

Research/Technical Note

# Indigenous Rights and Health: A Legal and Sociocultural Approach

Maria de Lourdes Beldi de Alcântara<sup>1,\*</sup> , Juliana Mafra<sup>2</sup> , Alejandro Parellada<sup>3</sup> 

<sup>1</sup>Medical Faculty, University of São Paulo, São Paulo, Brazil

<sup>2</sup>Ministry of Labor in Mato Grosso, Mato Grosso do Sul, Brazil

<sup>3</sup>Latin America Coordinator, International Work Group for Indigenous Affairs, Copenhagen, Denmark

## Abstract

This research note explores the intersection of Indigenous rights and health from a legal and sociocultural perspective, focusing on the unique challenges faced by Indigenous communities in Brazil. It critically examines the tension between individual and collective rights as they pertain to health, highlighting the divergence between Western biomedical models and Indigenous worldviews of "well-being" or "sumak kawsay." The study reviews the existing legal and normative frameworks—ranging from the Universal Declaration of Human Rights to Brazil's constitution—that aim to ensure culturally appropriate healthcare for Indigenous peoples. Despite these frameworks, significant challenges persist, including cultural and linguistic barriers, distrust of formal health services, inadequate access to care, and institutional discrimination. Through case studies, such as the health crisis among the Yanomami people, the note illustrates how these issues manifest in practice and argues for the need to incorporate Indigenous healing practices into the broader health system. The study concludes by advocating for a more intercultural health approach that respects and integrates Indigenous knowledge, enhances community participation, and fosters a more inclusive, just, and effective health system for Indigenous peoples in Brazil.

## Keywords

Indigenous Rights, Health Policy, Legal Frameworks, Intercultural Health, Collective Rights, Brazil, Well-being, Traditional Medicine

## 1. Introduction

The intersection of human rights, Indigenous peoples' rights, and health/well-being is a field that is cross-cutting and interdisciplinary, revealing its extreme complexity. This intertwining extends beyond traditional scientific methods, encompassing cultural, social, and economic aspects, alongside both collective and individual perceptions within Indigenous communities. The relationship between "human

rights" and "well-being" necessitates an understanding that transcends traditional human rights approaches based on universal and individualistic norms. The concept of "well-being" (or "sumak kawsay," in the Andean Indigenous worldview) emerges as an epistemological and ontological alternative to Western paradigms, emphasizing harmony and interconnectedness among humans, community, and na-

\*Corresponding author: [loubeldi@usp.br](mailto:loubeldi@usp.br) (Maria de Lourdes Beldi de Alcântara)

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ture/environment. While human rights, as articulated in documents such as the Universal Declaration of Human Rights, tend to prioritize the individual as the subject of rights, "well-being" places the collective and the relationship with the environment at the center of concerns, promoting an integrated understanding of health, where well-being is not limited to the absence of disease but includes spiritual, social, and ecological balance. This perspective necessitates the reinterpretation of health rights in light of Indigenous worldviews, recognizing that integral health includes spiritual and environmental aspects that are fundamental to the cultural and physical survival of Indigenous communities.

Since the adoption of the Universal Declaration of Human Rights in 1948, which establishes that everyone has the right to an adequate standard of living ensuring health and well-being, to the approval of the United Nations Declaration on the Rights of Indigenous Peoples in 2007, the hegemony of the Western/biomedical health system has been evident. It took 59 years for the health concept stemming from the world's Indigenous peoples to gain some voice regarding how to maintain and develop their traditional medicine systems through a holistic and integral approach.

Brazil presents a robust legal and regulatory framework aimed at ensuring the health of Indigenous peoples, not only through access to health services but also through the preservation of their traditional practices, thus promoting a context of respect for cultural diversity. However, the effective implementation of these rights faces significant tensions and challenges. The Unified Health System (SUS), although designed as a universal health system, often struggles to meet the cultural and geographical specificities of these populations.

In light of this broad and complex panorama, it is fundamental to deepen the understanding of how the network of rights, of which Brazil is a signatory, interacts with national and international legislation and norms, and how this structure can be woven in the pursuit of promoting effective and culturally appropriate health for Indigenous peoples. Only then will it be possible to outline paths that respect and integrate Indigenous traditions into health policies, contributing to a more just and inclusive system. The discussion of this web of rights must not be merely a theoretical reflection but also an invitation for action, engaging all social actors, governmental bodies, and the communities themselves in building solutions aimed at promoting the health and well-being of Indigenous peoples in Brazil.

### 1.1. Legal and Normative Framework

The distinction between individual and collective rights is essential for building a more inclusive and just health system. While individual rights safeguard the autonomy and dignity of each person individually, collective rights recognize the importance of cultural identity and the preservation of communities through respect for community rights that encom-

pass not only traditions but also the entire environment with which these communities interact.

The intersection of these two sets of rights in legislation and public policies is fundamental to ensure that all individuals, especially those belonging to minority groups, have equitable and respectful access to health, dignity, and well-being. Promoting the active participation of these communities in the formulation and implementation of policies is imperative for rights to be genuinely respected and practiced, creating a space where diversity is valued and protected.

### 1.2. Individual and Collective Rights

Individual rights are those that guarantee fundamental freedoms and protections for each person in isolation. These rights are typically rooted in modern liberal traditions and are often expressed in legal documents, such as the Universal Declaration of Human Rights and national legislation. Examples include the right to life, freedom of expression, property, and equality before the law. These rights are deemed inalienable and universal, applicable to all regardless of race, gender, or nationality.

In terms of health, as stipulated in the International Covenant on Civil and Political Rights, physical integrity and life are assured, promoting equitable access to health services. Protecting individual rights is essential to ensure that each person can enjoy a living standard, including health, according to their own values and needs.

On the other hand, collective rights focus on the protection of communities and groups, recognizing that certain rights are inseparable from the existence of specific social groups. These rights reflect the experiences of minority or marginalized groups and aim to ensure that their culture, identity, and ways of life are preserved and respected. Examples of collective rights include the right to self-determination, cultural preservation, and sustainable use of natural resources.

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) clearly illustrates the nature of collective rights by recognizing that Indigenous peoples have the right to maintain and develop their own traditional medical systems. This approach underscores the interdependence between health, culture, and identity, emphasizing that the well-being of an Indigenous community cannot be exclusively reduced to individual health indicators but must consider their cultural practices and traditional systems of knowledge and their applicability.

Conversely, the Universal Declaration of Human Rights (1948) establishes, in Article 25, the right to an adequate standard of living that ensures health and well-being, including nutrition, housing, medical care, and essential social services. This article underpins the right to health as a *sine qua non* condition for human dignity, integrating it into the set of internationally recognized economic, social, and cultural rights. The inclusion of the right to health in the Declaration highlights its centrality to the realization of other indi-

vidual human rights.

Within the framework of the Inter-American System of Human Rights, rights can be guaranteed through the Inter-American Commission on Human Rights (IACHR) and the Inter-American Court of Human Rights. The Charter of the Organization of American States, also known as the Charter of Bogotá of 1948, ratified by Brazil in 1950, established the Organization of American States, and, according to its Article 34, member states are committed to making their utmost efforts to promote social rights, among them access to modern scientific medical knowledge, to defend human potential.

In 1969, the American Convention on Human Rights (San José Pact) was adopted in the Inter-American System, ratified by Brazil in 1992. Article 26 provides for progressive development in social rights, including health, and guarantees Indigenous peoples, given their ethnic-racial minority status, susceptible to discrimination, the right to access health care on an equal basis with other members of society, and that the state shall make every effort to ensure that right is upheld.

The San José Pact received an Additional Protocol on Economic, Social, and Cultural Rights, the San Salvador Protocol, in 1988, ratified by Brazil in 1996. Its Article 3 imposes an obligation on the state parties to guarantee, without any discrimination, social rights, including health (Article 10), and also stipulates measures, such as meeting the needs of high-risk groups that are more vulnerable due to their poverty situation. Many Indigenous peoples in Brazil fall into this category, for example, given their genetic predisposition to diabetes, as well as their vulnerability resulting from the contamination of their territories by illegal mining.

The American Declaration on the Rights of Indigenous Peoples recognizes both collective and individual rights, highlighting that “Indigenous peoples have the right to their own health systems and practices, as well as to the use and protection of plants, animals, and minerals of vital interest, and other natural resources of medicinal use in their ancestral lands and territories (Article XVIII)” and also ensures the full enjoyment of the right to life, spirituality, worldview, and collective well-being (Article XIX).

To combat discrimination, Brazil ratified in 2021 the Inter-American Convention Against Racism, Racial Discrimination and Related Forms of Intolerance, which recognizes, in its preamble, that Indigenous peoples are victims of racism and provides for the protection of rights, including health (Article 7), in a collective manner (Article 3).

## 2. Challenges in the Implementation of Norms and Laws

Although there exists a robust legal framework that guarantees culturally appropriate health rights in Brazil, the effective realization of these rights faces significant challenges. The promotion of active participation of Indigenous peoples

in the formulation and implementation of health policies is crucial to ensure a health system that is just and inclusive. The implementation of policies that respect Indigenous traditions and ways of life, together with a continued effort to overcome practical barriers, is fundamental to ensuring that the right to health is genuinely a reality for all Indigenous peoples in Brazil.

According to Andrade and Figueiredo [1] “public policies aimed at Indigenous health often prove ineffective in light of the sociocultural particularities of these peoples, reflecting a difficulty in articulating traditional knowledge with biomedical knowledge.” At this moment, attention is drawn to how cultural dialogue is conducted: that is, there is no dialogue, but rather opacity/refraction of narratives. If we invoke the concepts of “illness” and “disease,” as discussed by Kleinman (1988) [2], they can offer an essential lens for understanding the cultural complexities and practical difficulties in implementing health policies directed at Indigenous populations.

“Disease” refers to the objective, diagnosable, and treatable pathology within the dominant biomedical paradigm, whereas “illness” encompasses the subjective and cultural dimensions of the experience of becoming ill. In Indigenous contexts, this distinction becomes particularly relevant, as communities often interpret illness through belief systems that are not recognized or valued by biomedicine. For example, among Indigenous peoples of the Amazon, illnesses may be understood as manifestations of spiritual and/or social imbalances, requiring interventions from healers or shamans rather than solely from biomedical professionals. Ignoring these cultural dimensions of illness can result in distrust and rejection of conventional health services, underscoring the need for an intercultural health system capable of dialoguing with and integrating different health knowledge and practices, a way to approach and create a symmetrical dialogue with well-being/sumak kawsay.

Challenges in Implementation: Navigating between Universality and Cultural Specificity in Indigenous Health in Brazil

The implementation of health policies for Indigenous peoples in Brazil reveals significant tensions between the universality of the Unified Health System (SUS) and the cultural specificity of Indigenous peoples, as Brazil is home to 305 ethnicities manifesting in 274 languages.

Amid this dense and complex scenario, several key points of tension are outlined:

1. Concepts of Health and Medical Practices: One of the primary challenges in Indigenous health is the dichotomy and opposition between scientific thought and holistic thought, often perceived as magical; between Western medicine, dominated by a deductive, biomedical approach, and traditional healing practices, which adopt an inductive approach. This divergence is fundamental to understanding how health policies become inadequate and often ineffective in meeting the needs

of these communities. The biomedical conception of health, which prevails in guidelines and public policies, with its organicist and hegemonic view, often does not consider the holistic views Indigenous peoples have regarding illness and well-being, leading to tensions and distrust regarding the health services offered. This is true for both the Indigenous population and SUS staff.

2. **Holistic View of Health in Indigenous Cultures:** Indigenous cultures generally possess a conception of health that is integral and holistic, presenting different worldviews and ways of living; considering the interconnection between body, mind, spirit, and environment. For many Indigenous peoples, health is not merely the absence of disease but a state of harmony with the world around them, including social, cultural, and spiritual relationships, as well as encompassing plant, animal, and mineral worlds. Thus, health is understood as total and collective well-being, not just physical. When a person becomes ill, it reflects a malady within the community; everyone is at risk. Therefore, holistic healing practices involve rituals, the use of medicinal plants, massage, and other methods encompassing cultural and spiritual communal aspects. According to Oliveira [3], “traditional healing practices do not limit themselves to treating symptoms but include restoring harmony and balance in relationships with nature and the community”. This ontological and epistemological difference is central to understanding the distrust many Indigenous peoples have towards Western medicine.
3. **Cultural and Linguistic Aspects:** Another element compromising access to healthcare is the cultural and linguistic diversity of Indigenous populations. Communication can be a significant barrier, as many peoples speak their native languages and may feel uncomfortable expressing themselves in Portuguese, resulting in misunderstandings and frustration during care. Moreover, the lack of professionals who can communicate in Indigenous languages further complicates the interaction between healthcare professionals and the communities served. According to Viana Ferreira [4], “the language barrier transfers a critical space of cultural communication where Indigenous knowledge can be invalidated or misinterpreted during medical care”. The inability to understand and respect Indigenous cultural practices and worldviews often leads to the exclusion of these populations from health care. The experience of receiving care that does not acknowledge local culture and knowledge can generate distrust and resistance from communities, which, in many cases, prefer to seek traditional healing methods.
4. **Distrust and Rejection of Health Services:** When public health policies ignore or delegitimize traditional knowledge, it generates a phenomenon of rejection by

Indigenous communities towards the health services offered. The imposition of biomedical practices, without consideration of local knowledge, leads to alienation of communities and abandonment of available health services. As Ribeiro and Santos [5] assert, “the imposition of biomedical practices without considering local knowledge results in a refusal by the communities to seek medical care, undermining the effectiveness of health policies”. This situation is exacerbated by the perception that healthcare professionals are not adequately prepared to meet the cultural specificities of Indigenous communities. The lack of trained professionals in intercultural practices can lead to inadequate care, increasing resistance to formal healthcare services. Therefore, there is an urgent need for more Indigenous health agents, who play a crucial role in the cultural hybridization resulting from the dialogue between traditional knowledge and biomedical knowledge.

5. **Access to Health Services:** One of the main barriers to access to healthcare for Indigenous populations is the remote location of their villages. Many communities are situated in hard-to-reach regions, such as forests, mountainous areas, or riverine regions. This implies that, in many cases, physical proximity to a health service is illusory, as the necessary structures for care are scarce or nonexistent nearby. The World Health Organization [6] highlights that “many Indigenous peoples face significant challenges, such as the location of distant health services and lack of adequate transportation, which limits access to care.” The distance between villages and health units often results in long and costly travel times for Indigenous peoples, who, in many cases, need to travel dozens or even hundreds of kilometers to receive care. This situation is further complicated by the precariousness of access routes, which can be affected by rainfall and adverse weather conditions. The lack of safe and adequate transport infrastructure contributes to this reality, leading many to choose not to seek medical attention.

To illustrate the challenges in implementing Indigenous health policies, it is essential to consider case studies demonstrating how the tensions between the universality of SUS and the cultural specificities of Indigenous communities manifest in practice. A relevant example is the case of the Yanomami communities, who inhabit remote regions of the Brazilian Amazon. Logistical difficulties, such as the absence of adequate transportation infrastructure and the distance from health units, combined with the lack of professionals trained in intercultural practices, lead to low adherence to available health services. A study conducted by Silva and Almeida [7] documents how the Yanomami prefer to resort to traditional healing practices led by their shamans rather than seek formal medical care, which is often perceived as insensitive to their cultural needs. This case study reveals the

importance of health policies that not only expand physical infrastructure but also promote intercultural training and recognition of traditional healing practices as legitimate components of the health system.

The tensions between the universality of SUS and the specificity of Indigenous communities require a rethinking of health policies in Brazil. For health strategies to be effective, it is essential to promote interculturality, ensure the active participation of Indigenous peoples, and build a system that respects cultural and social diversity. The overcoming of the challenges mentioned requires a continuous and collaborative commitment between the state, Indigenous communities, and healthcare professionals. But above all, it necessitates forming a dialogic consensus through the concepts of illness and well-being.

**Institutional Discrimination:** Institutional discrimination constitutes a form of unfavorable treatment that occurs in the functioning of public or private institutions. It is observable when their agents treat individuals or groups based on negative stereotypes internalized in culture. According to Moreira [8], institutional discrimination specifically aims to promote subordination and maintain social control over members of a particular group. The omission of public power in Brazil regarding health care led to the Yanomami humanitarian crisis in 2021-2022. This omission stemmed from a systematic political choice in favor of illegal miners, where health neglect was intensified in the face of the risks of activities in areas dominated by crime.

Reports of discrimination in healthcare for Indigenous people are recurrent and arise from stereotypes present in our culture, such as the notion that Indigenous individuals are criminals, lazy, unclean, and violent. This internalization of prejudice within institutions has been constructed and perpetuated by members of the dominant elite who control the mechanisms for accessing various social institutions, which, consequently, express the interests of these segments [9]. The solution necessarily involves strengthening public policies for the inclusion of Indigenous peoples in university courses within the healthcare sector and among the public service staff in this area, consulting Indigenous communities prior to constructing public policies, raising awareness about prejudice, and, especially, providing rapid responses to cases of rights violations by the Judiciary, Legislative, and Executive branches.

### 3. Critical Reflections

The contradictions observed between the normative framework and daily practice in the context of Indigenous health in Brazil reflect a series of structural and conjunctural challenges among different conceptions of health/well-being and disease/illness that must be addressed for health rights to be fully realized. The tension between the universality of the Unified Health System (SUS) and the cultural specificity of Indigenous communities points to the need for a more flexi-

ble and adaptable health model that substantively recognizes and incorporates the traditional health practices of Indigenous peoples.

In the dialogical tension between two models of thought arises the concept of "illness" as a point of intersection among different worldviews, resulting from the analysis of the healing process that presents itself as totally hybrid. It goes beyond mere integration of knowledge; it constitutes a true ontological and epistemological dialogue between two conceptions and practices of life [10]. In other words, interculturality in Indigenous health must be understood as the deep and equal exchange between various forms of knowledge and experiences, recognizing the legitimacy of Indigenous healing practices and their importance for the health and well-being of communities.

The intercultural training of healthcare professionals is a central aspect of overcoming challenges in Indigenous health and must be addressed through specific methodological strategies that include both initial training and continuing education. Training programs should be developed in partnership with Indigenous leadership. Indigenous health agents, Indigenous educators, and should include modules on the history, culture, and healing practices of different ethnic groups, in addition to training professionals in intercultural communication techniques. A methodological approach based on critical pedagogy, as proposed by Paulo Freire, and decolonial authors such as Mignon, can be applied to foster genuine dialogue between healthcare professionals and Indigenous communities, encouraging reflective practices that acknowledge the limitations of biomedical knowledge and value traditional knowledge. Furthermore, the implementation of pilot projects in specific areas can provide valuable empirical data for adapting and expanding these training strategies on a larger scale, contributing to building a health system that is genuinely inclusive and culturally sensitive. In reality, these practices are already underway; what is lacking is the recognition of new realities that surpass what the West calls science.

Adding to this is the lack of adequate infrastructure and limited social participation that highlight the importance of investing in solutions that not only expand physical access to health services but also promote genuine integration of Indigenous communities in the management and formulation of health policies that concern them. This integration involves recognizing traditional health practices as essential components of health care, necessitating a public policy that values and integrates these practices rather than merely attempting to adapt them to the dominant Western biomedical model [11].

To ensure that the health rights of Indigenous peoples, as established in the Federal Constitution, the Universal Declaration of Human Rights, and the United Nations Declaration on the Rights of Indigenous Peoples, are effectively guaranteed, it is imperative that public policies advance towards greater cultural sensitivity, robust infrastructure, and genuine

community participation. The incorporation of the concept of "illness" in the planning and execution of health policies can serve as a critical tool for promoting such cultural sensitivity, recognizing that the experience of becoming ill is culturally mediated and that healing practices vary according to specific cultural contexts.

Only then will it be possible to overcome the barriers that currently compromise the health and well-being of Indigenous populations in Brazil. Indigenous health, viewed from this perspective, is not merely a matter of providing medical services but of creating a space where different ways of understanding and treating illness can coexist and mutually enrich one another, promoting care that is more complete and culturally appropriate.

## 4. Sources

Universal Declaration of Human Rights, Article 25.

United Nations Declaration on the Rights of Indigenous Peoples, Article 24.

International Covenant on Economic, Social and Cultural Rights, Article 12.

International Covenant on Civil and Political Rights, Articles 6, 7, and 27.

Charter of the Organization of American States, Article 34.

American Convention on Human Rights, Article 26.

Additional Protocol on Economic, Social, and Cultural Rights, Articles 3 and 10.

Inter-American Convention Against Racism, Racial Discrimination and Related Forms of Intolerance, Preamble and Articles 3 and 7.

American Declaration on the Rights of Indigenous Peoples, Articles XVIII and XIX.

Federal Constitution of Brazil, Article 196.

Federal Constitution of Brazil, Article 231.

Case studies on logistical challenges faced by Indigenous communities in the Amazon.

Analysis of the predominance of the Western biomedical model and its implications for Indigenous health.

Data on inadequate infrastructure in Special Indigenous Health Districts (DSEI).

Observations on the limited participation of Indigenous communities in Indigenous Health District Councils (CONDISI).

Discussion of centralized SUS management and limitations for Indigenous self-determination.

Case study in the Amazon region regarding access difficulties and their consequences for public health.

Case analysis on limited integration of traditional health practices among the Guarani.

Reports on the public health crisis among the Yanomami and the state response.

## Abbreviations

SUS	Sistema Único de Saúde (Unified Health System)
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
ILO	International Labor Organization
IACHR	Inter-American Commission on Human Rights
DSEI	Distritos Sanitários Especiais Indígenas (Special Indigenous Health Districts)
CONDISI	Conselhos Distritais de Saúde Indígena (Indigenous Health District Councils)
OAS	Organization of American States

## Author Contributions

**Maria de Lourdes Beldi de Alcântara:** Conceptualization, Data curation, Formal Analysis, Investigation, Methodology, Writing – review & editing

**Juliana Mafra:** Conceptualization, Formal Analysis, Investigation, Methodology, Writing – original draft, Writing – review & editing

**Alejandro Parellada:** Conceptualization, Investigation, Methodology, Project administration, Writing – original draft, Writing – review & editing

## Conflicts of Interest

The authors declare no conflicts of interest.

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