participatory forums for Indigenous societal stakeholders were restricted to the two conferences"[7] (p.336).

The Forum was convened immediately after Varga was appointed to COSAI. In the presentation of the Forum report, he explained that the idea for a Forum had emerged during the Fourth Medical Anthropology Course at EPM in 1992, therefore, after the publication of Decree No. 23. At the end of this event, the participants sent an urgent request to FUNASA, already outlining what the future Forum would be. Varga, who was part of the Indigenous Health coordination team at the State Secretariat of São Paulo, worked with the Indigenous Health group at the EPM and became responsible for organizing the Forum a year after the request. In one month, the team he coordinated planned, organized, invited, and conducted the activity. Varga believed that the Forum would become a qualified, permanent, broad, and agile body capable of mobilizing stakeholders and directly influencing the direction of policies.

In the research, we could not find precise information on how many people participated in the First Forum. However, we identified 102 signatures on the attendance list contained in the Dossier. The financing of the event is also unclear. However, the documentation shows that the expenses for accommodation, meals, and transportation were covered by the United Nations Development Programme (UNDP), even though, as we will see later, FUNASA did not commit to holding the event. The call for participants to the Forum summoned "institutions and organizations interested in participating" to cooperate "by covering, as far as possible, their transportation, accommodation, and food expenses"[21] (p.6).

In his memorial attached to the Dossier, Varga highlights the idea of overcoming Indigenous Health disputes that marked the 1990s:

The First Forum aimed to establish and indicate, in an expanded public space, the diagnosis and solutions for the main political and operational problems of Indigenous Health, and facilitate the overcoming of disputes between FUNAI and FUNASA, through a democratic discussion, involving Indigenous representatives and employees of all levels, from both institutions, on their respective specific attributions in Indigenous Health, toward real interagency cooperation[8].

The final assessment contained in the document of the First Forum mentions progress and seeks to value the COSAI team's initiatives:

With a massive representation of FUNAI administrators and employees, non-governmental organizations, and the participation of several Indigenous representatives, the First Forum was relatively successful in achieving practically all the objectives and goals it set out to achieve[8].

However, despite the perception of success indicated in the records, the document points out critical difficulties that can be seen as, to a large extent, marks of the history of Indigenous Health. Thus, we underscore, firstly, the "lack of qualified correspondents [...] at FUNASA's central level [...] with the power to deliberate to provide answers to the questions, requests, and referrals of the Forum" and the "lack of the vast majority of FUNASA Regional Coordinators". Secondly, the document acknowledges the "insufficient Indigenous representation". It also mentions the lack of time to organize the event and the difficulty in identifying the "representative power and criteria for participation of the numerous Indigenous organizations in the country". It emphasizes the need "to define criteria and methodologies to ensure and foster Indigenous participation in organizing the Second Forum in 1994". Finally, it acknowledges the lack of financial resources for organizing the event. At the end of the presentation document of the report signed by Varga, attention is drawn to the fact that there were no funds even for publishing the final report. Varga emphasized that the distribution of the final Forum material "was only possible thanks to the contributions of the São Paulo State Health Secretariat (photocopying and binding), where Varga worked, and the Pan American Health Organization (postal service)".

Despite all these obstacles, two ordinances were published as a result of the Forum: Ordinance No. 540, which defined the implementation of the Interagency Indigenous Health Centers (NISI), and Ordinance No. 541, which appointed representatives from the Operations Department, the Attorney General's Office, the General Auditor's Office, the Strategic Planning Advisory Office and the Administration Department of FU-

NASA, to work together with FUNAI and elected representatives of the First Forum to discuss ways of applying funds for Indigenous Health.

According to Varga, the organization and operationalization of the First Forum and the Second CNSPI "disturbed the corporatist interests of the FUNASA and FUNAI staff", so that FUNASA did not send the coordinators and directors who held "vital information about the financial resources available for Indigenous Health", making a more in-depth discussion on this topic at the First Forum unfeasible[8]. Despite the COSAI team's initial proposal to hold this Forum annually, this did not happen. It is clear that although there was an initial intention to set up a mediation space, this possibility was met with strong resistance due to the intense disputes at that time.

We have chosen, here, the term 'sabotage', as we consider it more appropriate in this case than the term 'boycott', for example, since, as will be seen below, the several actions developed by the then FUNASA leaders to make these events [First Forum and Second CNSPI] unfeasible were developed in a concealed manner, while the institution gave official and public signs of providing broad support for their realization[8].

The First Forum Report is very brief (5 pages) and focuses on structuring a work plan to demarcate Indigenous Health relationships and actions. It is structured into four major lines of action, one motion, two recommendations, and the four reports (about five pages each) of the working groups held during the Forum, divided by Macro-regions, which contain diagnoses and specific proposals for each region.

The first axis ("Division of Responsibilities MS/FUNASA – MJ/FUNAI") seeks to determine (a word used in the report) lines of action for these institutions. Firstly, the report suggests that Indigenous Health social participation bodies should support any action in Indigenous Health. The report then highlights the need to promote technical training for Indigenous Health workers, health professionals, and technicians from the cooperation field and NGOs (one of the pre-conference reports highlights the issue of ethics in this training). Moreover, it suggests recruiting and incorporating Indigenous Health workers into the SUS staff.

The "Structural Measures" axis demands that the Indigenous Health Coordination be directly linked to the Minister of Health's Office (as proposed by the First CNPSI).

The "Political Strategies and Organizational Model" axis proposes the creation of Indigenous Health Interinstitutional Centers (NISI) in the Federation states, "with equal composition between users and service providers". The idea was that the NISIs would be established as strategic bodies in implementing the several Special Indigenous Health Districts. Diehl[7] emphasizes that the NISIs were initially conceived as strategic elements intended to facilitate the implementation of health districts. Later, the NISIs would serve as regional coordination bodies between the several districts, thus making them precursors of local and district Indigenous Health Councils. The NISI proposal was incorporated into the Second CNPSI but was not implemented nationwide, but only in some states, such as São Paulo and Roraima.

The last axis ("Measures to Implement a Joint Work Plan") presents the names of elected representatives to "prepare a consolidation of the problems and solutions listed by macro-regions"[8] (MR) and monitor the development of the work of the commission to be appointed by FUNASA and FUNAI. This commission would have the task of "regulating the application of the resources available for Indigenous Health per the guidelines established by the competent forums"[8].

Marcos Pellegrini and Elimilton Correia de Alencar were elected for the Amazon MR; Claudio Luiz Santana and Petrônio Cavalcante Filho were elected for the Northeast MR; José Fabio de Oliveira and Juraci Coelho de Oliveira were elected for the Midwest MR; and Angela Maria Bastos and Lucio Flávio Coelho were elected for the South-Southeast MR. Four Indigenous representatives were elected: Euclides Macuxi, Maiowê Kayabi, Pedro Salles, and João Saterê.

The motion approved in the report recommends "the review of the Presidential Decrees that removed the management of agricultural affairs, education, and environmental inspection from FUNAI", given the agency's technical capacity and knowledge.

Finally, the report presents two recommendations. The first was that COSAI should become a department of the Ministry of Health. The second recommended that the Second Conference make proposals for regulating Decree No. 23.

The MRs' reports consolidate the problems and specific solutions for each region. However, although the reports point out some specificities, in general, they reproduce the agenda of the First Forum, with the implementation of NISIs as the standard solution and the hierarchical position of COSAI in the MS, the relationships between FUNAI and FUNASA and the need for regulation

of Decree No. 23 as central themes. The issue of land invasion and the need for demarcation, the lack of funds for Indigenous Health, and the need to hire professionals were addressed cross-sectionally in these documents.

We understand that the MRs' reports can be seen as the result of a strategy to spread the central agendas of the COSAI coordination expressed in the First Forum report. This strategy was central to the proposal of strategies to address the devastating situation in Indigenous Health in the country.

In the months following the First Forum (May to October 1993), several State Conferences were held in preparation for the Second CNSPI. Several reports from these Conferences are also included in the Dossier. An analysis of this material shows that the State Conferences served as sounding boards for the ideas of the First Forum.

Finally, seeking to shed light on the disputes at the genesis of the Policy[9] and as an illustration of the level of tension out there, we highlight an episode reported by Varga during the final plenary session of the First Forum. There were two proposed paths to be adopted regarding Decree No. 23: one called "Revision", defended by FUNAI employees, and another called "Regulation", defended by FUNASA employees. There was room in the plenary for one person to defend each proposal. According to Varga, "In an opportunistic and unfair maneuver", a FUNASA employee asked to speak to defend the "Revision" proposal but ended up defending the opposite one. He said, "Chaos ensued in the plenary", and the "Regulation" proposal was effectively approved.

Final considerations

The contextualization of the documents in the Varga Dossier refers to the disputes and debates prevalent in Indigenous Health in the 1990s. They lead us to understand that there is a historical arc that started in the First CNPSI but with a strong anchoring in the First Forum, which led to the Second CNSPI, whose argumentative structures of its proposals were supported by State Conferences' reinforcement to the theses of the First Forum. Therefore, we should emphasize that the First and Second Indigenous Health Conferences are not isolated moments of bureaucratic compliance. On the contrary, they are closely connected events, separated only by time, whose fabric of the second was woven over the years (with the First Forum and the Pre-Conferences). Diehl[7] also highlights that some political strategies and organizational models proposed by the First Forum were strengthened through specific standardization and ratified during the Second CNSPI.

It seems to us that what qualitatively separates and distinguishes the First Conference (1986) and the Second CNSPI (1993) is precisely the historical and political distance between the experiences of the initial moment of the configuration of an Indigenous movement in Brazil led by a "vanguard", a more restricted number of leaders, and that of its expansion and achievements, after seven years of struggles and learning, with the much more massive direct participation of Indigenous communities[8].

A hallmark of this historical arc is the concretized idea of parity between Indigenous and non-Indigenous people in the social participation bodies, as demanded by the First CNSPI. After all, this was a context of attempts to overcome the idea of tutelage, which the CF88 suppressed. In an interview given to the project, Varga recognizes that FUNASA "struggled to work on this Social Control story". The final plenary session of the First Forum had already elected a joint working committee that would become the "political core of the Organizing Committee of the Second CNSPI"[8]. Since the First Forum, the idea of parity in representation has been identified in the most diverse bodies and institutional discussion stages, being the driving force behind municipal, state, macro-regional, and national pre-conferences, including the composition of the NISIs and the Indigenous Health District Councils.

The centrality of Indigenous participation became so prominent that the name of the Health Conference itself was changed at the request of Pedro Sales, a leader of the Kaingang people, as reported by Varga in the Dossier. Thus, the second conference was called the National Health Conference for Indigenous Peoples. The generic and homogenizing term "Indian" was replaced by the expression "Indigenous peoples", which, as argued, "makes explicit and emphasizes all this plurality and its communities". The expression "Health protection", which alluded to "the paternalistic and welfare-based nature of tutelage", was replaced by the term "Health". The pronoun "of" was replaced by the preposition "for", "since the initiative to convene and promote the Second CNSPI did not stem from the Indigenous people, but from the Ministry of Health".

Collaborations

MA Abrunhosa and FRS Machado worked on the conception, design, analysis, and interpretation of data, writing, and final review. ALM Pontes and RV Santos worked on the conception, design, and final review.

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