Cadernos Ibero-Americanos de Direito Sanitário
Cuadernos Iberoamericanos de Derecho Sanitario

ISSN: 2358-1824

Article

Indigenous people with disabilities in brazilian health policies: barriers and opportunities for inclusion

O indígena com deficiência nas políticas de saúde brasileiras: obstáculos e perspectivas para inclusão

Indígenas con discapacidad en las políticas sanitarias brasileñas: obstáculos y perspectivas de inclusión

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Submitted on: 02/27/25
Revision on: 05/16/25
Approved on: 05/16/25

Abstract

Objective: To investigate the intersection of ethnicity and disability in Brazilian health policies for Indigenous peoples and persons with disabilities, and to identify how and whether Indigenous persons with disabilities have been included in Brazilian health policies. **Methodology:** A documentary analysis of the National Policy for Indigenous Health Care and the National Policy for the Health Care of Persons with Disabilities was conducted, complemented by a literature review. **Results:** Although Brazil has strong legislation to guarantee the health of its citizens, a Unified Health System based on universality, equity, and comprehensiveness, and an Indigenous health subsystem focused on specialized care, it was observed that neither of the two policies mentioned Indigenous persons with disabilities. **Conclusion:** Despite the fact that Indigenous health in Brazil aligns with the 1988 Federal Constitution, which establishes health as a responsibility of the State and a social, human, and fundamental right, and acknowledges the unfavorable health conditions of Indigenous peoples, there are gaps in Brazilian health policies concerning Indigenous persons with disabilities. This highlights the need for the development of more specific policies and more appropriate health care practices.
Keywords: Indigenous Peoples; Persons with Disabilities; Health Policy; Brazil.

Resumo

Objetivo: investigar a interseção etnia-deficiência nas políticas brasileiras de saúde indígena e da pessoa com deficiência, a fim de identificar como e se o indígena com deficiência tem sido abordado nas políticas de saúde do país. **Metodologia:** foi realizada a análise documental da Política Nacional de Atenção à Saúde Indígena e da Política Nacional de Atenção Integral à Saúde da Pessoa com Deficiência, complementada por revisão de literatura. **Resultados:** embora o Brasil possua fortes leis que visam garantir a saúde de seus cidadãos e conte com um Sistema Único de Saúde ancorado na universalidade, equidade e integralidade, bem como um subsistema de saúde indígena pautado na atenção diferenciada, verificou-se que em nenhuma das duas políticas os indígenas com deficiência foram citados. **Conclusão:** Apesar de a saúde indígena no Brasil dialogar com o disposto na Constituição Federal de 1988, a qual estabelece a saúde como dever do Estado e direito social, humano e fundamental, reconhecendo as condições desfavoráveis de saúde dos povos indígenas, existem

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https://doi.org/10.17566/ciads.v14i2.1349

lacunas evidentes quando se trata de indígenas com deficiência nas políticas brasileiras, tornando imprescindível a elaboração de ações de saúde mais específicas e o atendimento e cuidado de saúde mais adequados.

Palavras-chave: Povos Indígenas; Pessoas com Deficiência; Política de Saúde; Brasil.

Resumen

Objetivo: Analizar la intersección entre etnicidad y discapacidad en las políticas brasileñas de salud dirigidas a los pueblos indígenas y a las personas con discapacidad, con el propósito de identificar cómo y si las personas indígenas con discapacidad han sido contempladas en dichas políticas. **Metodología:** Se realizó un análisis documental de la Política Nacional de Atención a la Salud de los Pueblos Indígenas y de la Política Nacional de Atención Integral a la Salud de las Personas con Discapacidad, complementado con una revisión bibliográfica. **Resultados:** A pesar de que Brasil cuenta con una legislación sólida orientada a garantizar el derecho a la salud de sus ciudadanos, así como con un Sistema Único de Salud basado en los principios de universalidad, equidad e integralidad, y un subsistema de salud indígena fundamentado en la atención diferenciada, se constató que ninguna de las dos políticas menciona a las personas indígenas con discapacidad. **Conclusión:** Aunque la salud indígena en Brasil está en consonancia con la Constitución Federal de 1988, que establece la salud como un deber del Estado y un derecho social, humano y fundamental, y reconoce las condiciones desfavorables de salud de los pueblos indígenas, existen vacíos en las políticas de salud brasileñas en lo que respecta a las personas indígenas con discapacidad. Esto evidencia la necesidad de desarrollar políticas más específicas y estrategias de atención sanitaria más adecuadas.

Palabras clave: Pueblos Indígenas; Personas con Discapacidad; Política de Salud; Brasil.

Introduction

With regard to public policies for vulnerable populations, Brazil has a strong legal framework to guarantee and promote the health of its citizens. Constitutionally safeguarded, health is considered a right of all and a duty of the State, and is understood to be a social, human and fundamental right (1) reinforcing the country’s commitment to health based on universality, equity and comprehensiveness, principles that govern the country's Unified Health System (SUS).

Indigenous health in Brazil is in dialogue with the 1988 Federal Constitution, which recognizes not only the diversity and specificity of indigenous peoples, but also their unfavourable health conditions as a result of their historical exploitation, colonization and tutelage. Legal advances have been made to guarantee differentiated health care for indigenous peoples within the SUS, respecting their cultures, knowledge and epidemiological particularities. An example of this was the creation of the Indigenous Health Care Subsystem (Sasi) and the National Indigenous Peoples' Health Care Policy (PNASPI)(2) which are under the responsibility of the Secretariat for Indigenous Health (SESAI), a body created in 2010 and linked to the Ministry of Health(3).

Similarly, Brazil has made progress in building policies aimed at the health of people with disabilities, establishing actions that guarantee the integration and inclusion of these individuals in the health system, as well as measures that provide for accessibility, articulating and expanding health care within the SUS. In this sense, the National Policy for Comprehensive Health Care for People with Disabilities (PNAISPD) was created in 2002, expanded and updated in 2023, representing an important advance in guaranteeing the health and lives of people with disabilities in the country(4,5).

Despite the regulatory advances in the health of people with disabilities and indigenous health, Brazil still faces problems in the execution and proper implementation of these measures. When it comes to access to health systems for people with disabilities, different authors have highlighted major

https://doi.org/10.17566/ciads.v14i2.1349

challenges in terms of access and accessibility to health institutions(6,7,8,9). Communication problems, lack of adequate services and care, difficulties in getting to institutions and infrastructure problems were some of the issues diagnosed, violating the principle of equity in the SUS.

In indigenous health, mismatches were also identified between health actions and the sociocultural particularities of native peoples. The concept of differentiated care, for example, a pillar of indigenous health policy, is still not well defined by the PNASPI, opening up space for strictly biomedical care and disregarding the specificities of this population(10). Furthermore, the quality of care is still generally precarious and poorly resolved, as it is permeated by unpreparedness, high turnover and a shortage of qualified professionals, as well as a lack of adequate structure(10,11). The health of the indigenous population and people with disabilities in Brazil therefore seems to reflect the idea of Da Cunha and colleagues that “good policies do not automatically translate into good practices and good results”(6) (pag. 2).

In addition to the general issues faced by the two policies, PNASPI and PNAISPD still face clear gaps when it comes to actions aimed at a specific part of the indigenous population, namely indigenous people with disabilities. Currently, more than 50 million indigenous people in the world have some kind of disability(12). In Brazil, the last census covering the indigenous population with disabilities, dated 2010, identified more than 15,000 indigenous people with severe disabilities, i.e. individuals who are unable to see, hear, walk, climb stairs and people with intellectual disabilities(13). Although indigenous peoples represent 0.83% of the country’s population(14) the incidence of certain types of disability among indigenous peoples is even higher than the national average, depending on the region observed(13).

Despite this, policies aimed at this population are incipient and there is a lack of studies on the effectiveness of existing health interventions to support indigenous people with disabilities, making them even more vulnerable when it comes to the right to health(13,15). According to the Brazilian Institute of Geography and Statistics (IBGE), new data on the number of indigenous people with disabilities in Brazil should be released in 2025(16). This may help not only in the reflection and discussion on the issue in the political and scientific agendas, but also in the development of more comprehensive and appropriate health policies.

In view of the above, this study aims to add to efforts to improve indigenous health in Brazil by investigating the intersection of ethnicity and disability in the field of health, in order to identify how and whether indigenous people with disabilities have been addressed in the country's health policies. In this way, it is hoped that it will be possible to reflect on and aspire to appropriate public policies and legal measures in order to guarantee the right to life and health of indigenous people with disabilities.

Methodology

The methodology of this study is based on a qualitative approach, based on document analysis and critical and interpretative reading of the materials. According to Lakatos and Marconi(17) documentary research and analysis consists of examining and interpreting documents, with the aim of improving scientific research and gaining an in-depth understanding of historical and social phenomena and events. In this sense, the methodology requires the researcher to take an active role in the production of knowledge by selecting, analyzing and systematizing the data, in order to understand not only the document itself, but the context in which it was produced(18). Two types of sources stand out in documentary analysis: primary and secondary. An example of primary sources are documents from public archives, which will be analyzed throughout this article(17).

The focus of this study is therefore the National Policy for Health Care for Indigenous Peoples and the National Policy for Comprehensive Health Care for People with Disabilities. These two policies were chosen because they are not only a reliable source of data on public health policies, but are also the two main health regulations when it comes to indigenous populations and people with disabilities at a national level, and their contents can cover the intersection of ethnicity and disability. In addition, bibliographical references on the subject were also consulted in order to improve what was proposed in the article and dialogue with the two policies chosen.

Thus, the methodology employed consisted of consulting the aforementioned policies on the portals of the Federal Government, especially the Ministry of Health, as well as a bibliographic search in databases and journals on the subject of health, indigenous health and disability. After searching the material, the policies were analyzed in full and in detail, with the aim of examining possible intersections between indigenous and disability issues. Key points in the two policies were highlighted and compiled for comparison and then interpreted in the light of the bibliography chosen for the best development of the research.

Results and discussion

The advances and more progressive health policies for indigenous peoples and people with disabilities in Brazil have been the result of an intense political movement by these individuals over the years. Historically invisibilized, indigenous people and people with disabilities shared not only the oppression and biomedicalization of their bodies, but also the suppression of their autonomy, individuality and their undue inclusion in political decisions, since they were considered inferior and incapable beings for years, and were therefore mediated by the state's tutelary regime.

It was only in the 1970s, driven by the ideals of the re-democratization of the country and the Health Reform Movement, that the health of indigenous people and people with disabilities began to be guided by respect for their bodies, specificities, demands and decisions(19,20). With the promulgation of the 1988 Federal Constitution, known as the Citizen's Constitution, which makes health a right for all and a duty of the state, new health policies and government measures were established for the population, also taking into account indigenous peoples and people with disabilities.

As a result of the indigenous movement, the PNASPI was regulated in 1999 by Decree No. 3,156 with the aim of guaranteeing access to health care for indigenous peoples, recognizing the need for differentiated care adapted to their particularities, as well as the importance of ensuring the participation of indigenous peoples in drawing up health policies(2). At the beginning of the 2000s, the PNASPI was restructured with broad indigenous participation and was finally instituted by Ministry of Health Ordinance No. 254(2) representing an advance in the implementation of actions aimed at the specificities and health demands of this population.

The PNASPI is part of the National Health Policy and aims not only to guarantee the rights of indigenous peoples to full, equitable and universal access to health, but also to recognize the value and complementarity of indigenous medicine practices in health care. The policy also aims to involve communities in drawing up policies, highlighting the need for health care for indigenous peoples to be carried out in a differentiated way, taking into account the specificities of ethnic groups, their practices and demands, and developing appropriate forms of care by integrating conventional services with the knowledge of indigenous peoples(2).

The organization of indigenous health is divided into 34 Special Indigenous Health Districts (DSEIs), responsible for primary health care. According to the PNASPI, the actions of the DSEIs should be oriented towards "a dynamic ethnocultural, geographic, population and administrative space that is well delimited"(2,13). and should include a set of technical activities aimed at establishing qualified health care measures for indigenous peoples. Each DSEI has a District Council for Indigenous Health, responsible for monitoring the health actions carried out in the territories.

The PNASPI also highlights the training and qualification of Indigenous Health Agents (AIS), who make up the team providing health care in the villages. The AIS are central to promoting differentiated care and guaranteeing social participation in all stages of the planning, implementation and operation of the DSEIs(2). Despite the fact that the Policy deals with important points for guaranteeing adequate health care for indigenous populations, more than two decades after its implementation, the PNASPI still faces practical difficulties in providing differentiated care to indigenous peoples(10).

Ferreira(10) Langdon, Diehl and Dias-Scopel(21) pointed out that the concept of differentiated care is not well clarified by the PNASPI, leaving room for indigenous health actions to be carried out and understood through the ideological bias of integration and guardianship. In the same vein, Ribeiro and colleagues(22)pointed out that there is still a biomedical and ethnocentric centrality in the knowledge of indigenous health professionals, which contributes to the failure to realize the health rights of indigenous peoples.

Cardoso(11) and Garnelo(23) added to this by pointing out the unpreparedness and lack of qualified professionals to care for the indigenous population, along with the high turnover of professionals and the lack of infrastructure, transportation and necessary equipment. These issues corroborate the non-recognition of indigenous therapeutic practices and reinforce the essentialist and biomedical view of care, disregarding the agency of indigenous peoples in strengthening health. Added to this is the lack of actions aimed at indigenous people with disabilities.

Although the PNASPI recognizes the historical vulnerability of indigenous peoples, it was noted that there is no mention of indigenous people with disabilities, nor are there any health actions, strategies or recommendations aimed at this population. Furthermore, the policy does not include non-indigenous people, who are the responsibility of the SUS and not the Sasi(2). This issue has a direct impact on the health of indigenous people with disabilities who, given the low supply of actions and services, the remoteness of their territories from health centers and the precariousness of transport, are forced to travel indefinitely to urban centers in search of care. Unassisted by PNASPI and Sasi, this population loses any guarantee of differentiated care, the basis of indigenous policy, when they arrive in the cities.

Since 2024, the current secretary of indigenous health, Weibe Tapeba, has shown an interest in improving the PNASPI(24) although he has not mentioned the issue of disability in his actions. However, initiatives to improve inclusive practices for indigenous people with disabilities have been expressed by SESAI. In 2023, SESAI promoted an inter-ministerial dialog on inclusive practices for indigenous people with disabilities in Sasi, with the aim of improving access for this population to health services(25). In 2024, the National Foundation for Indigenous Peoples and SESAI took part in the First Regional and Inter-institutional Meeting on Policies for Indigenous People with Disabilities and Deaf Indigenous People, in the state of Bahia, discussing proposals for public policies for and with this population, in order to draw up an action plan with demands and indications for health care for this segment(26).

With regard to the invisibility of indigenous people with disabilities in indigenous policies, similar problems were found in the PNAISPD. Hitherto known as the National Health Policy for People with Disabilities (PNSPD), this policy was approved in 2002 by Ministerial Order 1.060/2002 of the Ministry of Health(27). This policy represented a significant advance in access to healthcare for people with disabilities, since it was created to include these individuals in the entire SUS care network. The aim was to recognize the real needs of people with disabilities so that appropriate care measures and responses could be implemented, as well as preventing possible problems that could lead to the onset of disabilities(4).

Over the years, the political movement of people with disabilities in Brazil has culminated in results similar to those of the indigenous movement. Since 2010, the country has had a National Secretariat for the Rights of People with Disabilities (SNDPD), which is part of the Ministry of Human Rights and Citizenship and works to articulate and coordinate public policies aimed at this population(28). In addition to a secretariat and a specific health policy, over the course of the 2000s the country made progress in legal frameworks aimed at this population segment, with the International Convention on the Rights of Persons with Disabilities, adopted by the United Nations in 2006, as the basis for many of its actions(29).

The International Convention on the Rights of Persons with Disabilities aims to promote, protect and ensure the full and equal enjoyment of human rights by all persons with disabilities and to promote respect for their dignity(29). The document also raises concerns about the living conditions of these individuals when associated with other conditions, such as ethnic and racial issues(29). Brazil, through Legislative Decree No. 186 of 2008(30) and Executive Decree No. 6.949 of 2009(31) ratified the International Convention and its Optional Protocol, giving the document the equivalent of a Constitutional Amendment, consolidating the advances made by the movement of people with disabilities. The International Convention is the main international treaty on the rights of people with disabilities and was the first international treaty with constitutional equivalence, making it possible to establish measures and legal references based on human rights for the inclusion and full participation of these people in Brazil.

In this sense, based on the International Convention on the Rights of Persons with Disabilities, the Brazilian Law on the Inclusion of Persons with Disabilities (LBI), Law No. 13.146/15(32) was established in 2015. The LBI establishes principles and guidelines with the aim of ensuring accessibility, inclusion and priority and specialized care in various sectors, including health(32). However, although the document emphasizes the need for the state to provide health services to people with disabilities as close as possible to their communities, including in rural areas, there is no mention of indigenous peoples.

In 2017, the Ministry of Health consolidated the rules on SUS health actions and services through Consolidation Ordinance No. 05/2017(33). The document contains important points for people with disabilities, such as the establishment of a National Advisory and Support Committee for health actions aimed at the segment, whose technical-consultative nature helps not only to subsidize actions of the Ministry of Health, but also establishes quality standards for services aimed at people with disabilities(33). It should also be pointed out that this ordinance also includes a chapter on the health of indigenous peoples in conjunction with SESAI, but it mainly deals with integrated care strategies for prevalent childhood diseases(33).

Considering the history of measures designed to support the disabled population, in 2023, with Ordinance GM/MS No. 1,526(5) the PNSPD was updated and expanded and renamed the National Policy for Comprehensive Health Care for People with Disabilities. Notably improved, the PNAISPD aims to promote and protect health by expanding access to care, which is now, by law, comprehensive, intersectoral and interprofessional within the SUS(5). The policy also brings innovations such as promoting the health of caregivers and tackling ableism - that is, discrimination against people with disabilities - representing an important advance in guaranteeing the health and lives of people with disabilities in the country.

It should be noted that one of the pillars of the PNAISPD is the issue of intersectionality and the singularities of people with disabilities, with a view to the protagonism of people with disabilities in the care process(5). In this sense, the PNAISPD understands that the experiences of health, illness and disability are different depending on the individual and the social markers that permeate their life. In addition, the policy understands health care as intersectoral, which needs to be promoted comprehensively within the SUS, in order to contribute to the quality of life, autonomy and inclusion of individuals(5). Another novelty of the PNAISPD is that Article 7 includes as a health promotion strategy the promotion of actions aimed at minimizing inequities involving ethnic aspects(5). However, the policy does not provide in-depth information on strategies aimed at indigenous peoples.

In 2023, another important advance was made in the health of people with disabilities. Decree No. 11.793(34) established the National Plan for the Health of People with Disabilities established the National Plan for the Rights of People with Disabilities - New Living Without Limits. The new Plan, the result of dialogue between the SNDPD and various ministries, also involving civil society, aims to promote, through the articulation of policies and actions, the full and equal exercise of citizenship by people with disabilities, tackling ableism and recognizing intersectionality as a constituent component of the identities of people with disabilities(35). Among the Plan's structuring axes is the promotion of the right to health, with the creation of programs more suited to the realities of the subjects(35). Although the New Living Without Limits has brought significant innovations and advances for people with disabilities, it is important to remember that, although the Ministry of Indigenous Peoples was involved in its drafting, there is no mention of indigenous people with disabilities in any of the 95 actions in the current Plan(35).

In 2024, the National Care Policy was sanctioned by Law No. 15.069/2024(36) seeking to guarantee access and the right to care, taking into account the multiple inequalities of individuals. The policy also aims to integrate public policies in areas such as health, social assistance and human rights, focusing not only on those being cared for, but also on their respective caregivers. Among the policy's priority public are people with disabilities, however, the ethnic issue is mentioned only once throughout the policy, in the definition "multiple inequalities". Although brief, the reminder of ethnicity and disability within the policy, as it appears in the PNAISPD, could be an indication of greater attention within health policies for indigenous people with disabilities.

Despite the progress made in Brazilian legislation, interest in the health of indigenous people with disabilities is still incipient. In order to fill the gaps in the agendas for indigenous health and people with disabilities, public policies need to identify, recognize and meet the specific demands of indigenous people with disabilities. In this sense, it is important to consider the intercultural perspective when it comes to the health-disease-care process among indigenous peoples with disabilities. Interculturality, according to Walsh(37) is a process of learning and exchange between cultures, based on mutual respect, symmetry, equality and legitimacy, and is therefore an important point when talking about actions that can support the indigenous population.

In addition to the intercultural perspective, when addressing the health of indigenous people with disabilities, it is important to consider what Menéndez(38) has called medical pluralism. According to the author(38) the term refers to the articulation of different medicines used, such as indigenous medicine and biomedical medicine, to treat health problems more adequately. In this sense, both interculturality and medical pluralism should not only be the pillar of the implementation of the differentiated health care proposed by the PNASPI, but should also be considered in the health actions aimed at intersectionality proposed by the PNAISPD.

The failure to consider the intersection of ethnicity and disability in Brazilian health policies also seems to be linked to the lack of concrete data on this population. Worldwide, the United Nations (UN) has already acknowledged the lack of data on indigenous people with disabilities(39). In Brazil, the latest data on this population dates from the 2010 census, which shows that it is significantly out of date. The underreporting and often non-existence of data on indigenous people with disabilities contributes to the erasure of this population from public policies, causing these peoples to suffer multiple forms of discrimination and to be prevented from fully enjoying their rights. Therefore, in order to reverse this situation, it is necessary to collect official and statistical data on indigenous people with disabilities, so that it is possible to map their main health demands.

Conclusion

Despite significant advances in Brazilian health policies for the indigenous population and for people with disabilities, consideration of the intersection of ethnicity and disability still seems to be incipient in both political agendas. It should be noted that the lack of assistance for indigenous people with disabilities has already been recognized by the UN, which has stressed the need for special health measures for this population(39) and has drawn attention to the fact that this population segment has not yet been centrally addressed by either of the two movements, i.e. the indigenous movement and the movement of people with disabilities.

An analysis of the National Policy for the Health Care of Indigenous Peoples revealed the absence of specific guidelines for indigenous people with disabilities, leaving them on the margins of health policies and unassisted by Sasi and differentiated care. Furthermore, there is no support for those who need to leave their communities in search of adequate treatment, given that the PNASPI only deals with the health of indigenous villagers. These issues leave indigenous people with disabilities doubly vulnerable, since they often have to go to urban centers in search of better health care. Although the PNASPI does not seem to meet the needs of indigenous people with disabilities, Brazil has made progress in recent years in guaranteeing the recognition and right to health of this population.

The analysis of the National Policy for Comprehensive Health Care for People with Disabilities followed a similar line to indigenous health. Although specific actions for indigenous peoples were not explicitly mentioned in the policy, the expansion of the PNAISPD and the consideration of intersectionality, including ethnic aspects in its actions, indicates a possible path to be opened up and explored by Brazilian health policies. Despite this, it was observed that the agenda of indigenous people with disabilities was not included in the actions of the New National Plan for the Rights of People with Disabilities, which highlights the persistent invisibility of this population segment.

Despite the difficulties and gaps encountered, Brazil seems to have decided to move forward by showing interest in guaranteeing the health rights of indigenous people with disabilities. Policy updates and the move made by SESAI point to a possible inclusion of the segment in future health actions. The first step, recognizing the existence and health needs of this population, seems to have been taken. However, it is necessary to recognize, identify and confront the challenges that still persist when it comes to this population in health policies. The creation of measures and public policies that adequately serve indigenous people with disabilities is essential and must not be left aside by indigenous health and disability health policies. The hope is that the journey will continue towards a health system that is truly based on the principles of the SUS.

Funding

This work was carried out with the support of the Coordenação de Aperfeiçoamento de Pessoal de Nível Superior – Brasil (CAPES) – Funding Code 001.

Conflict of interest

The author declares that there is no conflict of interest.

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How to cite

Garcia JV. Indigenous people with disabilities in brazilian health policies: barriers and opportunities for inclusion. Cadernos Ibero-Americanos de Direito Sanitário. 2025 apr./jun.;14(2):51-61.
https://doi.org/10.17566/ciads.v14i2.1349

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