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Differentiated Primary Healthcare in the Pataxó Indigenous Communities in Bahia, Brazil: Polyphonic Ethnography of Healthcare Practices from an Intercultural Perspective

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Abstract: A lack of culturally appropriate healthcare is a common problem for colonial nations, and this can explain the different patterns of health in indigenous populations worldwide. Our study is the first ethnography realized with the neglected Pataxó indigenous people from the south of the state of Bahia, Brazil, that analyzes the representations and practices of “differentiated” public healthcare. The polysemic conceptualization and polymorphism of the healthcare practices highlight some spontaneous intercultural competences, particularly those of the indigenous professionals, within the hegemony of non-indigenous health knowledge and the lack of awareness of intercultural healthcare. Intercultural training and empowerment still remain a priority.

Keywords: indigenous health; cultural competence; primary healthcare; ethnography; Brazil



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1. Introduction

Reducing the historical gap in the health conditions and outcomes of indigenous populations is a persistent challenging priority for the global health agenda, for both developing and developed countries. Although epidemiologic studies on indigenous global health have well described this problem (Anderson et al. 2016), they cannot explain the variety of health patterns of indigenous groups either inside the same national health system or among different health systems. From a critical anthropological perspective, this reflects the need for a deeper and better understanding of the multiple sociocultural determinations of the local experiences of the colonialization process (Kirmayer and Brass 2016). In addition to this, this complexity points to the need to consider and recognize the heterogeneous definitions of and perspectives on indigenous health by indigenous people worldwide (King et al. 2009).

Furthermore, this critical perspective permits us to question the local impacts of the (in)action of national healthcare systems for indigenous communities, groups, and populations. In other terms, it shows the necessity to critically investigate the formulation and implementation of public health policies in order to understand if and how they are another face of the “coloniality” of the power of the State (Maldonado-Torres 2007).

Starting from the Alma Ata declaration of 1978, the “alliance” between the traditional healer and the community health worker is considered key for community engagement in the organization of primary healthcare. The priority of culturally appropriate healthcare for indigenous populations is based on the recognition and respect of specific social and cultural health needs (ILO 169 Convention), along with different and higher barriers of access to universal, integrated, appropriate, and comprehensive public health (PAHO 2007; WHO 2016). Instead of public healthcare “for” indigenous people, in order to practice indigenous healthcare “with” indigenous groups in a (inter)culturally appropriate praxis, articulation with indigenous knowledge (UN 2007) and the recognition of traditional

health knowledge (WHO 2016) are possible paths emphasized by international health organizations.

Formally, even though, in the Anglo-Saxon colonized indigenous contexts, as well as in the Hispanic–Portuguese ones, we find the conceptualization and paradigms for culturally appropriate public health policies, there is a global consensus on the lack of its operationalization (Ferdinand et al. 2020; Howse 2011; Truong et al. 2012). In the Global North, some authors have evidenced the persistence of cultural determinants and barriers of access to healthcare for indigenous populations, besides the socioeconomic ones (Pulver et al. 2010). For the more critical ones, this expresses the continuity of the domination of Western biomedical knowledge against the ideals of articulation, dialogue, and respect between healthcare practices based on the “cultural safety” and “cultural competence” healthcare model (Lavoie 2004). In Latin America, as a result of the struggles of the indigenous movements in the 1980s, the concept of interculturality oriented the formulation of most of the national indigenous education and health policies, but structural violence defined a bigger gap between the health conditions of indigenous and non-indigenous people (Cardoso 2015). In the end, the formulation of culturally appropriate health policies did not turn into operationalized healthcare practices with respect to and in dialogue with indigenous knowledge of indigenous health systems.

In Brazil, the indigenous population is very heterogeneous, with at least 305 ethnicities registered (IBGE 2010), representing only 0.4% of the national population. In the last 20 years, it was possible to create and implement a national public health policy for indigenous groups (*Política Nacional de Atenção à Saúde dos Povos Indígenas*—PNASPI), (FUNASA 2002) and a healthcare sub-system (SASISUS) within the national universal health system—*Sistema Único de Saúde* (SUS)—based on the questionable and contradictory concept of “Differentiated Healthcare”—*Atenção diferenciada*—in terms of articulation between healthcare systems (Diehl and Langdon 2015). Even if we agree that they represent a result of the indigenous movements’ struggles, as well as one of the most inclusive health policies of the area (Cardoso 2015), we and other authors have already pointed out how the biomedical hegemony is rooted in the PNASPI formulation, in addition to highlighting some ethnocentric issues that can paradoxically produce cultural shocks and create barriers in accessing differentiated healthcare services for indigenous people (Pedrana et al. 2018; Pontes et al. 2014; Cardoso 2004). There is, in fact, a lack of evaluation by the public authorities and only a small number of studies focusing on the operationalization of indigenous healthcare policy. At the local level, some of these analyses have evidenced the nuances of the healthcare relationship between possible mutual effects (Novo 2011; Diehl and Pellegrini 2014) and possibilities for the emergence of indigenous healthcare knowledge in public policies (Ferreira 2013), while others have highlighted the hegemony of the non-indigenous biomedical healthcare model (Cardoso 2015, 2004; Pontes et al. 2014).

In addition, only one study has considered the limits and potentialities of the interculturality of indigenous health workers’ profiles and practices within the indigenous healthcare multidisciplinary teams—*Equipes Multidisciplinares de Saúde Indígena* (EMSI)—which are usually characterized by non-indigenous professionals, particularly the most powerful categories—physicians, dentists, and nurses—while no attention has been dedicated to the increasing presence of indigenous nurse technicians and assistants (Garnelo 2014).

Furthermore, academic attention has mainly concentrated on the indigenous populations of specific areas of Brazil (Mato Grosso do Sul, Amazonas, Rondônia), without considering the “mixture indigenous” (de Oliveira 1998) groups of the northeast of Brazil, with their long history of contact and urbanization.

Starting from these premises, we present the results of an exploratory ethnography on the differentiated primary healthcare in two Pataxó communities in the south of the state of Bahia, Brazil. The Pataxó are one of the biggest indigenous groups of Bahia (13.588 in.), the third Brazilian state in terms of number of indigenous people registered (56.381 in.), after Amazonas (168.680 in.) and Mato Grosso do Sul (73.295 in.) (IBGE 2010).

Our aim was to analyze the emic concepts and practices of primary healthcare for the Pataxó indigenous people to better understand the barriers and facilitators of intercultural healthcare. This permits the emergence of multiple meanings and possibilities of understanding the complex concept of “indigenous differentiated healthcare” in terms of polysemy (Falkum and Vicente 2015) that can lead to heteroglossia (Bakhtin 1981) and, thus, to multiple practices of care for indigenous health.

2. Materials and Methods

This qualitative exploratory research comprised part of the results of the first author’s PhD thesis in Public Health at the Collective Health Institute (*Instituto de Saúde Coletiva*, ISC) of the Federal University of Bahia (*Universidade Federal da Bahia*, UFBA). It is a multi-site, polyphonic, and intercultural ethnography of the primary healthcare in two territories of the Pataxó people in the far south of Bahia, Brazil. The research period lasted four years, and the total immersion in the two communities—*Barra Velha* in the municipality of Porto Seguro and *Corôa Vermelha* in the municipality of *Santa Cruz de Cabralia*—lasted 10 months.

We chose the two local indigenous services in *Barra Velha* and *Corôa Vermelha* as the focus of our research because of the strong presence of indigenous health professionals within the local healthcare teams (EMSI) and articulations between the two health systems—the Pataxó and the primary differentiated healthcare.

The conceptual framework of our study is rooted in the southern American and Brazilian critical anthropology paradigms on intercultural process. The Critical Interculturality conceptualization (Walsh 2005) was useful to question the healthcare relationship and communication process between the patients and the professionals of the local Indigenous healthcare model. The Walsh definition of interculturality permitted us to question the power relationships and to highlight the negotiations in indigenous healthcare: “A permanent strategy, action and process of relationship and space of negotiation in conditions of respect, legitimacy, symmetry, equity and equality. (...) a construction of a political, social, ethical and epistemic project, which affirms the need to change not only relationships, but also the structures, the conditions and devices of power that guarantee inequality, racialization and discrimination” (Walsh 2010; authors’ translation). Walsh conceptualized it as a transformation practice, as “an exchange built up between people, knowledge, culturally different practices, seeking to develop a new meaning between them in their difference” (Walsh 2005). Following this conceptual framework, our ethnography practice was oriented by the intercultural ethnography model proposed by Gunther Dietz (2012) that also forms a dialogue with the conceptualization of what Boaventura De Sousa Santos (2009) defined as “diapoptic hermeneutics” to produce mutual comprehension and intelligibility of social and cultural problems. Dietz’s model proposes to approach three main research dimensions—semantic, pragmatic, and syntactic—to better understand: (1) The emic perspective emerging from the identity discourse of the actors, analyzed in relation to their strategies of ethnicity; (2) the interaction from an ethic perspective based on the intracultural habitus and intercultural competences; and (3) the interaction practices between institutions where identity discourses and interaction practices are articulated.

In regard to the first dimension, we used both informal conversations and recorded interviews with several Pataxó actors—patients, health professionals, traditional healers, community leaders, and students—in order to describe their perceptions of healthcare practices. As for the second dimension, we used participant and non-participant observations of the sociocultural intra-ethnic life and focused on the interethnic relations of the multi-professional healthcare teams—EMSI—during healthcare practice. In regard to the last dimension, we considered the public institutions and community actors of the operationalization of the differentiated care—public managers, indigenous health counselors, community leaders, and elders—and the power dynamics involved in the process of providing local healthcare.

We used thematic content analysis (Lorelli Nowell et al. 2017) to categorize and classify the main dimensions of the intercultural local healthcare. In order to guarantee the

interculturality of our research steps and analysis, it was fundamental to collaborate with an indigenous local expert on indigenous health and education processes to co-evaluate the interpretation of the results.

We ensured ethical standards to preserve the identity and psychophysical integrity of the participants. This study was approved by the Research Ethics Committee of the Institute of Collective Health of the Federal University of Bahia and complies with the Brazilian National Health Council resolutions 304/2000-CNS, 466/2012-CNS, and 510/2016-CNS.

3. Results

3.1. *The Pataxó of the “Discovery Coast”—The Longest Painful History of Contact in Brazil*

When the Portuguese colonizer Cabral Pedro (1500 A.D.) took his first step in the south of the state of Bahia, the Pataxó were one of the various indigenous groups living in that area, and they were the only ones who were able to resist and survive until today. Until the middle of the 18th century, some family groups lived as “natives and adopted citizens” and actively participated in the life and institutions of the town centers of the local commerce and strategic outpost of the Brazilian empire, while some other groups lived in isolated areas as “brave” (Carvalho 2010); however, in 1861, all indigenous groups were obliged by the State authorities of Bahia to move to a remote and confined area. This somehow allowed the Pataxó to protect themselves and maintain their cultural unity and autonomy, as well as to be forgotten by the public authorities and anthropological researchers until 1951, when the so-called “Foco do ‘51”—The Fire of 1951—exploded and marked the Pataxó history with more violence, torture, and death (ANAI 2007). This event caused the Pataxó diaspora and initiated the hybridization process into the local context, giving birth to 34 communities in four municipalities representing the third tourist pole of Brazil—Belmonte, Porto Seguro, Santa Cruz de Cabrália, and Prado—while another group moved into the state of Minas Gerais.

Up to the present day, only a few of these communities are officially recognized by the Brazilian government. Local conflicts with different local actors—farmers, sawmillers, real estate enterprises, and also the government of Brazil—regarding access to and ownership of indigenous land still define the everyday life of most of the Pataxó communities (Grünwald 2008). The continuous exposure to violence and land deprivation is probably the main determinant of the vulnerability of the Pataxó to health conditions.

Within this context, our research focused on two communities with a high symbolic value, both having been recognized by the Federal Government after four generations of history of fights and political strategies promoted by the elders, the “native politicians” (de Oliveira 1998): The remote, “well preserved” (Agostino 1972), rural, and traditional Pataxó mother village, *Aldeia Mãe*, of *Barra Velha*—Old River Mouth—with 3200 inhabitants in the same area where the first colonizer set foot, and its first and biggest daughter, *Corôa Vermelha*—Red Crown—represented as the place where the colonizer celebrated the first mass in Brazil, the Pataxó modern “tourist indigenous village” (Grünwald 2003). This is the biggest Pataxó artisan marketplace and tourist center, with almost 7000 indigenous inhabitants living in the heart of the international mass tourist pole of Porto Seguro, among the properties of the *Yndi’hi*—the non-indigenous people in *Patxoã*, the rescued Pataxó language.

The history of the Pataxó—their ethnogenesis and territorialization processes—is an example of the trajectories of the multiple forms of oppression, resilience, and resistance of the Brazilian indigenous groups that allowed them to find a collective praxis to balance fighting with dialogue, along with self-isolation from and adaptation to the local society, the local aggressive mass tourism and rapid urbanization processes, the interests in their land, and, lastly, the lack of State protection.

We started to consider the two community contexts as a representation of two polarized models between a conservative, rural, and monocultural indigenous community and an urban, modern, and multicultural one. When we analyzed the local transformation processes of their ethnicity, we found the same—although diachronic—cultural dynamics

and sociocultural tensions with the development and rapid transformations (urbanization and hybridization) of the local society determined by economic interests. This means that in these two different community contexts, the Pataxó have to face the same health determinants but at different times and with different intensities. The constant contact with the non-indigenous society and its different modern or urban lifestyle is commonly represented as the principal determinant of the health of the Pataxó. It is considered by the elders and young leaders as a continuous menace to their ethnicity and well-being, their “good living”—the Kichwa’s *Sumak Kawsay*—and so to their unity and organic solidarity: “*To the harmony of the spirit and body of the communities*” (Young Leader 1 of *Corôa Vermelha*).

In fact, in the two areas, multiple inter- and intra-ethnic conflicts are present due to:

- Drug trafficking, which is the first factor of youth mortality and women’s depression and precludes aggregation community spaces and moments;
- International tourism, which stimulates drug commerce and prostitution as a new possibility to make money for indigenous young people and women;
- The strong presence of new churches and, consequently, the growing demystification of the Pataxó traditional spirituality, reducing the demand for indigenous healthcare practices and healers’ knowledge (prayers, experts in medicinal plants, etc.).

Lastly, to better contextualize the (determinants of) health conditions, we have to consider that both communities suffer a lack of basic sanitation, even in the urban community where we find the biggest population-based socioeconomic differences, a high impact of the immigration of indigenous and non-indigenous people, and the worst habitational and socioeconomic conditions of indigenous families.

3.2. *The Polysemy of the Concept of Differentiated Primary Healthcare for the Pataxó Indigenous People*

For many community members, the expression “differentiated healthcare” sounds new, even if the local differentiated health services were implemented more than 20 years ago. In other cases, it is generally perceived by both the Pataxó and their indigenous health professionals in several ways and conceptualizations, mostly neither based on nor in line with the formulation of “differentiated healthcare” in the PNASPI.

The perception of a formally differentiated model and different access to public health as basically alternative and separated from the universal national health system puts the emphasis on the different formal organization and logistics—transport, health center, etc.—and is somehow linked to the idea of the “privilege” of dedicated healthcare attention as special and alternative access to the public and universal healthcare system.

On the contrary, we can also find that the low quality of the indigenous differentiated healthcare sub-model is what defines its qualitative differentiation in relation to the healthcare for non-indigenous people. Following the more radical and contrastive perspective, indigenous healthcare is defined by its iatrogenic impacts of the “pharmacolization” (Williams et al. 2011) and hypermedica(menta)lization of the Pataxó people. In this case, it is represented as a “differentiated decimation strategy of the indigenous bodies” (Chief—*Cacique*—of *Barra Velha*). Therefore, the hegemony of non-indigenous practices, medicines, and cures is considered an epistemicide strategy reducing the Pataxó millenary knowledge, with the only solution being to resist the “contamination due to the contact with non-indigenous society” (Ibidem).

From a more functional perspective, universal or non-indigenous public healthcare is considered a possible alternative when the Pataxó health system cannot treat some specific diseases—mainly the ones caused by the White man—or in some emergency circumstances, such as when a traditional midwife’s knowledge is not considered enough to resolve certain complications of childbirth. From this perspective, the differentiation of indigenous healthcare is represented as a functional complementarity between the two health systems considered as differently competent and powerful. Thus, this coexistence offers different and multiple possibilities of therapeutic pathways that other patients of the universal healthcare system do not have.

For some other Pataxó, indigenous healthcare is differentiated because it is an opportunity for indigenous people to occupy the roles of non-indigenous health professionals—the indigenization of indigenous health. This is because the community chief (*Cacique*) has the full power to accept, refuse, and impose all healthcare professionals of the local EMSI teams. In fact, in both of the Pataxó communities, the local healthcare teams are, in their majority, composed of local indigenous professionals (community health workers, nurse assistants, nurse and dental technicians, and nurses), and even if the physicians and dentists are non-indigenous, they are well accepted because of their long experience and engagement in indigenous health (particularly in *Barra Velha*). This is why, in day-by-day health assistance, they are controlled and monitored by the community leaders, especially in *Corôa Vermelha*.

In many communities, particularly those far away from urban areas—such as in the area of *Barra Velha*—or with geographical barriers to accessing more complex healthcare levels, the indigenous primary healthcare service in the community is considered differentiated because it represents a comfort zone far away from institutional racism, such as the obstetric violence and various healthcare omissions that frequently occur in the municipal (universal) hospitals in urban areas.

To conclude, only a few political and public institutions or Pataxó social movement leaders with long experience in intercultural teaching represent healthcare differentiation in intercultural terms as “a possibility to produce an innovative integration with the practices and traditional knowledge, to find a way to conciliate different visions, including the religious ones” (Youth Leader I, *Corôa Vermelha*).

In any case, nobody was able to define how, in practice, intercultural dialogue could turn into a differentiated healthcare praxis. This emerged more clearly from the participant observations of day-by-day healthcare practices and relations.

3.3. Primary Healthcare Practices for the Pataxó: Between Differentiated, Universal, and Unequal

The two indigenous primary healthcare centers of *Barra Velha* (established in 1998) and *Corôa Vermelha* (established in 2001) cover several small indigenous communities; therefore, they are always crowded, with patients waiting outside in long lines. Even though the model and standard organization of the universal and differentiated primary healthcare service—*Unidade Básica de Saúde (UBS)*—are clearly defined by the MoH (BRASIL 2012), the two indigenous health unit services have undergone transformation and adaptation according to the Pataxó community’s different health needs, with a high presence of indigenous health professionals—more than 3/4 in *Barra Velha* and 3/5 in *Corôa Vermelha*.

In fact, in the urban area of *Corôa Vermelha*, there is a complex health service with three different indigenous health teams (EMSI) of 35 professionals in order to satisfy the local health demand of the community members—7000 inhabitants from 11 communities. In addition to a specific vaccine service, three other services have been institutionalized and implemented: a waiting list for access to the municipal and state hospitals and specialist visits, an indigenous health information system (SIASI), and indigenous massotherapy offered by the indigenous community health workers.

In the health service of the remote rural areas of *Barra Velha*, there are 15 health professionals working in the unique local indigenous health team covering over than 3200 inhabitants from 9 communities. Health assistance—a physician, dentist, nurses, and technicians—and access to the pharmacy are available 24 h a day, seven days a week, because the communities are too far away from the city hospitals and need first aid and emergency care besides primary healthcare assistance. Here, the indigenous nurse technicians have greater autonomy and power within the hierarchies of the local healthcare team, while the non-indigenous professionals—only the physician and the dentist—live and are well integrated in the community; those who commute from the towns—two nurses—are hosted in an apartment in the health unit built by the community of *Barra Velha* in a collective community work (*mutirão*).

Even though in these two different healthcare services both types of professionals—indigenous and non-indigenous—have had only biomedical training, the interculturality

is evident in both of them in their spontaneous sensitivity and healthcare relationship practices. Most of the time, this is not institutionalized and is paradoxically not even recognized by the professionals who put it into practice in every single moment of their relationship with the patient.

“You have to take care of the patient like you take care of one of your family members, you will never abandon him/her till the end!” (Indigenous Health Technician 3, *Barra Velha*); this recurring phrase of the indigenous professionals was also deeply shared by the non-indigenous ones. “It is forbidden to forbid” is another common rule shared by indigenous and non-indigenous professionals, expressing the unconditional respect and acceptance of a community member’s choice of their therapeutic itinerary and the use of natural medicines and spiritual cures as alternatives to, or combined with, non-indigenous pharmaceutical drugs.

Particularly in *Barra Velha*, as a matter of course, the non-indigenous physicians and dentists offer a double orientation when they prescribe treatment. Their knowledge of the use of herbal medicines comes from their long-term experience in the Pataxó communities, their praxis of frequent conversations not only with the traditional healers—*Pajé, parteiras, rezadores*—but also with each single patient during their visit.

In any case, in both of the indigenous healthcare centers, the indigenous healthcare professionals show stronger intercultural attitudes and competences compared to the non-indigenous ones. This allows them to perceive the patient’s profile in terms of being more or less medicalized, observing their level of hybridization to better define efficient intercultural communication patterns for health information and cure orientation.

Their verbal and non-verbal communication, information skills, and expertise are based on community codes, and this facilitates horizontality and mutual comprehension of health issues. This also allows the indigenous professional to make a diagnosis more quickly, because they know the patient’s health and family history well. Furthermore, the indigenous professionals are able to translate the biomedical information and terms for their relatives through intercultural and linguistic mediation, using creativity to promote health prevention and education practices.

There are also some intercultural healthcare practices that are somehow recognized and institutionalized but not well monitored, evaluated, or valorized by the local indigenous health management. While in the urban environment, the proximity to municipal hospitals and easy geographical access have reduced the demand for Pataxó midwives’ services, in *Barra Velha*, the midwives are still the first reference for all the women in the area. The non-indigenous nurse is allowed to assist in childbirth, but only in the case of an emergency does she take charge of the situation. The presence of both these two different healers creates moments and spaces of intercultural collaboration, interexchange of knowledge and practices, and a perfect complementarity between the two healthcare systems. It is important to highlight that the Health Secretary of the state of Bahia promoted a meeting in the capital city with a selection of indigenous midwives in order to align the different healthcare rules and reach a common “gold standard” of safe childbirth practices. In actuality, for most Pataxó midwives, that intercultural exchange sounded more such as an appropriation of indigenous knowledge by the urban, biomedical, non-indigenous professionals.

In *Corôa Vermelha*, where the pent-up demand for mental healthcare is stronger than that in the rural area of *Barra Velha* due to the higher impact of land and drug traffic conflicts, a son of one of the community chief shamans (*Pajé*) has developed, with the support of the Federal University of Ceará (UFCE), a model of community indigenous therapy based on articulation between Pataxó healthcare knowledge and the Integrative Community Therapy paradigm—*Terapia Comunitária Integrativa* (TCI) (Barreto 2005). Thanks to this healthcare practice, the indigenous health workers are able to promote these intercultural techniques and practices of indigenous healing in public indigenous primary healthcare. At the moment, this young leader is participating in international intercultural research projects, spreading this new knowledge worldwide (<https://ubiracipataxo.com/>, accessed on 10 December 2021).

4. Conclusions

In this study we highlighted some possibilities of intercultural concepts and spontaneous practices in indigenous primary healthcare for the Pataxó indigenous people in the south of Bahia. However, the effectiveness, relevance, and visibility of this interculturality are limited by the low quality and strong hegemony of biomedical knowledge and practices in public health assistance. The polysemy and polymorphism of the differentiated healthcare concepts and practices show their complexity.

To improve interculturality in this local context, the participants in this study pointed out a set of priorities and actions centered on three main cluster dimensions. First is the rescue of Pataxó health knowledge in order to reinforce their ethnic identity in differentiated indigenous healthcare and to equilibrate the complementarity and articulation between different health knowledge bases against pharmacologization. Second is the implementation of intercultural training to address the heterogeneity of local actors participating in the community healthcare process. This is to improve intercultural awareness in the indigenous communities and to guarantee the right of access to culturally differentiated healthcare. Third and last but not least: the recognition, institutionalization, and empowerment of indigenous professionals' intercultural mediation skills and non-indigenous intercultural facilitation competence (Youmbi 2011), in order to improve spontaneous intercultural practices and enhance the quality of health information and education in intercultural terms.

In our future publications, we will further define these proposals to operationalize interculturality in the national policy of healthcare provided to indigenous people. We think this could be a new way to create critical interculturality in indigenous health, particularly urgent in this current political conjuncture, when the Brazilian government is taking actions against the indigenous populations in the form of omission, neglect, institutional racism, and genocide policies (Mota et al. 2020).

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Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Review Board the Research Ethics Committee (*Comitê de Ética em Pesquisa-CEP*) of the *Instituto de Saúde Coletiva* (ISC) of the *Universidade Federal da Bahia* and complies with the Conselho Nacional de Saúde (CNS) resolutions 304/2000-CNS, 466/2012-CNS, and 510/2016-CNS.

Informed Consent Statement: We ensured ethical standards to preserve the identity and psychophysical integrity of the participants, and informed consent was obtained from all subjects involved in the study.

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