Dossier

Health policies and Indigenous peoples: experiences in managing the COVID-19 pandemic

Políticas de saúde e povos indígenas: experiências de gestão da pandemia de covid-19

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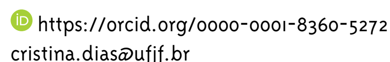
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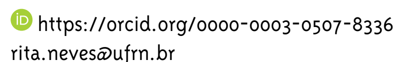
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Abstract

Since the 2000s, anthropological research has accumulated important insights on the universe of Indigenous health policies proposed by the Brazilian State, especially the reorganization of Indigenous health services via special Indigenous health districts (DSEI). This research systematically addresses the development of health policies for Indigenous peoples focusing on the possibilities and limits of the differentiated care model proposed, as well as on forms of social participation. Our objective is to analyze some strategies of action and resistance through an articulated analysis of two ethnographic fields: (1) the 2023 annual assembly of the Xukuru people of Ororubá (RN), which brought to the center of the debate an assessment of the subsystem and the actions carried out by them before and during the pandemic, (2) the coping plans and epidemiological bulletins released by the Special Secretariat for Indigenous Health (SESAI) during the 2020-2022 period. The pandemic was a period in which Indigenous peoples spoke out in defense of the subsystem. Thus, we sought to describe how the pandemic scenario highlighted aspects of forms of Indigenous mobilization that deserve space for reflection by revealing connections between therapeutic itineraries and political itineraries.

Keywords: Indigenous Health; Public Policy; COVID-19 pandemic; Document Ethnography; Ethnology.

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Resumo

Desde os anos 2000, as pesquisas antropológicas acumularam importantes perspectivas sobre o universo das políticas de saúde indígena proposta pelo Estado brasileiro, em especial a reorganização dos serviços de saúde indígena através de distritos sanitários especiais indígenas (DSEI). Tais pesquisas abordaram de forma sistemática a produção política da saúde voltada para os povos indígenas, com análises e questionamentos focados nas possibilidades e limites do modelo de atenção diferenciada proposto, bem como das formas de participação social. Nosso objetivo neste artigo é analisar algumas estratégias de ação e resistência por meio de uma análise articulada de dois campos etnográficos: (1) a assembleia anual de 2023 do povo Xukuru do Ororubá (RN), que trouxe para o centro do debate uma avaliação do subsistema e das ações realizadas por estes antes e durante a pandemia; (2) os planos de enfrentamento e boletins epidemiológicos divulgados pela Secretaria Especial de Saúde Indígena (SESAI) durante o período 2020-2022. A pandemia foi um período em que os povos indígenas se pronunciaram em defesa do subsistema. Assim, voltamo-nos a tentar imaginar como o cenário da pandemia destacou aspectos das formas de mobilização indígena que merecem espaço de reflexão por desvelar conexões entre itinerários terapêuticos e itinerários políticos.

Palavras-chave: saúde indígena; políticas públicas; pandemia de covid-19; etnografia de documentos; etnologia indígena.

Introduction

The purpose of this article is to reflect on the Indigenous health policies adopted by the Brazilian state, based on the conceptual debate produced by three anthropologists, Jean Langdon, Luiza Garnelo, and Carla Teixeira, who have systematically addressed the political production of Indigenous health. By dealing with different aspects of the problem, these authors' works focus on the possibilities and limits of the differentiated care model, as well as the forms of social participation. Based on this framework, we seek to analyze some of the strategies of Indigenous resistance to violence co-produced by the state as long-term historical situations. We therefore propose a debate based on two sets of ethnographic data: (1) the 2023 annual assembly of the Xukuru people of Ororubá (RN), whose accumulation of reflective production brought to the center of the debate an evaluation of the subsystem and the actions taken by them during the COVID-19 pandemic; (2) the coping plans and epidemiological bulletins released by the S*ecretaria de Saúde Indígena* (SESAI – Special Secretariat for Indigenous Health) during the 2020-2022 period. The pandemic was a time when Indigenous peoples spoke out in defense of the subsystem, and so we sought to understand how this scenario of profound crisis in public health highlighted forms of Indigenous mobilization that deserve space for reflection because they reveal the connection between therapeutic itineraries and political itineraries.

Historically, since the creation of the *Subsistema de Atenção à Saúde Indígena* (SasiSUS – Indigenous Health Subsystem) in 1999, anthropology has contributed to producing a qualified reflection on the subsystem, based on analysis and experiences with ethnographic data produced in different realities throughout Brazil. Several anthropologists, such as Garnelo (2003), Langdon (2004), Teixeira (2012), Athias and Machado (2001), Cardoso (2015), among others, have dedicated themselves to evaluating the subsystem over the years, not only to discuss public policies aimed at the reality of Indigenous peoples, but also to present proposals that articulate and respect cultural specificities in the field of

Indigenous health. For a better contextualization of the proposal, we understand that this literature complements each other and represents an important set of analyses and questions about the limits and possibilities of a certain model of differentiated care, the one proposed in the *Política Nacional de Atenção à Saúde dos Povos Indígenas* (PNASPI – National Policy for Health Care for Indigenous Peoples, BRASIL, 2002), whose forms of social participation continue to be built and demanded by Indigenous peoples as a central part of the subsystem's strategy. In theoretical-methodological terms, therefore, we propose reflecting on the situation of Indigenous health through this ongoing exercise of (re)contextualizing people and documents in detail, through a logic that acts on the networks of historically created relationships, based on the ethnographic case of the assemblies between the Xukuru of Ororubá and the documents, understood as part of state practices.

An anthropology of practices

Anthropologist Jean Langdon has worked as a researcher in the field of Indigenous health since before the creation of the Indigenous health subsystem and has always treated it as a social practice, a broad, non-neutral phenomenon, inserted in a political field, which is why her work, while emphasizing the importance of analyzing local practices and knowledge, discusses the circulation and possibilities of dialogue or confrontation in the biomedical field.

One of the concepts most debated by Langdon is that of differentiated care as proposed in the PNASPI. As the fundamental concept that defines the subsystem, in many of the texts produced individually or together with other researchers, Langdon criticized the rigid way in which the model was implemented (Langdon, 2004; Langdon and Diehl, 2007; Langdon and Cardoso, 2015; Langdon and Garnelo, 2017). For the author, the ethnographic dimension of research with indigenous people has shown that issues such as medical pluralism and multiplicity, which are necessary for the debate on differentiated care, are permeated by conflicts, contradictions and power relations. From an "anthropology of praxis," the author carried out a critical analysis of the subsystem itself, identifying the distance between legislation and the day-to-day practices of local health teams. In addition, Langdon criticized the differentiated care model based on its transformations over the years, highlighting the changes that have taken place since the first Indigenous health conference in 1986, where the focus of the debate on differentiated care was to articulate distinct cultural health systems within a public policy, something that was later incorporated into the PNASPI text. In the following conferences, 1993, 2001, and 2006, the proposal to articulate different cultural systems gave way to the idea of incorporating Indigenous health practices into the subsystem. Langdon's criticism was based on a wide range of ethnographic experiences she and other researchers had in the south of the country. In an article published with Garnelo in 2017, the authors critically examine Indigenous health policies in Brazil and the meaning of articulating or integrating traditional medical practices, pointing out the contradictions and tensions present in the structural organization of the Subsystem:

> The debate undertaken by the network of Indigenous health researchers on the integration or articulation of traditional medical practices in primary care is even more complex and difficult. Any dialog between such diverse knowledge systems and practices implies communication between markedly different epistemologies and requires a willingness to put one's own point of view into perspective (Langdon; Garnelo, 2017, p. 466, free translation).

Luiza Garnelo is one of the leading researchers on Indigenous health in the country, especially in the Amazon region. She has dedicated herself continuously to analyzing the situation of health policy for Indigenous peoples since the 1990s, producing a very important overview of the political setbacks in the production of health care. Through a detailed contextual reconstruction of the implementation of the district model in Indigenous health, the author compares elements of Indigenous policy, understanding it as a tradition of thought among Brazilian government agents, with elements

of the neoliberal policy of reducing the state made possible by the government of Fernando Henrique Cardoso at the time. The paradox between two different ideas about the state, one that thinks of the Brazilian Unified Health System (SUS) as decentralization to strengthen social policies and social participation, and the other that emerges as the State's unaccountability, provides us with the complex political and historical context of the emergence of the SUS and the Indigenous Health Subsystem. As the author points out:

> At the end of this veritable chronicle of daily life, it can be seen that the Indigenous health subsystem represents an important advance in the new social policy-making for Indigenous peoples. However, it also contains a profound ambiguity, as it pits the universalizing democracy of the Unified Health System against the rights to ethnic difference (Garnelo, 2004, p. 24, free translation).

In this sense, Garnelo recognizes not only ethnic diversity as a paradigm that needs to be urgently considered within Indigenous health policies, but also alerts us to the diversity of Brazilian regional situations. The Northeast, the Amazon and the Midwest/South-Southeast have historically distinct clashes and problems. In their texts (Garnelo, 2004; Garnelo and Sampaio, 2003, 2005), this dynamic reading of the processes that involved the implementation of the Indigenous health policy in Brazil is evident: the emphasis in the Northeast is on the process of districtization carried out in partnership with the municipalities; in the Amazon region, Indigenous associations stand out; and in the Midwest/South-Southeast axis, the presence of non-governmental organizations (NGOs) is mostly responsible for the partnerships signed around the provision of Indigenous health care according to the model of Health Districts.

Anthropologist Carla Teixeira's original work seeks to understand the relationship between Indigenous peoples and the health policies aimed at them by the Brazilian state, based on an ethnography of state institutions and practices (Teixeira, 2010, 2012, 2017). Elaborating on aspects of the health-disease process that are not very pronounced, but which are of fundamental importance for understanding the contradictions and paradoxes of therapeutic itineraries, the author highlights the political itineraries and processes that constitute the setbacks of a differentiated citizenship (Teixeira; Silva, 2013, 2015, 2019). For this research agenda, issues such as autonomy, social participation and social control have become—beyond normative concepts of public health policies—categories to be investigated and deconstructed and which, through this theoretical-methodological approach, have allowed us to shed light on the process of producing power relations in Indigenous contexts in Brazil, as well as giving ethnographic relevance to the strategies and possibilities of disputing the meanings attributed to Indigenous health and their therapeutic itineraries.

In the text in which she specifically discusses the meanings attributed to the notion of autonomy in the field of Indigenous health, the author points out that "Brazilian Indigenous peoples have a practical knowledge and are in the process of reflecting on the possibilities of autonomy and protagonism that pass through the internal intricacies of the institutional engineering of the national state" (Teixeira, 2010, p. 120, free translation). Thus, the debate on the processes of Indigenous participation in the production of public health policies requires an attentive look at (1) the reframing of perspectives and ways of understanding the normative concepts used in everyday state practices; and (2) the political handling of concepts coming from the paradigm of cultural diversity, as is the case with differentiated care. By questioning their plasticity and their capacity to produce other meanings, the author's texts focus on the disputes over meaning that occur in the day-to-day management of Indigenous health policies.

By bringing this set of references to the debate, we propose to carry out a reflection that involves a methodological detachment regarding the meanings attributed to public policies, the state and social participation in order to elucidate epistemic and political conflicts that arise in the wake of emergency actions for Indigenous health, pointing to the possibilities of Indigenous protagonism, without losing sight of the state practices that cross the social dynamics in the field of Indigenous health in Brazil.

The Xukuru Indigenous People of Ororubá — an experience of social participation

The Xukuru of Ororubá live in the Serra do Ororubá—a region between the *agreste* and the *sertão* in the state of Pernambuco—and have three *Equipes Multidisciplinares de Saúde Indígena* (EMSI – Multidisciplinary Indigenous Health Teams). They have a local health council (CISXO), which regulates and supervises the work of the health teams, including the Indigenous Health Agents (AIS) and the Indigenous Sanitation Agents (AISAN). In recent years, a nutritionist and a psychologist have joined the team. At the same time, the Xukuru have been investing in the biomedical training of their staff for many years, so that some nursing technicians and assistants are Indigenous.

Simultaneously with the implementation of the Indigenous health subsystem in the Xukuru, an internal movement on the part of the leaders began to rethink and return to practices considered traditional, promoting meetings, debates, and specific actions such as meetings between traditional connoisseurs and other members of the health teams and meetings called "Urubá Terra" to promote health and exchange seeds, as well as promoting meetings where nature and agriculture are considered in conjunction with the belief in the "Enchanted Ones" (spiritual entities that guide the lives of the Xukuru people), which are the basis of Xukuru health and religion.

This is how the Xukuru have promoted various meetings since 2006, with clear objectives of discussing health through the relationship between traditional healers and the EMSI. Although there have been other more recent meetings, we should highlight the first two in partnership with the *Distrito Sanitário Especial Indígena* (DSEI-PE – Special Indigenous Health District), to discuss traditional cures and the use of medicinal plants, with the presence of all the EMSI and the traditional healers.

The first meeting was held on February 17 and 18, 2006, in the village of Pedra D'Água, where the sacred forest of the King of Ororubá is located, where the Enchanted Ones live and are present. The aim of this meeting was, according to the report produced by the Xukuru themselves, "to systematize the healing practices developed by connoisseurs of natural science" (2006 p. 6, free translation) and had as its central theme: "Traditional Medicine based on respect for nature." The second meeting was held in the same place on September 7, 8, and 9, 2006. In this second meeting, the objectives centered on the power of traditional cures and medicinal herbs; valuing traditions and ways of continuing them and, finally, the association of Indigenous medicine with biomedicine. Both meetings were attended by local leaders, traditional connoisseurs (healers, blessers), shaman, chief, members of EMSI (Indigenous Sanitation Agents/AISAN, doctors, nurses, technicians, assistants, AIS, and the Polo Base coordinator), as well as a representative of DSEI-PE.

These two meetings are interesting because they show that the Xukuru's concern with the practice of traditional medicine, including linking healing with ritual, is long-standing and has been encouraged for almost twenty years. Additionally, we identified a special focus on so-called "natural medicine," which can be thought of in a broader sense of the term. In other words, "natural medicine" is a category that involves cultural feeding practices, the control of water resources, the use of medicinal plants, family relationships, food distribution, the relationship with death, rituals, the sustainable use of water, etc. From these meetings and from a demand arising from the annual assemblies of the Xukuru people, the Urubá Terra meetings emerged.

In addition to these specific meetings in the field of health, the Xukuru assemblies are also a major part of this scenario. These began in 2001, three years after the murder of Chief Xikão in 1998 at the behest of a farmer who owned land in the Serra do Ororubá. Since 1999, the Xukuru have held a public act on May 20 in honor of the chief, but since 2001, this act has been preceded by an assembly which has continued to this day. What began as an act of protest gradually took on other connotations. The Xukuru have re-signified this day, associating the date of Xicão's murder with collective conquests and decisions. In 1999, on the anniversary of the chief's death, May 20th had a character of ethnic affirmation and political demand, combined with a feeling of loss.

The following year, in 2000, this event was preceded by two days of meetings in the village of Pedra D'Água, called the *post-Indigenous* conference, because it followed the Indigenous conference that took place in Porto Seguro (BA) in April of that same year. In 2001, the Xukuru held their First Assembly of the Xukuru People on May 18 and 19. The assemblies have always been the scene of debates on criminalization, legal and political confrontations, but also on the management of the territory in the environmental, health and education fields.

In 2014, for example, the 14th Assembly of the Xukuru People of the Ororubá had as its theme: "Limolaigo Toípe - Land of the Ancestors: Water is the blood of the Earth", in which the Xukuru reaffirmed their concern about the use of pesticides in plantations within the territory, as a practice that contaminates springs and the water table. One of the objectives of this assembly was to discuss health in relation to land management and water management.

This set of reflective meetings implemented by the Xukuru over the years provided support for confronting COVID-19 in 2020. In addition, in 2018, the Xukuru people had their struggle recognized by the Inter-American Court of Human Rights, in which the Brazilian state was ordered to pay compensation for the delay in the legal process of removing squatters from the territory already demarcated more than 20 years ago, in addition to signing an agreement to conclude the removal process as soon as possible. In possession of this money, and with all the reflective experience of the meetings and assemblies, the Xukuru made a very consistent plan to combat the COVID-19 virus, and, at the 2023 assembly, they reported on the use of the money on various fronts, including the amount used to combat the virus.

During the pandemic, Indigenous peoples were the most vulnerable. It was not known exactly how many Indigenous people had the disease, or even died during the pandemic. This situation was only alleviated by the work of SESAI, which began to produce epidemiological bulletins in an attempt to compile the data that arrived through the health districts, above all through the work of the Indigenous Health Agents. Even so, data from peoples who were not yet assisted by SESAI and Indigenous people living in cities were still left out. It was also a period when there was divergent data collected by the Ministry of Health, SESAI, and Indigenous organizations such as *Articulação dos Povos Indígenas do Brasil* (APIB - Articulation of Indigenous Peoples of Brazil) and *Articulação dos Povos e Organizções Indígenas do Nordeste, Minas Gerais e Espírito Santo* (APOINME - Articulation of Indigenous Peoples and Organizations of the states of Northeast, Minas Gerais and Espírito Santo)[1]. For now, it is important to say that during the Bolsonaro administration (2019-2022) there were several attempts to dismantle the health subsystem. Thus, the political context proved to be doubly perverse, not only for ignoring serious demands for care from Indigenous peoples but also because the Indigenous health subsystem has always been a fundamental collective struggle, despite being extensively criticized by researchers and Indigenous people over the years. All the criticism was used as a basis for reflecting on the quality of health care on offer, with the aim of improving the subsystem rather than eliminating it. Thus, the period required researchers to reflect attentively on the political processes that tried to frame the understanding of the importance of an Indigenous health subsystem and the SUS itself [2].

The subsystem is focused on preventing the disease with primary care, and during the COVID-19 pandemic, the fight against the disease was centered on the hospital-centric (tertiary) model, not taking advantage of the enormous experience of primary care in Indigenous lands. We can highlight that, among the plans to combat the virus published by SESAI from 2020 to 2021, the prevention strategies

1 In the case of the state ofPernambuco, there is an important data production network, the *rede de Monitoramento de Direitos Indígenas em Pernambuco* (REMDIPE - Indigenous Rights Monitoring Network in Pernambuco), associated with the work of APOINME, which can be visited at: https://www.indigenascontracovidpe.com/boletimremdipe.

2 During the pandemic, many texts were produced linking the situation of Indigenous peoples and the SUS. These include: Cruz; Fernandes; Jesus, 2020; Modesto; Neves, 2020; Santos; Pontes; Coimbra Jr., 2020; Scopel; Dias-Scopel; Neves; Segata, 2021; Alarcon and Pontes, 2022.

are linked to avoiding contact but have little to do with the ways of life in the villages and the effective participation of Indigenous people in their development. Perhaps this is why we were able to identify the relevance of the Xukuru, who were able to produce a strategic plan, revealing a system of priorities connected to the daily life of the Indigenous community.

The Xukuru, with their own budget and a great deal of reflective experience, as mentioned above, established a combat plan whose communication strategy consisted of a campaign entitled "Xukuru People of Ororubá in Defense of Life":

> *In view of the internal discussions about combating COVID-19, the Xukuru do Ororubá People's health and education agents visited every house in every community to hand out leaflets, masks, 70% alcohol gel and shirts, raising awareness among all community residents about combating crowding, maintaining social isolation and all the health measures needed to prevent COVID-19, including health barriers in the villages. Total investment in the plan: R$90,000.00. (slides presented by the Xukuru do Ororubá Indigenous Health Council [CISXO] at the 23rd Xukuru Assembly)*

In addition, they turned the schools in the Xukuru Indigenous Land into small field hospitals, where COVID-19 cases were sent, isolating them from other family members, but remaining in the territory. As a result, according to the health councilors and chief Marcos, at the peak of the pandemic, while the municipality of Pesqueira-PE had around 6,000 to 7,000 cases, with 128 deaths, the Xukuru had 130 cases, with 3 deaths. For them, this joint action between the Xukuru Association, education and health has saved many lives. In addition, according to Chief Marcos, many other things have been done to contain the pandemic:

> *The DSEI, the municipality, in this pandemic period, didn't know what to do, and the professionals here were afraid because they were on the front line in this process and often didn't know how to handle things, worried, left their homes to face this issue and we found a team that had expertise in this matter, how equipment should be used, what the concerns were and we hired a team to do training for our health agents and our other health professionals, so they would know how to take precautions and how to explain to the population, taking away that tension. Everyone had to isolate themselves, but the health team was there, at the front, making the work happen. We bought kits for the drivers who circulated in the area and who took people shopping in the city, to sanitize the cars so that the families could get into the car safely. For example, in the village of Canabrava, right from the start, we had eight cases, and we set up a collective reception space, isolated the school, set up a whole structure, a whole team set up and focused on it. At the time, the information was that when a person became infected, they would isolate themselves at home, but we would say: Gee, but won't it infect the others in the house? And we thought: let's do the opposite! We brought together everyone who was from the same village, in the same space, with the team there and the family assistance and they stayed there, with the accompaniment of a prepared team and us, as an association, providing assistance. We put in beds, internet, television, a whole hospital structure to accommodate these people who had been contaminated by COVID-19. So, it was a struggle, and the association acted quickly, given that the state wasn't in a position to monitor this. SESAI and the federal government didn't arrive, and the association stepped in with all its might to be able to provide this cover. (Speech by Chief Marcos Xukuru at the 23rd Xukuru Assembly).*

This account makes us think in various directions. Certainly, one of the interesting aspects is the theme of Indigenous autonomy in the conduct of health actions, which in the Xukuru case occurred through the development of a collaborative action plan that brought results, protecting the community from the virus, reaffirmed by the chief based on the discrepancy with the epidemiological data of the municipality. However, and perhaps the most important debate, was the Xukuru's choice to strengthen primary care by building *affective spaces of isolation* in the villages, demonstrating the sense of prevention and collective organization

that has always been systematically valued by the Xukuru over the years. This places the debate back into another perspective, of how we can have an effective subsystem when it is well managed, not in the budgetary sense of the term, but in the sense of the accumulation of knowledge and organizational models structured locally over the years. The Xukuru experienced this during the pandemic and the money they received was important, but this was mainly due to the accumulation of knowledge and not just having budgetary control. In addition, the Xukuru case points out that differentiated care is not only about trying to articulate different health systems, but also about the ability to present and carry out particular actions in the midst of generalist public policies. The case of the Xukuru people is similar to what anthropologists have said in other situations, that in the midst of a health crisis and a management crisis (by the state), the actions of these peoples had a fundamental impact, reaffirming the importance of effective social participation as the basis of the subsystem. This does not mean that there were no irreparable losses, as evidenced by the three volumes of the book "*Pandemia e Território*" (Almeida; Marim; Melo, 2020), which gave us an overview of the dramas and lives snatched away in the first year of the pandemic.

Document production during the COVID-19 pandemic: some notes

Analyzing some of the documents produced during the period, considering the reports issued by SESAI, as well as the coping plans drawn up for each Health District, we can see that the emphasis of the data revolved around the constant increase in the number of infected people and was the main form of official knowledge production in the years 2020-2022. A great deal of information was produced during this period, and it is still being explored with due attention by researchers.

In the collection organized by anthropologists Ferreira and Lowenkron (2020), we have the opportunity to reflect on documents not just as sets of technical data with purely informational objectives, but rather as cultural artefacts that have both a material and aesthetic dimension, and which are produced in contexts of interaction between people and documents. The forms of this documental production should not be naturalized but treated as research problems. Specifically, we can think of the welcome confluence between these reflections and the anthropological debate on state practices in Brazil, with emphasis on the complex context in which Brazilian Indigenous policies have been constituted over the years (Souza Lima, 2002a, 2002b, 2014). Within the space of this article, we would like to highlight and endorse the perspective that "documents are central technologies in the production and manufacture of the realities they govern, be they bodies, territories, relationships" (Ferreira; Lowenkron, 2020, p. 9, free translation).

Thus, our intention here is to draw attention to two aspects of this production of official texts that make up the content of the documents consulted: the absence of collaborative planning with Indigenous peoples (devaluing social participation as a way of coping) and the lack of coordination with primary care staff, since the emphasis was on isolation measures designed to suspend daily life, without properly contextualizing the different possibilities for adherence to isolation practices within Indigenous communities. We will look in more detail at two types of documents: (1) the government's coping plans for the Special Indigenous Health Districts, based on the case of the DSEI Pernambuco and (2) the epidemiological bulletins of the Special Secretariat for Indigenous Health (SESAI).

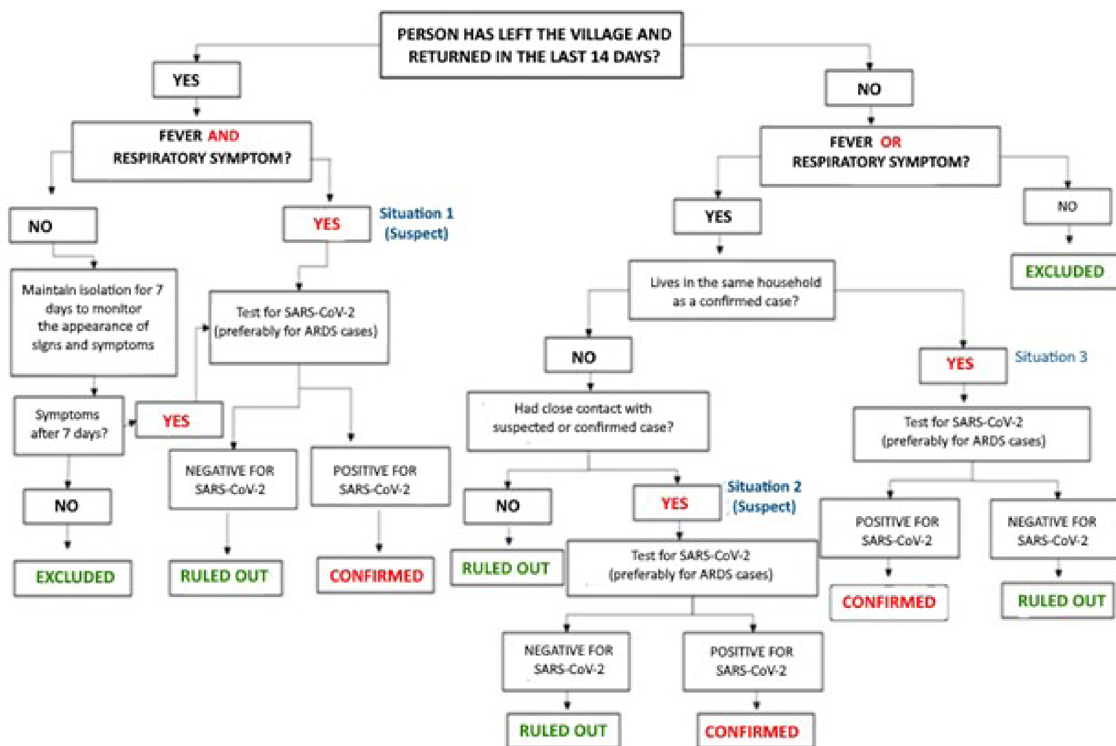
The coping plan (District Contingency Plan for Human Infection by the new coronavirus [COVID-19] in Indigenous Peoples) is a type of official document, designed to be a set of action strategies to contain the virus. We note right from the introduction that the document is aimed at health professionals, through which it reinforces technical actions such as identification, reporting, and timely management of those infected, and therefore does not deal with an experience of collective handling or management of the pandemic. Despite mentioning the context of Indigenous populations, the specific objectives listed do not address the issue, as we can see below:

- updating health services based on national and/or international technical and scientific evidence.

- prevent the transmission of the virus to healthcare workers and close contacts.
- prevent confirmed cases from dying through clinical support.
- *advise on how to deal with close contacts.*
- monitor the trend in morbidity and mortality associated with the disease.
- produce and disseminate epidemiological information.

Following this, we have a paragraph in which data is presented on the epidemiological situation of DSEI Pernambuco in relation to flu syndromes, with the number of absolute cases in 2019, highlighting epidemiological weeks 18 to 22 as the most critical weeks of the year due to the changing seasonal conditions, with more rain and cold. There is no other epidemiological data. The Xukuru do Ororubá, Atikum, and Pankararu ethnic groups are mentioned at this point to indicate the most populous services centers. The document then turns to "operational case definitions," which consist of outpatient procedures for care, dividing the population into Indigenous people who have left the village in the last 14 days and Indigenous people who have not left the village. However, the document does not mention the strategies for movement *within the village* (as we highlighted above, we only see a general mention of *advising on how to deal with close contacts*). As we saw in the speech by Cacique Marcos, who highlighted precisely another type of isolation, special consideration was given to internal circulation as a reference, culminating in the creation of small field hospitals within the Xukuru villages. In contrast to this, the response plan emphasizes to health professionals that "the assessment of the contact's degree of exposure *must be individualized*, taking into account the environment and the length of exposure." A flow chart based on this individualized perception of the subject has been added, as shown below:

Figure 1 - Assessment of the degree of exposure to COVID-19



Source: District Contingency Plan for Human Infection by the new Coronavirus (COVID-19) in Indigenous Peoples, DSEI Pernambuco, July 2020, SESAI, Ministry of Health.

The chart offers a map of possible diagnoses with the village as the territorial limit and the individual as the reference. Leaving and entering the village has become the main way of actively searching for possibly contaminated people. At the same time as the active search is focused on the itineraries of individuals who need to be mapped and located, the main spatial unit that regulates the itineraries is the village in all its collectivity.

Although there are no further details on how to combine a search for individuals and, at the same time, take the village as a border to be guarded, the document goes on to attempt to clarify 3 levels of response that health professionals in the Indigenous health subsystem need to be prepared to give: Alert, Imminent Danger, and Public Health Emergency. There are differences in the degree of intervention, but the recommendations revolve around set categories: Surveillance in SASISUS, Surveillance in municipalities and states, Laboratory support, Infection control measures, Assistance in SASISUS, Assistance in municipalities and states, pharmaceutical assistance in SASISUS, pharmaceutical assistance in municipalities and states, Health surveillance - health measures at points of entry to Indigenous lands, Risk communication, and Management. Each of these categories has an increase in the speed and breadth of responses. However, it is only at the last level of response, Public Health Emergency, that a notion of cultural specificity is mentioned, when the possibility of translating information material into Indigenous languages is mentioned under Risk Communication. There is no reflection on the forms of collective action capable of producing effective responses in crisis situations. At no point does the idea of social participation actually appear in the text. In fact, during the health crisis, we noticed that the notion of social participation became less present in the official texts. And although the text is aimed at health professionals, there is no specific mention of the work of primary care professionals, who are directly involved in the routines within the different Indigenous territories and cultures.

We wonder, therefore, if social participation might not have become more valued at times of crisis, as we see in the case of the Xukuru, whose effectiveness in prevention and social isolation actions was directly linked to a specific notion of autonomy: the possibility of combining the form of data production and assistance provided by government agents (epidemiological reports and coping protocols produced by health teams), in cooperation with Indigenous peoples, who produced significant evaluations on the best way to deal with the pandemic in Indigenous territories and presented results that are interesting to discuss, with a reduction in the number of cases among the Xukuru, whose data production carried out by the Xukuru association (such as REMDIPE and APOINME) includes networks of people that blur the boundaries between village and city.

Epidemiological reports, on the other hand, play a role in giving dynamism to daily decisions, constantly updating the number of infected people who have been officially registered, that is, who have been diagnosed by health professionals and whose notification has been computed. In terms of weekly epidemiological bulletins alone, we collected 820 reports issued by the SESAI and another 90 reports produced by the Secretariat for Health Surveillance, the latter providing contrasting data between Brazilian regions.

Our interest in revisiting the production of this type of document is, firstly, to highlight the dynamics of the transfer of information, which travels along a route that leaves the villages/localities, reaches the secretariat's data consolidation systems and is transformed into figures that are periodically published. The production of data and the meanings attributed to it are, in themselves, ethnographic situations to be explored. Secondly, we want to draw attention to the way in which they are produced. As in the case of the coping protocols, the reports also have six fixed categories that seek to provide an overview of the general situation of Brazil's Indigenous peoples by providing the number of cases: (1) suspected, (2) confirmed, (3) ruled out, (4) infected, (5) recovered, and (6) deaths. Even though these figures are not precise, i.e. their data is relative to the diverse and complex contexts in which they are produced, the practice of monitoring these indices on a daily basis has nevertheless become a form of language established by the official documents

produced to contain the pandemic. The intensity with which these bulletins are produced has become an event that is as important, if not more important, than the numbers they contain, since the frequency with which they are published seems to us to be the central element of their form of production.

It should also be noted that this document does not fall into the category of those that promote specific actions but is understood as a basis for action. In these terms, Indigenous peoples located outside the territories covered by the health districts are left out of this account. On the other hand, the Indigenous networks activated by Indigenous organizations, as in the Xukuru case, seem to point to possibilities that complement the official data insofar as they detach themselves from strict district territorialization and choose collective and locally connected forms of action.

Final considerations

The COVID-19 pandemic has alerted us to several issues. Before the pandemic, the Indigenous Health Care Subsystem was under strong threat, as was the SUS, which went through a period of intense devaluation. At the time, consideration was given to linking the public health system with the private one. However, the pandemic brought a debate to the general public about the importance of the SUS in combating events of this magnitude. SUS remained when the private system almost collapsed. Reality showed that with the arrival of the vaccine, the primary care network was activated and Brazil, with a huge population, was able to distribute and vaccinate people quickly.

In the case of the Subsystem, Indigenous people from all over the country came out in defense of it. Of course, the adoption of health measures and epidemiological guidelines were the basis of primary care on this occasion, but as we have discussed, it was also a time when a huge amount of learning was put aside and due attention was not paid to the principle of management and social participation, the basis of the subsystem. We missed the chance to boost and improve the subsystem based on local experiences of fighting the virus. The Xukuru case is one that shows us the importance of overcoming the "campaign" model of generalist policies, which give little recognition to local forces at work. From this set of issues and with the creation of the Ministry of Indigenous Peoples, perhaps we can resume the debate, considering organizational forms of health management that encompass cultural specificities in a broad sense, linking health and illness experiences to political processes of management and data production.

To return to the debate established between the reference authors we cited at the beginning of the text, it would be important to recognize that, although Indigenous actions around the pandemic have not been taken advantage of as they could, we seek to problematize the type of bond built politically and historically that goes back to a time long before the COVID-19 pandemic. After all, the autonomy that is being fought for is not that of doing it alone, it is not self-management, as we see in cases such as the relationship between Indigenous peoples and the state in Canada, analyzed by Teixeira (2009). Furthermore, as Langdon and Garnelo (2004) pointed out in a seminal collection on the subject, the idea of linking health systems should be thought of as the participation of Indigenous users, health professionals, and anthropologists involved in the process of Indigenous health care.

Thus, rather than comparing the normative language of official texts to "concrete" reality, considering that both are constituted in the midst of disputes over meanings, our intention was to point out that the documentary production itself (both with the Xucuru assemblies and with the official government reports) already configures a set of practices to be analyzed, that is, they represent forms of conflict produced within the scope of Indigenous health. In this way, we avoid naturalizing state practices and encourage a pressing debate in Indigenous health: how do we articulate not only different perceptions of health, but also different perceptions of the state in the production of care within the Brazilian Indigenous health subsystem?

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