

# Reproductive planning in Indigenous area and the search for differentiated care: the dilemmas between inequality and difference

Planejamento reprodutivo em área indígena e a busca pela atenção diferenciada: os dilemas entre desigualdade e diferença

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## Abstract

Differentiated care is a fundamental principle for a non-colonizing care of the Indigenous populations. One of the challenges within this field is reproductive planning since it involves tensions between collective and individual wills, as well as between authority and autonomy, especially with the more continuous insertion of professionals with the *Programa Mais Médicos* (More Doctor Program), as occurred in the Yanomami Territory. This article aims to discuss the aspects involved in a differentiated care regarding reproductive planning by comparing the work of health professionals in Indigenous and non-Indigenous areas. Thus, an ethnographic case study was conducted based on participant observation of the teams' practice, accessed via the *Programa Mais Médicos* Supervision, and interviews with six professionals, selected for the diversity of their profile. From the content analysis, three categories were identified: difference and inequality, similarities, and challenges. These divisions allows for the notion of physiological comparison, which generates a biomedical approach, encompassing the confusion between difference and inequality, the aspect responsible for favoring colonization and the denial of rights - and even the understandings of professionals about the culture - which permeates the intercultural dialogue.

**Keywords:** Differentiated Attention; Reproductive Health; Indigenous People's Health; Mais Médicos Program.

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## Resumo

A atenção diferenciada é um princípio fundamental para um cuidado não colonizador das populações indígenas. Um dos desafios nesse campo é o planejamento reprodutivo, por envolver tensões entre vontades coletivas e individuais, além da tutela e da autonomia, principalmente com a inserção mais contínua de profissionais via Programa Mais Médicos, como ocorreu no Território Yanomami. O objetivo deste artigo é discutir os aspectos envolvidos na atenção diferenciada ao planejamento reprodutivo, por meio da comparação entre o trabalho de profissionais de saúde em área indígena e não indígena. Para tanto, foi realizado um estudo de caso etnográfico com observação participante do exercício das equipes acessadas pela Supervisão do Programa Mais Médicos e entrevistas com seis profissionais, selecionados pela diversidade de seus perfis. A partir da análise de conteúdo, foram identificadas três categorias: diferença e desigualdade; similaridades; e desafios. Tais divisões trazem a noção de comparação fisiológica, que gera abordagem biomédica, passando pela confusão entre diferença e desigualdade, aspecto responsável por favorecer a colonização e a negação dos direitos - e até as compreensões dos profissionais sobre a cultura - que atravessam o diálogo intercultural.

**Palavras-chave:** Atenção Diferenciada; Saúde Reprodutiva; Saúde de Populações Indígenas; Programa Mais Médicos.

## Introduction

The Indigenous health care model in Brazil is based on comprehensive care, associated with the notion of differentiated care, which provides respect for the cultural diversity (Brasil, 2002). However, this process of “interculturality” presents conflicts and ambiguities that are reflected both in health actions and in the sociopolitical culture and organization of the Indigenous villages. Among such conflicts are the actions toward Indigenous women, especially in the field of reproductive planning, which may reveal differences regarding the understandings of reproductive health and rights, as well as raise delicate issues of population control. Collective and individual wills and hierarchies are incorporated to the ethnic and gender consciousnesses in the everyday dynamic between authority and autonomy within the healthcare work (Souza, 2007; Souza, 2017).

The Yanomami population and its subgroups went through a complex process of contact with non-Indigenous peoples and with the insertion of healthcare services in their territory. The health condition of this people, after the invasion of the mining prospectors, motivated the creation of the Yanomami Sanitary District (DSY), before the creation of the Indigenous Health Subsystem (Eusebi, 1991). With the insertion of healthcare teams within the communities, there was an expansion of long-term care, with significant impacts on the villages. Currently, these teams are practically complete, even in remote areas, such as the *Programa Mais Médicos para o Brasil* (More Doctors for Brazil - PMMB) in communities in the Brazilian Yanomami Territory.

The PMMB is responsible for the emergency provision of physicians to priority regions, with the development of professionals - providing academic supervision, in which a pedagogical monitoring of professionals is conducted by supervising physicians linked to the Ministry of Education. This process raised some of the issues presented in this study, aimed at communities of the Indigenous Special Sanitary District (*Distrito Sanitário Especial Indígena* - DSEI) Yanomami and Ye'kuana (Brasil, 2013). This organization is responsible for ensuring Primary Care, while the other levels of

complexity are offered by the care network of the Brazilian National Health System (SUS) (Brasil, 1999).

John Early and John Peters (1990), analyzing the demographic dynamics of the Yanomami population near the Mucajaí River in Roraima, defined four distinct periods: (1) pre-contact, from 1930 to 1956; (2) first contacts, from 1957 to 1960; (3) connection, from 1961 to 1981; and (4) Brazilian, from 1982 to 1995. The elements that influenced each of these transitions went through different trajectories, from the system of cross-cousin marriages<sup>1</sup>, migrations, to illness and death from infectious diseases due to contact. The insertion of the healthcare service seems to have contributed to the reduction of mortality in this population; in certain areas, during this process, it was even observed a return of the population growth rate to pre-contact patterns.

The Brazilian period stands out as the one with the most intense contact with non-Indigenous peoples, due to sudden increase of mining, migration to cities, and with the participation of the Indigenous movement advocating for rights and lands. There was a low populational growth due to several factors, such as a fall in the fertility rate and an increase in the age of the first cohabitation, on average at fourteen years of age (Pagliaro et al., 2005). Despite the factors that may have influenced this population dynamics, the authors state that reproductive behavior was maintained over these years in most of these communities.

A recent study, which considered the bienniums of 1987-1988, 1994-1995, 2001-2002, and 2008-2009, reveals that the Yanomami population doubled within all its regions, with lower growth rates in the years 1987-1988 to 1994-1995, characterized as moments of greater interference of mining prospectors. According to Nilsson and Fearnside (2017), the implementation of healthcare services could be the most important element in the demographic behavior of these people, within the period.

Moreover, other transformations may have occurred due to socioeconomic, territorial, and cultural changes, such as the attempt to criminalize

the practice of terminal (postpartum) abortion<sup>2</sup> and access to synthetic contraceptive methods. The access to such drugs was facilitated by Ordinance No. 1,059, of July 23, 2015, by including hormonal contraceptive methods in the National Relation of Essential Medicines for Indigenous Health (RENAME/Indígena), which began to be provided by the Special Secretariat of Indigenous Health (SESAI) (Brazil, 2015).

Research with Suruí-Rondonia women (Valencia et al., 2010) revealed a maintenance of high fertility rate and brought important parallels to the literature of the Yanomami people. However, they also pointed out particular aspects, such as increased levels of education, medicalization of childbirth, and the use of contraceptives. Although not sufficiently evaluated, there seems to be a lack of preparation of healthcare services in relation to the reproductive health of Indigenous women, due to the lack of knowledge about their specificities and contexts, among other reasons (Valencia et al., 2010).

Reproductive planning could be understood as the notion of a woman's autonomy and control over their sexuality, which can be a complex issue for the indigenous reality; or as a more Neo-Malthusian conception, in which it is an instrument for reducing poverty through population decrease. We reiterate here that reproductive planning should always be a right and not an imposition of public policies and/or health services (Espinosa, 2003).

The expectation of professionals may be that the community adapts to the demands of the official healthcare system, while still assuming the discourse of intercultural dialogue, since in practice the Indigenous is perceived as the "other." Thus, the "interculturality" necessary for differentiated care can be prescriptive and functional, acting as a new form of power, which uses the Indigenous healthcare policy itself and biopower to maintain the colonization process (Rabinow; Rose, 2006). Thus, the homogenizing discourse of neoliberal multiculturalism - with its stereotypical views of "Indigenous medicine" focused on cultural

1 Cross-cousin marriages are those on which the preferred spouse is a cross cousin, i.e., preferential marriage with the father's sister's son or with the mother's sister's daughter. In addition to being characterized as exchanges, they can promote alliances between ethnic groups. (Pinto, 2016)

2 Note: Here, it is preferred to use this term instead of "infanticide," since it carries a value that can be expanded. For further details: Albert (2011).

differences - disregards political, economic, social, and cultural inequalities (Ferreira, 2015).

The Indigenous population simultaneously uses different health resources, articulating forms of care through diverse therapeutic itineraries (Menéndez, 2005). The *habitus* of Indigenous and non-Indigenous peoples, however, is different, implying the need for agreements to resolve possible conflicts (Engelhardt apud Pontes et al., 2014).

One of the aspects that evidence these differences is the fact that Indigenous peoples are asked to make decisions in clinical situations from a biomedical perspective. Their notion of health and disease, however, goes beyond biomedical and social aspects (Barreto et al., 2017). The elements that guide the Indigenous peoples' decision-making processes regarding health are not different from those used in other situations. Moreover, these resolutions are dependent on the relational values of trusting the professionals and of the family and community context (Pontes et al., 2014).

Paternalism is hegemonic in Brazilian and Cuban medical practice - the latter is taken into consideration since it is the nationality of the physicians who worked with the teams' object of this study. This practice reinforces the idea of health restoration and prolongation of life, regardless of the individual's will, thus subordinating the body and the person to technological knowledge, contrary to the Indigenous perspective in which the commitment to quality of life is greater than the search for cure (Menéndez, 2005).

Such a posture may disrespect the user's autonomy, which would be understandable only if there were enough elements to justify the benefit (Silva, 2010). In Western society, the prioritization of respect for autonomy is guided by individual decision-making, but this tenuous relationship presents itself with different characteristics within the Indigenous reality, in which autonomy may not be individual, but of the family or community (Pontes et al., 2014).

Additionally, the Indigenous health service inevitably takes as reference Primary Health Care

and the Family Health Strategy (*Estratégia Saúde da Família* - ESF), which should be guided by the precepts of accessibility, longitudinality, integrality, humanization, coordination of care, and health surveillance. This strategy plays a primary role in the provision of care but may not be adequate for Indigenous realities when programmatic actions - such as reproductive planning - are transposed, due to conflicts between the idea of planning reproduction and the expectations of Indigenous peoples in relation to fertility/birth.

Thus, for the health service to provide non-colonizing care, differentiated care is fundamental, but it involves a multiplicity of factors in its practice, including the professionals' perception of how this process is to be conducted. One of the elements that can evidence this perception is the comparison of the work experience in an Indigenous and non-Indigenous area, raising issues on the construction of a truly differentiated practice.

Despite the existence of other studies in this sense, they rarely dive into the components that influence the perspective of these professionals. This article discusses the aspects involved in the differentiated care toward reproductive planning, while comparing the work of health professionals in Indigenous and non-Indigenous areas.

## Methods

The populations in the Yanomami Territory are assisted by 37 bases and 200 healthcare unit, which are articulated with the services of the municipalities of the area. They are 67 Indigenous Health Multidisciplinary Teams (EMSI), with more than 460 professionals. Currently, most of these are composed of PMMB physicians<sup>3</sup>.

Since it is a specific reality in which the researcher is inserted, this is an exploratory study with a qualitative focus of an ethnographic case study type (Martucci, 2001). Interviews and participant observation techniques were used to collect evidence during 2017. The interviews included the following questions: What elements do

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3 2017 data provided by the Technical Responsible for Epidemiology and Information System of DSEI Yanomami and Ye'kuana during the XIX Meeting of the District Council of Indigenous Health Yanomami and Ye'kuana.

you think influence your approach to reproductive planning in Indigenous area? And what elements differentiate it from the performance in a non-Indigenous area? The field notes on the monitoring of the work of the teams were elaborated during the supervision activities, every two months, at the time of visits to different communities that had PMMB physicians.

For the selection, we considered professionals (physicians, nurses, and nursing technicians) who were working, during the study period, in closer interaction with the Indigenous and who had also worked in non-Indigenous Primary Care, providing the desired comparison objective.

Two of each category were chosen from divergent profiles, considering mainly: sex/gender (there were no women physician, only nurses and nursing techniques); time working in an Indigenous area; and quantity and diversity of bases in which they had worked. These were the central elements used to capture a wider diversity of experiences. Indigenous professionals were not included since the study focused on the non-Indigenous perspective to highlight contradictions. The participants were identified by a letter of the alphabet at random. Chart 1 shows the components of the interviewees' profile, with omission of some details due to the risk of identification of the subjects:

**Chart 1 – Profile of the participants interviewed**

Participant	Occupation	Time worked*	Amount of bases worked
A	Nursing technician	1 year	2
B	Nurse	2 years	3
C	Nurse	5 years	8
D	Nursing technician	10 years	10
E	Physician	3 months	1
F	Physician	3 anos	3

\*In Indigenous areas

The interviews were conducted in their workplaces, counting on good receptivity, after the authorization from local management, signing the Informed Consent Form (TCLE), and after the approval by the Research Ethics Committee of the Center for Health Sciences of the Federal University of Pernambuco (CEP/UFPE).

After a literal transcription of the interviews and the organization of the field notes, a reading was made, highlighting the meanings present in the background. The organization of the acquired materials and evidence was carried out systematically, followed by the analysis itself, from the thematic content analysis model, adaptation of the technique proposed by Bardin (Gomes, 2013). Three categories were identified: **difference and inequality, similarities, and challenges.**

## Difference and inequality

This category explores differences, as understood by professionals, between working with Indigenous populations and with non-Indigenous peoples, helping to understand how they believe differentiated care is to be exercised and what elements influence it. **Difference and inequality** need to be addressed together, since focusing exclusively on difference can disregard the inequality present in each context.

The stereotypical view of “Indigenous medicine” - focused on cultural differences and not on political, economic, and social - is shown as a homogenizing discourse of neoliberal multiculturalism. And it can, in fact, reveal a concept of culture founded on the difference, disregarding and disqualifying the inequalities, thus revealing themselves as

a violent historical process of contact with non-Indigenous peoples, causing the genocide of this peoples over the years (Ferreira, 2015); despite some political advances, such as territorial demarcations, their condition remain unprotected. Therefore, it is important to discuss the perspective that guides the professionals' approach, revealing the displacement of something that is from the scope of difference to that of inequality, or vice versa (Barros, 2018). In this sense, one of the aspects perceived as different was the greater need, in an Indigenous area, to build a continuous relationship that would enable dialogue. We observed that professionals with more time in the same territory could earn more of the women's trust. And regarding some situations, as in the case of antinatal abortion methods, this access to the women was difficult, which may justify this being a subject that is still scarce in the literature on the Yanomami.

Pierre Clatres (1978) uses the term coercive power as that which is exercised by the State to demand the obedience of individuals; and non-coercive and persuasive power for stateless societies, such as the Indigenous ones, in which relations are based on kinship, generosity, and oratory.

Thus, this idea is reinforced, as we see in D's speech, by bringing the importance of time and interest in the relationship between professional and user:

*The Indigenous women, especially the Yanomami, for you to gain their trust, requires a little time. From the moment she sees that you are a well-educated professional, well interested, she sees that you have that vigor to help her. (D)*

Among the professionals who were under observation and the interviewees, the predominant perception is that the Indigenous women are more submissive to the men and the collective than non-Indigenous women. Gender relations are complex in this reality and difficult to be interpreted through "Western" feminist theories. Some issues posed by professionals, however, agree with those pointed out by the collectives of Indigenous women, such as the Voice of Indigenous Women Project, implemented by UN Women (UN Women, 2018). Among these, are the discomfort with low female

participation in politics and individual decision-making and with the rate of domestic violence. These expressions of gender inequality are understood by the professionals as part of the culture:

*When they come to the team to talk about it [reproductive planning] is because she's already agreed with family and the leadership. [...] and it is always women who go to the farm and husbands stay only at home, women suffer more than they do. (A)*

*The Yanomami there, I think it's the ethnicity in which the woman is most submissive to the man. She's submissive to the community. There, they really live in groups. What one says, goes. The leadership said this, okay, no more talk... they won't even question anything. (C)*

A and C, female professionals, understand that Indigenous women suffer more than men and that this is inherent to the culture. However, it is observed in the field that these distinct perceptions are harmful, to the extent that there is close involvement with non-Indigenous areas. Thus, we reinforce the notion of not separating *difference* and *inequality* when comparing the care given to the Indigenous and non-Indigenous women, especially in this contradictory process of interaction. On the other hand, the possibility of change in gender inequalities and their forms of expression is identified, based on initiatives of Indigenous women's collectives, with organizations throughout Brazil and within the Yanomami territory. In some speeches appears:

*So women are, now, fighting for their rights as well. And it's a good sign because, before, they didn't take this attitude of wanting these drugs [reproductive planning] those were of our use, of whites, right. (D)*

In this sense, from hierarchical and ethnocentric comparison, we observe professionals who consider the indigenous way of living as a generator of problems, increasing the difficulties for their work in the area. This understanding, often identified in the field, can lead to a more reticent and interventionist approach, in this case, in relation to contraception:

*They says it's culture right... And when they go to the plantations who stays with the little child is another little brother too. And then, that's why they start seeing the difficulties of always being pregnant (A)*

*If you can't raise two, why are you going to have eight? They end up getting sick... so there's also the issue of when they come to town, this question of who's going to stay, who's going to take care of them. And so, for them it's a lot of difficulty and I think there should be that kind of control over the amount of Indians in the community. (B)*

In the statements of A and B, there is a concern with the women and children, but it can be harmful to assume that what is different is bad, minimizing the importance of inequalities in living conditions, which are due to the vulnerability of the territory and the restriction of rights, as E says:

*Now, if there is more food, more nutrition, I think it would be the same way [...] they will remain the same. They've never had so much food. (B)*

According to Coimbra Jr and Santos (2000 apud Coimbra JR; Santos; Escobar, 2005, p. 36), "Higher morbidity and mortality coefficients [...] hunger and malnutrition, occupational risks, and social violence are just some of the multiple health reflexes resulting from the persistence of inequalities." In this sense, the bad living conditions (harsh territory, conflicts with prospectors) would be the real problems to be faced, and not the Indigenous way of living.

Thus, the findings of Souza and other authors (2017) are resumed, in which the women living in unmarked reserves have higher birth rates than those living in demarcated areas, due to the need for population growth to maintain their fight for rights. This issue was explained when comparing the way professionals work in areas with greater or lesser mining influence, in addition to being present in the reports by C and D, by stating that inequality and unprotection of territories influence the decision on reproductive planning. This perception can come with time, since they have more experience:

*Because, in the place that has mining the woman will have the boy, child goes there to the mine and will suffer from pneumonia and maybe will die. (C)*

*But the Indigenous man's response was that we killed more than they did, because they did it ("infanticide") because of survival and non-Indigenous, didn't. (D)*

Regarding differences, the professionals reported that working in this context would primarily require for them to consider culture, which is in accordance with the principles of differentiated care as a guiding element of action in these realities, for the construction of non-harmful processes:

*Respect because we're the trespassers. We're going there. I speak for two lives... here I have one life, in the forest I have another. So, when I go there, I'm coming to their house. So, I have to respect how it works there. (D)*

However, the predominant view is that the main reason to respect their culture is for the protection of professionals from community reprisals. Reactions of this nature were even experienced by PMMB physicians, however, considering them as the main reason for the exercise of differentiated care can generate falsely empathic and even colonizing approaches. In the statements of B, D, and F, it is perceived that this concern is greater than the possibility of generating damage to the women:

*But we leave them very comfortable, we don't force it. Because sometimes, when you force it and she doesn't get accustomed to the birth control because there's bleeding or something is wrong, then they turn against the team. (B)*

*The leadership has this strong voice also of not wanting, because we cannot go there and give the medicine without their consent. Because if something goes wrong, they're going to blame the professional for using the drug. (D)*

*I think that yes, they should use birth control. It just depends on the culture of each of the community*

*you're facing. Because you can't impose. Because if you impose, in many communities, the doctor will not be well-seen, they will be rejected by the community.* (F)

## Similarities

The category **similarities** seek to identify common aspects between the work in a non-Indigenous area and work in the communities of the Yanomami Territory, based on the statements of these professionals. This can signal how these elements are seen and how they could facilitate empathy and intercultural dialogue, including considering the importance of the Indigenous in the formation of the Brazilian people, as elaborated by Darcy Ribeiro (1995) in *The Brazilian people: the formation and meaning of Brazil*.

This perspective could reveal more difficulties among Cuban physicians, since, with the extermination of the Indigenous peoples in Cuba, they had less participation in the formation of their citizenship than those in Brazil. Among the **similarities**, the Brazilian professionals do not, culturally nor historically, identify with the Indigenous peoples, denying the process of formation of the Brazilian people.

The experience ratifies this issue, but the interviews brought elements that influence the practice. There seems to be a contradictory notion that Indigenous peoples are, simultaneously, equal and different from non-Indigenous people. They would be equal because they are also human, a concept based on a biomedical approach, with the transposition of programmatic actions, such as Reproductive Planning.

*It should be the same. It should be the same. Because it's a basic unit. The Indian is a being just like us, non-Indian, right?* (B)

This idea disregards, in this case, that the human body is in an interethnic scenario. While the *napë* (white) is "enemy," it also means a supplier of objects (Kelly, 2005), so the use of pills or injections may imply some benefit, but also implies a transformation into "white."

This complexity does not seem to be perceived in its magnitude, given the difficulties of understanding

and implementing differentiated care. Some professionals, such as A, also report that, despite the differences and starting from a hierarchical perspective, the approach should be the same:

*I've worked in PSF ("Family Health Program") and of course there is a difference. Here in the city women already give great importance to family planning, because it already includes education, the difficulty of raising a child. In the field, they don't have much understanding about it and for them this does not influence much. The performance is the same in field or in the city, we take the importance of condom use and STD and methods to take care of themselves.* (A)

Comparisons are made between the differences regarding the social and cultural workings, only to conclude that, despite the differences, this would not change the approach, since non-Indigenous people also have their culture:

*It's the ways of healing, the ways of praying, the ways of dancing... just like us, we have the forró, they have the... are different cultures.* (B).

However, the role of culture in differentiating care should also happen among non-Indigenous peoples.

To this issue, we call cultural competence, a concept that consists in the ability to be resolute, considering cultural aspects without hierarchy. This involves being both sensitive to the beliefs and expectations of people in any territory and modulating the organization of health services to each reality (Helman, 2009).

## Challenges

The elements previously discussed contribute to the next category, **challenges**. It was unanimous, both for the professionals interviewed and for those involved, how challenging it was to provide care to these people, influenced by adversities of access to the areas, high turnover of the teams, different forms of professional performance, intersectoral difficulties, intercultural dialogue, and language/communication.

The need for intercultural dialogue was often perceived not as something instigating, but as an obstacle:

*What does not exist in the other bases, this issue of natality, this practically does not exist, because it is governed by culture, by community leaders. They are the ones who decide on this issue of birthrate. So, it's tough (F)*

In this dialogue, the language is identified as a challenging factor for the work, reaffirming the need for linguistic training of the teams. However, there are other communication difficulties, understood as obstacles in daily life:

*The only difficulty, the only obstacle for us is about how to pass on to her, which would be the interpreters to do correctly. Because our biggest difficulty is this, you say something, they understand in a way, that possibly the Indigenous woman or man will not understand in the same way that we are saying. It's very delicate to work with an Indian. (B)*

It can also be seen as a necessary and possible challenge to be worked on both in the perspective and practice of some professionals, C, for example, speaks the local language and, in relation to reproductive issues, this seems to be even more important:

*because as we are there 24 hours, taking care, we end up looking. We say... 'If you're pregnant you have to tell me so I can do your prenatal care.' 'No, I'm not' 'Blood cua... (in Yanomami) ... so many moons. (C)*

Furthermore, priority must be given to care for these peoples in their own places, but the difficulty of access to more isolated areas is understood by professionals as a barrier when building continuous and close relationships. Considering that this relationship is an essential criterion for the construction of care, this difficulty of access is a hindrance of difficult resolution. It is pointed out, therefore, as a limiting factor for a more appropriate approach to reproductive planning:

*so you have to keep monitoring her, so she doesn't go to another community at that time that day. (B)*

*In Yanomami, we do not have a range of options for pregnancy prevention methods... in the case*

*of Family Planning. We don't have any reason to... oral use has no condition. The woman lives five hours away, every day you go there to give her that birth control? (C)*

*Many Indigenous people are sometimes fixed in some regions, but we do not know until when. Because their land has a plantation cycle, sometimes they move, so. (D)*

B, C, and D place the isolation and mobility of communities as limiting for monitoring reproductive planning. This statement also questions the understanding of professionals about what differentiated primary care would be, since differentiation includes thinking about care formats that are organized according to the way of living of each people and, in such a way, that considers the difficulty of access to them. This interferes in the organization and structuring of services in relation to Private Health Care even in a non-Indigenous area, as shown in the statements of B and D, considering that primary care in Indigenous territories needs to be different from non-Indigenous primary care, which means being differentiated:

*There in Auaris, it is a base, it has a certain structure, but for primary care, sometimes we do the impossible. (B)*

*She said the team here is bad. I asked this person: 'Have you ever been to an Indigenous community? In a real community... where culture prevails? Or have you been in a community where you have a big runway and a well-structured post?' I Say: 'Look, that's the problem.' (D)*

Another challenge pointed out was the turnover of the teams, causing differences in the ways of acting and difficulties to build relationships with the locals, especially in the case of reproductive planning, since they are not fixed in a community. Pontes et al (2014) state that, in addition to the difficulty described, this process is really hindered by the short time for dialogue during the visits, short period of permanence of the teams in the communities and lack of longitudinal follow-up.

Thus, despite having changed in recent years, with more complete teams, especially with the provision of physicians by the PMMB who remain 15 days in a row in the area, the experience of these challenges was still reported by these professionals:

*The immense difficulty we have, to begin family planning, in 15 days we pick up a professional who does not have the intimacy with this situation, is now starting the work and will not continue. In the Indigenous area there is this difficulty, of continuity.* (B)

*As you see, every professional has their vision. I spend seven days there, then I have to leave, then another colleague comes in, who has another vision. Who's gonna say other things, say differently, or who think that they can't do something... because they are different heads right.* (D)

Moreover, living and territory conditions would also be challenging factors and would not be under the governance of professionals, but other sectors:

*So, the Indigenous women already have involvement with the miners. So, to make a planning for this family with a pregnant Indigenous and really sees how we will do it and make our planning go right... it's complicated.* (D)

D reinforces that the unprotection of the territory influences the approach, pointing out that the differentiated attention of reproductive planning is challenging, and that it needs to consider not only the differences, but also the inequality. Therefore, it is necessary to recognize the cultural diversity allied to the knowledge of the territory, fighting inequities and relativizing differences (Garnelo; Langdon, 2005).

## Final considerations

The integrity of Indigenous peoples can be threatened by functional interculturality, as the power relationship present in the approach of reproductive planning further strengthens differences and neglects the inequalities, as shown in this study.

The exercise of comparing the work conducted at an Indigenous and non-Indigenous area brought elements that influence the approach of these professionals. These elements range from comparison based on a biomedical approach, the confusion between difference and inequality that favors colonization and denial of rights, to the understandings of professionals about culture, who cross intercultural dialogue.

These aspects make the performance in these areas challenging, since it is associated with other conjuncture factors of denial of rights and unprotection of territories. These could have had more in-depth analysis with an even longer experience with the researcher in this reality and a greater number and diversity of professionals interviewed, which can be pointed out as a limitation of the study.

The need to use synthetic contraceptive methods was justified on the women's way of living in the Yanomami Territory, which was understood as the cause of the issues and, sometimes, even as an immutable factor. Only in a few situations is the need for reproduction control acknowledged due to poor living conditions, which can generate or reinforce deficiencies and suggests being related to elements such as time of experience.

At the same time, we suggest that reflecting with professionals and managements about these visions of what is similar, but mainly, of what is different and what is unequal, may enable the construction of better paths for differentiated care (in all its aspects) to these Indigenous women and to this people, and not an approach that strengthens or ignores inequality.

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### Authors' Contribution

Teixeira and Valongueiro participated in the conception, analysis, and interpretation of the results, writing and revisions of the article. Teixeira was also responsible for data collection.

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