Interview with Putira Sacuena

Entrevista com Putira Sacuena

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Abstract

In this interview, Putira Sacuena shares reflections on her journey as an indigenous woman, leader, biomedical scientist, and current director of the Department of Primary Indigenous Health Care at the Indigenous Health Secretariat. The conversation articulates personal and political dimensions, composing a narrative committed to transforming the structures that have historically rendered indigenous peoples invisible. Putira reflects on her community upbringing, highlighting the knowledge inherited, especially from her paternal grandmother, a midwife in the Rio Negro territory. This knowledge, intertwined with her academic training, underpins her work as a "relatable doctor." Based on her experience in public health and public administration, Putira discusses the challenges of training health professionals, confronting institutional racism, and the need for policies that recognize the cross-cutting nature of indigenous health within the Brazilian Unified Health System (SUS). She advocates for the strengthening of indigenous medicines as legitimate forms of care, science, and politics. Putira invites us to rethink the SUS from the perspective of indigenous territories and to recognize indigenous sciences as the foundation for truly differentiated and anti-racist care.

Keywords: Indigenous Health; Primary Health Care; Institutional Racism; Indigenous Medicines; Indigenous Women.

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Resumo

Nesta entrevista, Putira Sacuena compartilha reflexões sobre sua trajetória como mulher indígena, liderança, biomédica, cientista e atual diretora do Departamento de Atenção Primária à Saúde Indígena da Secretaria de Saúde Indígena. A conversa articula dimensões pessoais e políticas, compondo uma narrativa comprometida com a transformação das estruturas que historicamente invisibilizaram os povos indígenas. Putira reflete sobre sua formação na comunidade, destacando os saberes herdados, especialmente de sua avó paterna, parteira no território do Rio Negro. Esses conhecimentos, entrelaçados à sua formação acadêmica, sustentam sua atuação como "doutora parente". Com base em sua experiência na saúde coletiva e na gestão pública, Putira discute os desafios da formação de profissionais de saúde, o enfrentamento ao racismo institucional e a necessidade de políticas que reconheçam a transversalidade da saúde indígena no SUS. Defende o fortalecimento das medicinas indígenas como formas legítimas de cuidado, ciência e política. Putira nos convida a repensar o SUS a partir dos territórios indígenas e a reconhecer as ciências indígenas como fundamento para uma atenção verdadeiramente diferenciada e antirracista.

Palavras-Chave: Saúde Indígena; Atenção Primária à Saúde; Racismo Institucional; Medicinas Indígenas; Mulheres Indígenas.

Interviewee

Putira Sacuena

A biomedical scientist with a Ph.D. in biological anthropology specializing in forensic genetics from the Federal University of Pará (UFPA), she serves as director of the Department of Primary Indigenous Health Care (DAPSI) at the Secretariat of Indigenous Health (SESAI) of the Ministry of Health. She conducts postdoctoral research at UFPA, focusing on human genetics and indigenous medicines. Her work connects indigenous health, primary care, public policies, and indigenous sciences. She is a co-founder of the Brazilian Network of Indigenous Anthropologists (ABIA) and a member of the National Network of Indigenous Women Warriors of Ancestry (ANMIGA). She also participates in initiatives such as the Rede Unida network.

Natalia Farias: *Putira, going back to what we discussed earlier... This is an interview about your current work as Director of the Department of Primary Indigenous Health Care (DAPSI), but it is not limited to that; it is also about your life trajectory as an indigenous woman, leader, scientist, and political figure... I will ask some guiding questions, along with Elizângela, but the space is all yours; speak however you like.*
So, starting with the basics... How do you introduce yourself?

Putira Sacuena: My name is Putira; I've always been called that. My father used to say, "It is not just any Putira; it is Sacuena," so I am Putira Sacuena. But my given name is Eliene dos Santos Rodrigues—a name that even my grandmother said she didn't know where it came from. There's a funny story: when I worked in the laboratory of the general hospital in Santa Isabel do Rio Negro, a relative who knew me as Putira came looking for Eliene in the lab, and then I told her that was me. She exclaimed, "Wow! What an ugly name they gave you!" Elinete Baniwa, an indigenous doctor who also worked there, still laughs about it to this day.

The truth is that even I sometimes forget that this is my "official" name. Everyone knows me as Putira Sacuena.

Natalia Farias: *Does this name have a meaning?*

Putira Sacuena: A simple translation would be "fragrant flower." But when we translate it into Portuguese, it loses a lot of its meaning. My father used to say that "sacuena" was a flower that grew in the Serra do Jacamin, near my Uncle Jaime Rodrigues' house. This small yellow flower, when it bloomed, perfumed the entire mountain range. When we passed by slowly in our canoe, we could smell it in the air. That was the sacuena, a strong and pleasant scent that marked the entire landscape. But when translated into Portuguese, it loses a bit of its meaning, you know? And we need to give things new meaning so it just becomes "fragrant flower."

Natalia Farias: *Please tell us more about your life and your involvement in social and student movements, both in Santa Isabel and later in college.*

Putira Sacuena: Well, I just had my birthday; I was born on June 2, 1977. I have three sons, two daughters, and a granddaughter. I always say that when we leave our home regions, we bring our families with us. As a result, we leave our children behind in the big cities, but over time, we realize that returning is important so we do not lose contact with our roots and do not forget who we are.

My first trip to Belém was in the late 1990s. Then, I returned in 2012 to stay longer studying biomedicine, and it was there that I became involved with the indigenous student movement. I was the president of the Indigenous Student Association at UFPA three times; at that time, I was the only one from the Rio Negro region. Gradually, more relatives arrived, like Elinete Baniwa... and we fought for policies that guaranteed our continued presence.

In Santa Isabel, I collaborated extensively with the Youth Department in the years 1993, 1994, and 1995. We did educational work in the communities, talking about alcohol, drugs, and prevention. At the time, my father was a city councilor, and city hall did not want to provide gasoline for our trips. I accompanied my father to the meetings and questioned everything from an early age, demanding support from the city hall.

Today, when I look at the youth in our communities, I become worried. In Santa Isabel, for example, back in the day, we fought over a single sports court. Now, several sports courts exist, but many of them remain abandoned. There was a lack of education and public policies; many of my youth peers were affected by alcohol, and we still do not have enough psychosocial support to address it.

Natalia Farias: *On other occasions when I've had the opportunity to hear you tell your story about your childhood, I have noticed that you often speak about your grandmother with immense respect regarding her teachings. What role did she play in the education of your father, who was a teacher, and in your upbringing?*

Putira Sacuena: I always talk a lot about my grandmother... I am going to become emotional... because she could not read or write, yet she deeply believed in education. It was a very strong conviction in her.

During my father's era, towns along the riverbank established boarding schools, leading to the growth of the municipality around them. My grandmother would row for three days to take my uncles and my father to the boarding school. The girls stayed with the nuns, and my father and uncles stayed with the priests. She did this journey four times a year—eight trips, actually: she would go with them, return alone, then go back to pick them up and take them again, all by rowing. She would bring salted smoked fish and flour, among other items. Her flour was very good; everyone liked it a lot.

She truly believed that her children could become teachers; that belief was very strong. And it happened; my father was one of the first teachers in the region. He started teaching when he was 17 or 18 years old. Back in the day, this

kind of teacher training, like there is today, did not exist. They learned as they went along and took on classes. Later, my father studied in the modular model that only existed in Belém. He and his classmates traveled by Buffalo airplane to study at UFPA (Federal University of Pará).[1]

Education has always been central to my family. My grandmother was proud of my father; seeing him become a teacher was like a dream come true for her. Later, my mother also became a teacher. She comes from a mixed-race background; as we say... the daughter of a Baniwa woman and a Nadëb man. My maternal grandmother died young, and my grandfather remarried, this time to a Nadëb woman. My mother's brothers took excellent care of her, always bringing us food in the city, like flour and smoked fish, while we studied. Perhaps because of this care I had more contact with my mother's family.

I know the entire Uneuixi River region, where my maternal grandfather lived. I traveled a lot in those thatched canoes... we slept inside, all crammed together. To this day, we joke with my younger sister, who would complain at night. "It is too cramped!"

We are five siblings, and I am the oldest. Everything was carefully planned and regulated... It took a while before we even got a car. We lived in Mufubé, near Boa Vista, across from Cartucho, where all our family lived. We studied in the morning and worked in the fields, or went to the fields and then to school. We traveled on foot, without bicycles, motorcycles, or cars. My father's family was Baré merchants, but because he married a Baniwa woman, he did not have the same privileges. Everything was more difficult. But I am proud of our situation: we do not owe political favors to anyone. We never received any help. Everything my siblings and I have access to in terms of education has been through great sacrifice—from my grandmother way back then, and also from my father and mother.

My grandmother was a very inspiring person to me. I talk about her a lot because I learned so much from her. She was a midwife and always invited me to accompany her to the births. Back then, she did not even have scissors; she used what she called a pauixi—a thin, sharp black stick, like a small razor. That's what she used to cut the baby's umbilical cord.

I used to see people calling my grandmother in the middle of the night to attend births—and she always went. As my grandfather traveled a lot—hunting and collecting rubber to trade for lamps, kerosene, fuel...—she stayed at home with my aunt and us children. But people were afraid to approach her, saying that my grandmother would shoot them. And it was true! My grandfather taught her to defend herself, because it was the rubber boom era.

I remember well that, because of this, when someone needed to deliver birth, they would shout from the riverbank. And my grandmother already recognized who it was just by the shout because she had been following the pregnancy.

I think it was she who taught me almost everything I know and am today. I had my first child when I was 18, and he was born with her help. She was the one who supported me and looked after me.

I had the privilege of experiencing that. My sisters say I was the favorite, but I was not. It is just that, being the oldest, I learned more from my grandmother. I always say that my father wanted a son, but I came along, a woman, instead. And I have become a woman.

Natalia Farias: *What do you mean by "I have become a woman"?*

Putira Sacuena: It is that we are born indigenous, but we become women. I became a woman through my grandmother, my mother, my aunts, and my older cousins. We learn who we are, recognizing ourselves as women. And I went through the whole ritual.

When I got my first period, I went to Serra do Jacamin. Ms. Catarina, the wife of Mr. Zé Grande, the healer, made special food for me as part of the ritual, and she took care of me along with my father and mother. She told me what I could eat and what I could not.

Back then, there were a lot of cubiu fish. I could not eat them or bathe in the river. Everything

1 Federal University of Pará.

was separate... there was a bucket, a hammock, no exertion, and I could not eat fish with skin either because it would cause inflammation and colic; only after I got better could I return to normal life. There was the moment of the breath sealing, the "closing of the body," so I could walk and not feel anything. I remember Mr. Zé Grande telling my parents, "When she wants to fly, do not clip her wings."

Later, during my doctoral studies, my mother said, "The flight happened," and I thought it was beautiful. She was a Baniwa woman who spoke little but always very firmly. It was not about flying on an airplane; it was about carrying the name of the people, the knowledge, our sciences, and our ancestry, taking all of that forward.

We become women, but we also become indigenous. It is knowledge that is not just spoken; it is lived and felt.

Because we talk a lot about the shamans and the *Kumu* and forget that there are women involved too, like Ms. Catarina, who oversaw my training during the healing rituals. Often these women are made invisible.

Natalia Farias: *It is very important to hear all of this from you, Putira. And how did you decide to study Biomedicine and, in the end, specialize in biological anthropology?*

Putira Sacuena: Look, everything has its time, right? I'll tell you so you can put this information in the interview. Did you know that I was the first indigenous woman microscopist in Santa Isabel? I was the only woman on the team; I joined when I was 18 and still had to wait three months to be hired, because when I took the test and passed, I was still a minor.

Another young woman also started the microscopist course, but she had to drop out. So I carried on. The others were all men. I had never looked through a microscope before, but when I did for the first time, I fell in love with that little thing. I would fall asleep looking at those figures and sometimes wake up with my father wiping the paper off my face... I studied diligently to be able to identify everything on the test. And it worked! I got the highest grade and was hired.

I went to work on the Marauiá River, working in many communities along the Middle Rio Negro: Serrinha, Roçado, Maricota, Boa Vista, and Cartucho... I got to know the entire Yanomami region. There were long walks; I remember an eight-hour trek through the jungle to Pororoá. After that, I was chosen to replace a laboratory technician who was retiring, Dona Conceição, and I went to Manaus to take a technical course in laboratory work. In Manaus, everything was different. I was amazed to see the big city, children in the streets, and everything so different from our communities. I felt very unwell on the bus, but I finished the course and returned to Santa Isabel to work in the hospital laboratory. During that time, I got married and had my children. My grandmother still helped me take care of them all, and then I discovered the Biomedical Sciences course and the possibility of working in research.

I've always been very curious. I used to watch anthropologists from various research institutions who lived in our region. I even talk about these experiences in my thesis: we would watch them writing everything down in their notebooks, and I wondered what they were writing so much about us.

Once, back in Boa Vista, we were bathing on the rocks, and a woman in a long dress was watching and writing, taking notes nonstop. That had a lasting impact on me and was very much a part of my childhood, because my father usually accompanied researchers in our community. It was always research about us, without us. Now we are trying to deconstruct that.

I entered UFPA (Federal University of Pará) in 2012 to study biomedicine. The entrance exam was still different, being one of the first to include indigenous people. The change meant a lot of responsibility: we had to succeed so that the policies would continue.

It was only during my pharmacology course that I understood that the greatest pharmacologist I ever had was my grandmother. She didn't need to kill plants or go to a laboratory to learn about them. That really affected me.

When I finished my undergraduate degree, I immediately went on to do a master's program.

I wanted a field that connected health, culture, and epidemiology. I met Professor João Guerreiro during my undergraduate studies; I did a scientific initiation with him. We had few indigenous professors at the university, and he had already worked with several indigenous peoples in Pará. He was my advisor for my undergraduate thesis, and I still consider him my advisor today. I chose bioanthropology because I could articulate anthropology, epidemiology, and genetics, but it was very difficult. The Genetics labs are considered the best, with the best infrastructure. I had to learn to read and write in English—I took an introductory course. I confused the letters W, V, and U, but I eventually learned. I read the articles, translated... It was complex, and institutional racism is real. If you don't have a firm foundation in what you want, you give up.

But I always say: giving up is also a type of courage, the courage to not get sick again.

I met a relative there who told me he was going to give up. I said, "You're brave." He was surprised. I explained, "You're going back to the community. That takes courage." And he reconsidered.

The master's degree was more difficult than the doctorate, even more so than the Ph.D., because we, as indigenous people, don't pursue postgraduate studies just for the sake of it; we want to solve problems, to leave a legacy for our people. We contemplate public policy, about transformation. And not everyone in academia thinks like that. That's what's missing: a return to the communities, to the people. The academy needs to learn that.

Natalia Farias: *Wow, that's great! Thank you for sharing all of this so generously. Much of what you've shared so far points to important avenues for continuing our conversation about the paths that led you to your current work at SESAI (Indigenous Health Secretariat) as director of DAPSI. Elizângela, in fact, often tells us about the research collective, noting that within academia, we tend to compartmentalize everything, separating topics into boxes: health on one side, education on the other, public policy, territory... as if these dimensions weren't, in practice, deeply intertwined with people's lives. And your trajectory shows exactly that: how these things go hand in hand, intertwining.*

With that in mind, I'd like to ask you to speak more specifically about your work at SESAI, based on your concrete experience. As an indigenous woman and as someone who comes from the territory, what is, from your perspective, the importance of this department within the SESAI structure? And, more than that, what have you been seeking to build and strengthen from the position you hold today?

Putira Sacuena: I think there's something that is very important. Before my time at SESAI, I was critical of the organization from the outside. I was on the National Health Council, representing COIAB.[2] We were very critical of the administration. But today I see that the indigenous movement is also in a learning process. Often we don't realize what's really happening in these places, who's in charge, or how the structure works.

When you ask me about the department, I can say with certainty: we have a lot to do, and we have an immense responsibility. But I also know that we can do more, provided there is a budget and political will.

I arrived at SESAI as an advisor. After less than a year, I was called to take over the directorship, but I didn't come alone. Before accepting, I spoke with COIAB and FOIRN.[3] I presented the proposal, saying that I needed the support of the base. And they said they were with me, so it was a collective decision.

The Primary Care Department is considered by many to be the "heart" of SESAI, but I usually say that we are the "brain." Even when the heart stops, the brain can continue functioning for a short period. We don't have our budget, but we keep functioning.

DAPSI is vital within SESAI because we are responsible for all aspects of healthcare, which requires infrastructure, and we are currently undergoing a restructuring process. In July 2025,

2 Coordination of Indigenous Organizations of the Brazilian Amazon (COIAB)

3 Federation of Indigenous Organizations of the Rio Negro

I will have completed one year in the position, but it feels like I've been here for three or four years, given how much we've already managed to accomplish.

I've been visiting DSEIs a lot lately,[4] and I realize how much we need to redefine healthcare and remind people why SESAI was created. Many people have forgotten, but SESAI emerged in 2010 from the Family Health Strategy (created in 2007). The model was designed to work in an integrated way: the indigenous health agent would go to the houses and observe who needed care and who was sick, and the nurse or doctor already knew where to go. That was true primary care, prevention.

In that regard, training professionals is something I see as an urgent and essential need. Even before this, at COIAB, we already discussed the need for professional qualification. But now, in management, I see that it is urgently necessary. And I'm not just talking about workshops; I'm talking about academia.

Indigenous health is not a mandatory subject in health science courses. Do we have public policies and a department, and yet indigenous health isn't taught? There's elderly health, women's health, and children's health, but not indigenous health. What exist are elective courses, based on the sensitivity of professors. When we talked to the Ministry of Education (MEC)...[5] they said, "You have an optional course." But we need it to be mandatory. How can we demand something from a professional who hasn't even had access to this content?

Of course, many possibilities exist today: online courses, available materials, but we cannot ignore institutional racism. For indigenous peoples, "anything goes."

There's a phrase I hear a lot that I try to deconstruct: "If it's not difficult, it's not indigenous health." It must come to an end. Indigenous health can indeed be structured. It can have adequate base centers, decent restrooms for professionals, and equipment. We need to stop normalizing the neglect and deterioration of resources.

By the time indigenous management took over in 2023, SESAI (Special Secretariat for Indigenous Health) was in a state of complete disarray. It was an isolated secretariat that didn't communicate with others. But indigenous health is cross-cutting. How can I discuss cervical cancer, for example, if there's no coordination between specialized and primary care in states and municipalities?

Furthermore, being in this place as an Indigenous woman means constantly confronting institutional sexism and racism. For many people, my education doesn't matter; it's as if I know nothing, as if I never had an undergraduate degree, a master's degree, a doctorate, or a Ph.D.

Let me give you an example: at a large event, I was at a table with other people, and everyone had their titles: "Dr. So-and-so" and "Dr. Such-and-such." For me, it only said "SESAI representative." That caught my attention. I started paying more attention to these subtleties.

Until one day, in Alto Rio Solimões, in the village of Filadélfia, my relatives gave me gifts and called me "Relative Doctor." I said that they didn't need to call me that. But one of them, a nurse, replied, "It's important, a relative, because now I want to take a master's degree. If you are a doctor, we can be too." That touched me deeply.

I've redefined the term "doctor." It's not as an ego-driven title but as a reference, as a possibility. And today I make a point of introducing myself like this: "I am Putira Sacuena, an indigenous woman of the Baré people, a biomedical scientist by training, with a master's degree and a doctorate..." And when I introduce myself like this, the way I listen is different, my speech changes, and people look at me differently.

Natalia Farias: *Putira, I wanted to hear your thoughts on the presence of indigenous people in institutional and academic spaces as well as in public administration. In your view, is it possible to challenge and transform these spaces from an indigenous perspective? What paths do you see for that, and what are the main challenges?*

4 Special Indigenous Health Districts

5 Ministry of Education

Putira Sacuena: It would be a dream for us to occupy these spaces in a truly representative way. But to talk about this, I always like to bring up experiences. For example, there was the launch of an initiative on equity and health without racism. And then I asked, "Where are our seats at the table?" I wasn't included either. And then Putira became "the annoying one" because she demanded indigenous presence. But that's the point; if we are not there, nobody remembers us. Not even with an agenda called "indigenous health" is indigenous presence guaranteed; at most, they use "SESAI" as a label, without listening to us. This is structural racism, and the worst part is that many times people don't even realize they're being racist.

Many things that have already been included in the anti-racist plan do not include indigenous peoples. And if we are not present in decision-making, management, and advisory spaces and if we are uncommitted to promoting public policies, we simply will not be included.

A clear example: the National Program for Gender and Race Equity and the Valorization of Women Workers in the SUS (Brazilian Public Health System). When it was launched, the category "ethnicity" was not included. Only after much pressure from indigenous people was the ordinance changed to include it. But why do we need to constantly react to being considered?

And look... sometimes racism appears in the most subtle forms. A professor in Brasília told me, "Wow, I never thought I'd meet such an intelligent indigenous woman." And I replied, "That's because you only met me now. You haven't met the others yet." Sometimes we need to name things. As my grandmother used to say, naming things is important. Racism is racism.

Now, when we talk about university, that's a whole different struggle. University has two sides, and it forces you to choose one. Either you lose yourself and stop being who you are, or you resist and remain. I've seen relatives who never came back. That's not to say they've forgotten the land, but they've forgotten who they are. And if you forget who you are, as my grandmother used to say, you "become lost along the way."

I was very lucky to have heard Father Justino Rezende say, "Damn it! Don't forget who you are." That stuck with me. If we forget who we are, we act wrongly, trying to fit into a model that was never made for us. The university wasn't prepared to receive us—and it won't prepare itself. We are the ones who have opened the door, and now we must close the back door and stay.

The university also gets sick, and sometimes the pain of saying "I am indigenous" is greater than the strength to remain indigenous. And this extends to the production of knowledge. When I say that I learned pharmacology from my grandmother, that she practiced metaphysics and metachemistry without killing a single plant, the university finds it scandalous. It demands scientific proof of everything, as if our knowledge were worthless if it hadn't been through a laboratory. "Prove that a maraca cures snake bites," they say. But why do we have to prove everything? Why is the university always the one that says "okay"?

Perhaps it's time to reframe the question. Instead of always asking, "What does the university mean to you, indigenous peoples?" maybe it's time to ask, "*What do we mean to the university?*"

Natalia Farias: *I would now like to delve somewhat deeper into the issue of anti-racist actions in healthcare. In 2023, the Ministry of Health published a decree establishing the National Strategy for Equity, Health Promotion, and Combating Institutional Racism in the SUS (Brazilian Public Health System). This regulation explicitly mentions the strengthening of the Indigenous Health Care Subsystem, recognizing the social organization, customs, languages, beliefs, and traditions of indigenous peoples.*

I wanted to ask you: has SESAI promoted any actions or initiatives based on this ordinance? And, based on your experience, what are the main challenges you see today in building a Primary Health Care system that is truly anti-racist and promotes equity for indigenous peoples?

Putira Sacuena: I believe the issue of professional training is fundamental. It's pointless to talk

about indigenous health without discussing undergraduate programs. Indigenous health cannot remain just as an optional subject for those who want it; it has to be a mandatory part of the training for health professionals.

But we are working with local and state governments to improve our referral network because it doesn't make sense for us to have training and qualifications in the subsystem, in indigenous health, based on the context of the communities of the Indigenous Health Care Centers (CASAIs)...[6] if, when it reaches the municipal or state referral network, it doesn't exist. That's where our most significant problem lies.

People still think they'll only serve indigenous people in their territories, but we're everywhere. That's why I talk about training, starting with academia. We'll end up in an emergency care unit.[7] We are currently at a polyclinic within a hospital, preparing for surgery, yet the medical professionals here do not know how to handle our situation. We are in all the referral networks, and we need truly qualified professionals.

Do you want to know what our biggest bottleneck is today? Maternity care. If there is one thing that bothers me today, as a manager, it is having to call a health secretary and explain—or rather, argue—why there's an indigenous woman there to have her baby and she still hasn't been seen for hours. This is very exhausting, but it's unbelievable that it still happens.

I remember a situation when I was still at UFPA (Federal University of Pará). An indigenous student—now a doctor—went to a referral center to have her baby. And, in her community, they perform a birth-painting ceremony before the birth. Do you know what happened? They didn't attend to her because they thought she was "dirty." They had to intervene through the university to guarantee she received care. She was only assisted when they managed to demand it, and then they realized she would need a cesarean section. This shows a total lack of understanding of our contexts; it's no use having a regulation if this still happens.

Something similar happened to me. I worked for the state government from 2020 to the beginning of 2023, before coming to SESAI. There was a referral hospital where I went every day. Everyone knew me: "Hi, Doctor," "Good morning," "Good afternoon..."

One day, they called me, saying that an indigenous person had been admitted and needed help. I said, "I'm heading over there." That day, I had just returned from the village, and my relatives had painted me after a ritual. I didn't even realize it... When I arrived at the hospital, they stopped me at the door. I had to prove my identity. The director of health surveillance had to call there and say who I was, and then they believed me.

And I started thinking, if this happened to me—someone who frequently goes to this hospital, who is called "doctor"—imagine what our relatives go through. This is blatant institutional racism.

So, we realize how much this anti-racist health policy still needs to advance. And it's not just in our subsystem. This is an issue for the entire SUS network. Because people think that indigenous health is a small, isolated issue, and this perception is totally wrong.

Indigenous health is part of the Brazilian Unified Health System (SUS). It's a subsystem, but it's cross-cutting. It's present throughout the Ministry of Health in all networks. Whether in primary care at the municipal level or in medium- and high-complexity care, we are everywhere.

Mr. Durvalino—Seu Dudu—who is a very good friend of my father, always said something that really stuck with me: that when the *Kumu*, the shaman, takes care of someone, he takes care of people. He doesn't choose who. It doesn't matter if it's a man, a woman, a child, or an elderly person... He even said he was learning the acronym LGBTQIA+, but, for him, it didn't change anything. "We take care of people," he would say.

And I think that's fantastic, you know? If we think about that statement in the context

6 Indigenous Health Center.

7 Emergency Care Unit.

of healthcare, it is a giant lesson for us as professionals. We need to take care of people, regardless of who they are. That's it.

But I believe... I'm very much like my grandmother. I believe that education can make all the difference, but it must start right away. We can't wait any longer.

Natalia Farias: *Putira, now moving on to a very important issue, which is that of indigenous medicines. In 2023, a working group on indigenous medicines was established—and I found this initiative compelling. I have been following it, and I see that you have been leading this in a very sensitive way.*

So, I wanted to hear a little from you about this: How do you see the paths to valuing and integrating indigenous medicines, especially within the scope of primary health care? Do you think it's possible to build this articulation in a respectful and effective way within the Brazilian Unified Health System (SUS)?

Putira Sacuena: The discussion about indigenous medicines began back in 2010, when SESAI and the subsystem were being created. We were already thinking about it at that time, but they said there was no basis, that it was all very new, and that we needed to study more, so we started studying. I have always been very concerned about research in this field. At that time, there were already some people talking about it—like João Paulo Barreto, Ednaldo Xukuru, and Priscila Kaingang—and we started to meet, hold gatherings, and share ideas.

Back then, we were even called "advisors" for indigenous medicine, but in practice, we had no structure or remuneration; it was just a title. It was not until 2023 that we presented a concrete proposal to the secretary of SESAI—at the time, I was not part of the secretariat yet—and he accepted it. The decision was a significant advancement, as prior to this, the Secretariat had shown no interest in the matter.

We also understood that it was necessary to move away from the term "traditional medicine." This is because the concept of "*traditional*" ends up encompassing many groups—quilombola communities, riverside dwellers, coconut breakers, and extractivists—and dilutes the specificity of indigenous medicines. So we decided to name them indigenous medicines, even with some criticism. They said that "medicine" was a colonizing word, but we used archaeology itself to argue that what they call medicine today, we have been doing for over 22,000 years. In other words, this is not an appropriation; it represents our ancestry and resistance; it is our science.

Each people has its own healing technology. In the Upper Rio Negro, for example, we speak of "*bassessé*"—which is not shamanism or folk healing; it is something else. Among the Yanomami of Maturacá, they speak of *recura* and *xapiris*, which are other forms. In other words, "indigenous medicines" is an umbrella term, yes, but one that encompasses an enormous diversity of practices and knowledge. Therefore, it is necessary to speak of valuing, strengthening, and recognizing them—always with protection. The idea is not to expose or "open up" these technologies to the outside world, but to ensure that they are recognized, respected, and protected.

This perspective led to the first specific ordinance on indigenous medicines—which would not have been issued without political sensitivity and extensive dialogue. Now, more recently, a new ordinance has been published, outlining the development of a national program. This program is being developed with the participation of COIAB and APIB.[8] and other partners. We want a program that is original, with our identity, and not a reproduction of outside models.

Our goal is clear: we want indigenous medicines to be effectively included in the National Policy for Indigenous Health Care (PNASPI). And they are already being incorporated, including in the PNASPI update, which we are finalizing for release by the end of the year. It is a policy that now reflects our approach and our regional context and that also holds municipalities and states accountable.

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But it is crucial to understand that indigenous medicines are not the same throughout the country. In the North, it is one way; in the South, the Midwest, and the Northeast, it is different. In some regions, they want to pay the shaman; in others, that is unthinkable. Some peoples don't want monetary payment, but rather structural support: a boat, fuel, gloves, and transportation for the midwife between villages. These are different forms of recognition and appreciation. Another fundamental point is recognizing that this knowledge is the result of long training periods. A kumu, for example, spends years training. You cannot learn it overnight. It is not simply a matter of picking up a maracá and thinking you can do the same. This is deep, spiritual, and physical training. And it is not academia that will teach it—it is the people themselves. In other words, the program must also protect these sciences, our ways of healing and living.

We are now heading to the last regional seminar in Maranhão, and after that we will hold the first in-person meeting of the Working Group, probably before COP30.[9] This is where we want to present this program. It is a historic milestone because, for the first time, Brazil will have an indigenous medicine program created by indigenous people, based on our own epistemologies. That's what it's about: respecting, protecting, and recognizing our medicines as science, as technology, and as a policy of care.

Natalia Farias: *Putira, regarding the approach you've already mentioned, how do you define "differentiated attention" and "interculturality" within the frameworks you are proposing?*

Putira Sacuena: I think most people misinterpret two words: *interculturality* and *intermedicality*. Interculturality is, in fact, when we try to help non-indigenous people understand. They must interpret things and empathize with the other person. It is when I, as a professional, set aside everything I have learned—my technical training—and begin to assist the person based on their cultural context. It means respecting, valuing, empowering, and acknowledging that this person has cultures different from mine.

Now, intermedicality comes from a different place: it's about negotiating knowledge and practices. For example, some people think that providing intercultural care in a hospital means putting up a headrest or a photo of an indigenous person on the wall. But that's not interculturality; for many peoples, for example, if a person has died, the relative cannot see that person's image. That offends their culture; it is not about undressing or about listening... it is about decoration.

Intermedicality occurs when there is genuine negotiation. For example, the shaman says he will perform a healing ritual on a child, but I know the child needs to take some medication. What do I do? I talk to him; I ask, "You will perform this treatment, but can I give him or her this medicine?" It is a conversation, an exchange between two practices, between two people, to build together what we call differentiated healthcare.

In other words, differentiated care requires these two dimensions to work together: interculturality and intermedicality.

Want a clear example? When we acknowledge that every CASAI must have a shaman—or a female shaman because there have always been women as well—and that these individuals have the same level of support as doctors and nurses and can communicate with these professionals... That means differentiated healthcare. It's not a theoretical concept: it's practical.

I remember a testimony during a qualification session for the Mais Médicos program. A doctor said that, when she arrived in the area, she thought she was the authority. In the morning, the nurse was already attending to the newborns with their mothers, weighing them, measuring them... But she was never called for deliveries. She would say, "But I'm the doctor!" And she didn't understand why the midwives didn't seek her out.

Over time, she realized that she was positioning herself as the ultimate authority and that the

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midwives were the authority there. So she started to get closer, sit down, and talk to them. And one day she was sitting on a small bench, watching the midwives deliver a baby, and she said, "I'm here; if you need me, I'm here." And they replied: "Okay, doctor, stay there." Until she gained that trust. This involves exposing oneself completely. That is about understanding what differentiated healthcare is and what interculturality is.

And that's why we cannot discuss the health of indigenous peoples without discussing indigenous medicines. All of SESAI's programs—indigenous health, child health, psychosocial care, women's health, and surveillance—need to engage with these medicines. They are cross-cutting.

You can't talk about children's health without talking about midwives, postpartum recovery, dietary restrictions, and protection. Who takes care of the child until the age of 40 or 60 days? Who observes and monitors them? The situation is similar when it comes to women's health. There are beautiful photos of doctors and midwives together. The midwife showed how to examine the belly, and the doctor said, "The midwife said it was a boy," and it was a boy.

Therefore, this is what differentiates indigenous healthcare: this set of care technologies, this intercultural context, this exercise of negotiation between knowledge systems, and also the fact that it is present both in the territories and in high-complexity care.

Therefore, if states and municipalities are not qualified, we cannot achieve what we want: *respect*, *acknowledgement*, and *strengthening* the care technologies that exist within the territories.

Natalia Farias: *Putira, to wrap things up, I'd like to hear from you about the paths you see today for indigenous health. What are the main challenges that still exist? And, on the other hand, what are the strengths and potential of indigenous health that deserve to be recognized and valued? Feel free to add anything else you'd like to share with us.*

Putira Sacuena:Look, I think one of our biggest challenges today is having qualified indigenous leaders. And when I say "qualified," I don't just mean in a technical sense but also in an intercultural one, because it is not enough to be indigenous; we need technical preparation, indeed, and we need to understand what it means to confront the diversity of our peoples. I, for example, am Baré, and today I am dealing with 304 ethnic groups. I know a little about the 23 peoples who live in my territory, but the others are still very new to me. So this intercultural training is essential, especially for those who take on management positions.

Another crucial point is the SESAI budget. The way the budget was designed does not consider the specificities of the territories. It is as if everything fits into the same box, and it doesn't. The secretary has strongly emphasized this point: the need for budgetary regionalization. The reality of the North is not the same as that of the South, Southeast, or Midwest. In our DSEI, in Alto Rio Negro, for example, the logistics are completely different. There are places we can only reach after days by speedboat or plane, that is, when the weather permits. How can we work with a budget that does not take these realities into account?

Furthermore, I think primary care needs to be strengthened in indigenous health. People still have a lot of difficulty understanding that primary care in indigenous territories is different from that in urban areas. An urban primary health care unit usually has a stabilization room, an observation room... Why doesn't indigenous health have that? The way indigenous health was structured in the beginning did not consider these factors. Now we are changing the regulations for health establishments and recognizing, for example, that a house of indigenous medicines is also a health establishment. But while it is not official, we cannot even build one. It is one challenge after the other.

On the other hand, we have enormous strengths. The first is the number of indigenous professionals who are graduating in various

fields in various regions; this is very significant. Indigenous health today is in our hands; it is led by us. And that changes everything! Our perspective is shaped by our experiences living in the territory. That, for me, is one of the greatest strengths.

But I also see the involvement of political parties within indigenous health as a challenge; it is still very complicated. There is often confusion between public policy and partisan politics, and this directly affects the processes. We have Special Indigenous Health Districts (DSEIs) with more than 80,000 indigenous people, which should have already been divided or restructured, but they cannot move forward because the budget doesn't keep pace with the complexity of these territories.

Therefore, even with the budget decentralization, we still don't have the necessary resources to guarantee infrastructure, construction, services, and all other demands. Things are changing, yes, but we still have a long way to go. I sincerely hope that we can achieve much more transformation.

Natalia Farias and Elizângela Baré: *Thank you so much! There is so much to hear and learn from you, but I think we had a wonderful conversation! Thank you, Putira!*

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