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THE BARRIERS IN ENSURING THE RIGHT TO HEALTH FOR INDIGENOUS PEOPLES IN BRAZIL DURING COVID-19*

AS BARREIRAS PARA SE GARANTIR O DIREITO À SAÚDE DOS POVOS INDÍGENAS NO BRASIL DURANTE A PANDEMIA DA COVID-19

LAS BARRERAS PARA SE GARANTIZAR EL DERECHO A LA SALUD DE LOS PUEBLOS INDÍGENAS EM BRASIL DURANTE LA PANDEMIA DE LA COVID-19

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Abstract: Health is recognized as a fundamental human right in Brazil, under the 1988 Federal Constitution. It states that health is a right for all peoples and that the state must guarantee universal and equal access to services. In the face of the coronavirus disease (COVID-19) pandemic, access to healthcare and health services proves to be exceedingly difficult for Indigenous Peoples in Brazil. This paper explores the barriers in ensuring the right to health for Indigenous Peoples in Brazil during COVID-19. The paper is divided into four parts: Section 1 provides a summary of the Brazilian healthcare subsystem for Indigenous Peoples; Section 2 outlines the impact of COVID-19 on Indigenous Peoples in Brazil; Section 3 explores the barriers to ensuring the right to health for Indigenous Peoples in Brazil during COVID-19; and Section 4 analyzes the extent to which the new Law 14021/2020 of July 8, 2020, ensures the right to health for Indigenous Peoples in Brazil during COVID-19. This paper was written from a qualitative research, using as research techniques documental analysis and bibliographical review.

Keywords: Right to health; COVID-19; Indigenous Peoples; Brazil; Law 14021/2020.

Resumo: A saúde é reconhecida como um direito humano fundamental no Brasil, pela Constituição Federal de 1988. Afirma que a saúde é um direito de todos os povos e que o Estado deve garantir o acesso universal e igualitário aos serviços. Diante da pandemia da doença coronavírus (COVID-19), o acesso aos serviços de saúde se mostra extremamente difícil para os povos indígenas no Brasil. Este artigo explora as barreiras para garantir o direito à saúde dos Povos Indígenas no Brasil durante a COVID-19. O artigo está dividido em

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quatro partes: a Seção 1 apresenta um resumo do Sistema Brasileiro de Saúde para os povos indígenas; A Seção 2 descreve o impacto da COVID-19 sobre os Povos Indígenas no Brasil; A Seção 3 explora as barreiras para garantir o direito à saúde dos Povos Indígenas no Brasil durante a COVID-19; e a Seção 4 analisa em que medida a nova Lei 14021/2020, de 8 de julho de 2020, garante o direito à saúde dos Povos Indígenas no Brasil durante o COVID-19. O presente texto foi elaborado a partir de pesquisa qualitativa, utilizando como técnicas de pesquisa a análise documental e a revisão bibliográfica.

Palavras-chave: Direito à saúde; COVID-19; Povos indígenas; Brasil; Lei 14.021/2020.

Resumen: La salud es reconocida como un derecho humano fundamental en Brasil, por la Constitución Federal de 1988. Afirma que la salud es un derecho de todos los pueblos y que el Estado debe garantizar el aceso universal e igualitario a los servicios. Delante la pandemia de la enfermedad coronavírus (COVID-19), el aceso a los servicios de salud se presenta extremadamente difícil para los pueblos indígenas en Brasil. Este artículo explora las barreras para se garantizar el derecho a la salud de los Pueblos Indígenas en Brasil durante la pandemia de la COVID-19. El artículo está dividido en cuatro partes: la Sección 1 presenta un resumen del *Sistema Brasileiro de Saúde* para los pueblos indígenas; la Sección 2 describe el impacto de la COVID-19 sobre los Pueblos Indígenas en Brasil; la Sección 3 explora las barreras para se garantizar el derecho a la salud de los Pueblos Indígenas en Brasil durante la COVID-19; y la Sección 4 analizar de que manera al nueva Ley 14.021/2020, de 8 de julio de 2020, garantiza el derecho a la salud de los Pueblos Indígenas en Brasil durante la pandemia de la COVID-19. Este artículo fue elaborado a partir de investigación cualitativa, utilizando como técnicas de investigación la análisis de documentos y revisión bibliográfica.

Palabras-Clave: Derecho a la salud; COVID-19; Pueblos indígenas; Brasil; Ley 14.021/2020.

Introduction

"Toda essa destruição não é nossa marca,
é a pegada dos brancos, o rastro de vocês na terra"
Davi Kopenawa Yanomami

The international community has made great efforts to develop a coherent body of human rights principles that recognize health as a fundamental human right. Article 25 of the Universal Declaration of Human Rights (UDHR) by the United Nations (UN) grants the universal protection of the right to a standard of living adequate for the health and well-being of all people, including food, clothing, housing, and medical care and necessary social services (UN, 1948). Even so, substantially less emphasis has been placed on the actual fulfilment of these commitments and the processes involved in their implementation within countries (MAZEL, 2018). This is evident concerning the often-neglected marginalized

populations, including Indigenous Peoples, who still experience inadequate access to healthcare and health services (MAZEL, 2018).

In 2007, the UN General Assembly adopted the UN Declaration on the Rights of Indigenous Peoples (UNDRIP) (UN, 2007). This international instrument not only recognized self-determination and specific rights of Indigenous Peoples, but it also emphasized the importance of the right to health and social determinants in improving health and for Indigenous Peoples to play an active role in decision-making processes in matters affecting their rights (MAZEL, 2018). Article 24 of the UNDRIP states that Indigenous Peoples have the right to access all social and health services and to have an equal right to the enjoyment of the highest attainable standard of physical and mental health (UN, 2007). It also declares that the state should take necessary measures to guarantee the full realization of these rights (UN, 2007).

Health is recognized as a fundamental human right in Brazil under the Federal Constitution (FEDERATIVE REPUBLIC OF BRAZIL, 1988). Article 196 of the constitution states that health is a right for all people. It is the state's duty to guarantee universal and equal access to services (FEDERATIVE REPUBLIC OF BRAZIL, 1988). The realization, protection, enforcement, and promotion of the right to health for Indigenous Peoples has been inadequate and precarious even under normal circumstances (MAZEL, 2018). In the face of the global coronavirus disease (COVID-19) outbreak, access to healthcare and health services proves to be exceedingly difficult for Indigenous Peoples in Brazil (CUPERTINO, 2020). All over the country, Indigenous individuals and communities, in particular, encounter greater risk to the exposure of COVID-19 due to a fragile healthcare system and weak institutions for the protection of Indigenous Peoples' rights (CUPERTINO, 2020). After the United States, Brazil has claimed the second-highest number of COVID-19 cases and deaths (JHU CSSE, 2020). At the time of finishing this article, on September 17, 2020, there were 32,017 confirmed cases of COVID-19 in Indigenous communities (APIB, 2020).

This paper explores the barriers in ensuring the right to health for Indigenous Peoples in Brazil during COVID-19. The paper is divided into four parts: Section 1 provides a summary of the Brazilian healthcare subsystem for Indigenous Peoples; Section 2 outlines the impact of COVID-19 on Indigenous Peoples in Brazil; Section 3 explores the barriers to ensuring the right to health for Indigenous Peoples in Brazil during COVID-19; and Section 4 analyzes the extent to which the new Brazilian Law n° 14021/2020 of July 7, 2020, ensures the right to health for Indigenous Peoples in Brazil during COVID-19.

The paper presents the current data available for COVID-19 government responses and measures to determine the impacts of COVID-19 on Indigenous Peoples in Brazil. A range of sources are evaluated, such as epidemiological data, academic literature, newspaper articles, and governmental and non-governmental publications and reports, to investigate the state of the COVID-19 pandemic and the new Brazilian legislation n° 14021/2020 for Indigenous Peoples.

Possible limitations to this paper include a lack of available and reliable data consolidation, as a result of writing the paper and the nature of reviewing data, academic, and grey literature amidst the progression of the pandemic in Brazil and around the world. The paper attempts to update its content to the best of its ability, as more recent data becomes available. Moreover, the lack of prior research studies on the topic requires exploring a range of literature and grey literature to lay the foundation for the research paper. Other possible limitations of the paper involve gaining access to people, organizations, data, and documents on the topic. This paper acknowledges and recognizes its limitations, yet it can provide an exploratory study intended to lay the groundwork for future comprehensive research on the right to health for Indigenous Peoples in Brazil.

1. Healthcare system in Brazil for Indigenous Peoples

A short overview of the healthcare system for Indigenous Peoples in Brazil provides context to understand the impact of COVID-19 on Indigenous Peoples and the barriers to ensuring the right to health for Indigenous Peoples in Brazil. This section summarizes the Brazilian healthcare subsystem for Indigenous Peoples, with an overview of the universal public healthcare system for the general population.

Guaranteeing the right to health is a shared responsibility of Brazil's three government spheres: federal, state, and municipal (DA MOTA, 2019). The Federal Constitution declared health as a universal right of citizenship, and the old public healthcare system was replaced with the Unified Health System (Sistema Único de Saúde (SUS)) (COELHO; SHANKLAND, 2011). Although the universal right to health is a founding principle of the SUS, inequities in access to primary health care and health services remain a significant barrier to universal coverage for Indigenous Peoples (COELHO; SHANKLAND, 2011).

Vast health inequalities continued to exist between the general population and those of specific ethnic groups (COELHO; SHANKLAND, 2011). The need to create a specific Indigenous subsystem of care with its agency had been expressed since the First National Conference on the Protection of Indian Health, held in Brasilia in 1986 (LUNA, 2020). The SUS had asserted the universal right to health for the entire Brazilian population. As such, Indigenous Peoples and other marginalized groups demanded more targeted federal and state health policies and programs focused on their specific needs by mobilizing citizen participation movements. (GARCIA, 2018).

In 1999, the National Congress approved *Lei Arouca* (Law 9836/1999, September 23) to provide primary health care to Indigenous populations (NOGUERIA, 2016). The law included the implementation of an Indigenous Health Subsystem (*Subsistema de Atenção à Saúde Indígena* – SASI) (Mendes *et al.*, 2018). Under the SUS, the SASI was comprised of 34 Special Indigenous Health Districts (Distritos Sanitários Especiais Indígenas (DSEIs)) (COELHO; SHANKLAND, 2011). The DSEIs are decentralized units of the Ministry of Health (*Ministério da Saúde* - MS) linked to the Special Secretariat of Indigenous Health (*Secretaria Especial de Saúde Indígena* - SESAI). The latter is responsible for carrying out the actions of the SASI. Within the scope of the DSEIs, healthcare is provided at basic health units, centres, and Indigenous Health Support Shelters (NOGUEIRA, 2016). In accordance with the Alma-Ata Declaration guidelines, healthcare teams included Indigenous personnel assigned the novel roles of Indigenous health agents and Indigenous sanitation agents (Mendes et al., 2018). In 2010, the DSEIs were integrated into the SUS.

The National Health Care Policy for Indigenous Peoples (*Política Nacional de Atenção à Saúde dos Povos Indígenas* – PNAPSI)) was created in 2000, after the establishment of SASI (MENDES, 2018). The policy emphasized the decentralization of actions and resources; universality, comprehensiveness, equity, and social participation; and issues related to cultural, ethnic, geographical, epidemiological, historical, and political diversity. The DSEIs influenced the organizational model of the PNAPSI, as social participation involves local and district Indigenous health councils and the selection of council members by Indigenous communities.

The SESAI was created to represent the establishment of an agency solely responsible for Indigenous health (MENDES, 2018). Until then, the responsibilities for Indigenous health was coordinated by several sectors within other agencies or institutions, often with broader mandates and not limited to Indigenous Peoples (MENDES, 2018). Management of the

SESAI remains centralized and has limitations in its staffing structure, high turnover rate, and inadequate health professionals training to work in Indigenous communities. In order to overcome healthcare system challenges, the strengthening of SASI to embody the goals of PNAPSI can progress towards ensuring the right to health for Indigenous Peoples in Brazil.

2. The impact of COVID-19 on the Indigenous Peoples in Brazil

On December 31, 2019, the World Health Organization's (WHO) Country Office in the People's Republic of China was informed of 'viral pneumonia' in Wuhan, China (WHO, 2020). Chinese authorities determined the outbreak was caused by a novel coronavirus, severe acute respiratory syndrome coronavirus 2. The virus soon spread to 18 countries outside China and the WHO announced that the disease caused by the novel coronavirus would be named coronavirus disease (COVID-19) (WHO, 2020). The disease had reached alarming spread and severity globally, and on March 11, 2020, the WHO declared it a pandemic (WHO, 2020).

On June 19, 2020, Brazil confirmed a total of 1,032,913 cases of COVID-19 and became the second country to confirm more than one million cases of COVID-19 (JHU CSSE, 2020). On September 17, 2020, Brazil had a total of 567,200 active cases, and a total of 134,174 deaths. This accelerating spread of COVID-19 raised concerns about the severity of the pandemic and its impact on Brazil's most vulnerable populations, especially Indigenous Peoples who are at higher risk than non-Indigenous people.

On April 1, 2020, a 20-year old Kokama Indigenous woman in northern Amazonas state was the first confirmed case of COVID-19 among Indigenous Brazilian Peoples in the Amazon (Farias, 2020). Since then, Kokama has registered the highest number of COVID-19 deaths among Indigenous Peoples in Brazil, and there has been a growing number of cases of COVID-19 in Indigenous territories (APIB, 2020a). On April 9, 2020, the SESAI reported the death of a 15-year old adolescent belonging to the Yanomami tribe from COVID-19[3].

Monitoring the evolution of COVID-19 among Indigenous Peoples in Brazil is a significant challenge, as official figures do not accurately reflect updated numbers on the development of the pandemic for these populations. The SESAI has underreported the confirmed cases of COVID-19 among Indigenous Peoples in Brazil, as they do not record

[3] The Yanomami are the largest isolated Indigenous tribe in the Americas, with approximately 35,000 members living in the Amazon rainforest (AMAZÔNIA REAL, 2020).

Indigenous Peoples who do not live on Indigenous territories (APIB, 2020a). As of September 17, 2020, according to SESAI, there is a total of 26,125 confirmed Indigenous cases and a total of 421 COVID-19 deaths among Indigenous People (MINISTÉRIO DA SAÚDe, 2020). On the same date, according to the Articulação dos Povos Indígenas do Brasil (*Articulation of Indigenous Peoples of Brazil* - APIB), there is a total of 32,017 confirmed Indigenous cases and a total of 808 COVID-19 deaths among Indigenous Peoples (APIB, 2020a). It is evident here that there is a large discrepancy between SESAI and APIB recorded data. In addition, APIB monitors the number of Indigenous ethnic groups affected by COVID-19. As of September, 17, 2020, there are 158 Indigenous ethnic groups affected by COVID-19 (APIB, 2020a).

This section outlines the impact of COVID-19 on Brazilian Indigenous Peoples, with a brief review on the timeline of events that led up to the outbreak in Brazil. This section is divided into two sub-sections: 2.1 describes the earliest events and the initial actions adopted by communities, public authorities, and non-governmental organizations (NGOs), to fight COVID-19 in Indigenous territories; and 2.2 elaborates on some factors that can increase the spread of COVID-19 in Indigenous communities that are associated with Indigenous health and Indigenous ways of knowing and living.

2.1 Early events and initial actions adopted to fight COVID-19 in Indigenous territories

The virus poses a particular threat to Indigenous Peoples living remotely in traditional territories and isolated communities or are uncontacted Peoples. Brazil has the highest number of Indigenous Peoples living in voluntary isolation, as *Fundação Nacional do Índio* (FUNAI) has identified 114 tribes (FUNAI, n.d.). Indigenous Peoples lack immunity to many infectious diseases (MAZEL, 2018). Once the virus spread to Brazil, Indigenous Peoples took their own measures to prevent the disease's spread and protect themselves through voluntary isolation (APIB, 2020b). Indigenous Peoples have mobilized their communities to close access to their territories, reactivate "self-defence committees" and urge the international community to support the protection of their rights to living on their lands (APIB, 2020b).

Since the WHO declared the pandemic, Indigenous leaders and communities have called on the federal government and its agencies to provide sufficient support and protection to combat the pandemic (APIB, 2020b). The *Conselho de Povo Terena*, an Indigenous organization under the APIB of the Terena region, publicly expressed concern on the extreme

vulnerability of their people to the pandemic (APIB, 2020c). The organization made recommendations for Indigenous chiefs and communities to adopt measures such as restricting the entry of visitors, tourists, and vendors into villages and avoiding non-essential travel into the cities unless for food or medical attention. In addition to their demand for an Emergency Action Plan for Indigenous Peoples from the federal government, the APIB reinforced in a letter to the 26 state governors to request the adoption of special measures to protect Indigenous Peoples and their territories (APIB, 2020d). The APIB partnered with academic institutions such as Projecto Xingu/Unifesp, Fiocruz, and *GT Saúde Indígena da Abrasco* to build hygiene recommendations for food delivery to Indigenous communities that maintained COVID-19 control measures based on SESAI guidelines (APIB, 2020e). These safety measures were put in place to prevent virus transmission. Food would be transported into Indigenous communities and villages through motor vehicles, aircraft, and boats coming from the city.

Moreover, some Indigenous Peoples lost their jobs due to voluntary isolation or could no longer sell their handicrafts or agricultural products (ISA, 2020). To advocate support from the general population, the APIB initiated campaigns to collect monetary and subsistence donations for Indigenous Peoples (APIB, 2020f). Other Indigenous communities followed suit and began mobilizing their community members to create online fundraisers for food, medicine, and protective equipment donations, hygiene and cleaning supplies, and financial resources. A bank of 68 initiatives had been created to promote the different fundraisers and campaigns, with partners such as the Norwegian Embassy and European Union (ISA, n.d.a). Some communities have also launched online petitions to call on the MS to provide COVID-19 testing kits.

Two months into the pandemic's announcement, Brazilian public authorities continued to dismiss safeguarding the health of Indigenous Peoples. The APIB launched *Assembleia Nacional de Resistência Indígena* (National Assembly of Indigenous Resistance (ANRI)) to debate plans for the confrontation of COVID-19 cases in Indigenous villages and the growing number of victims in Indigenous territories (APIB, 2020g). In some cases, it was found that health workers from SESAI had carried the virus into villages and infected Indigenous Peoples during health clinic visits (FARIAS, 2020). Regional leaders and non-Indigenous specialists collaborated to determine management and prevention practices in Indigenous communities and to ascertain the accessibility to health teams. The APIB necessitated SESAI's registration and immediate verification of COVID-19 cases of

Indigenous Peoples who live in Indigenous territories and urban areas. Moreover, the APIB proposed memorial services and better funeral systems to recognize and raise awareness of the loss of Indigenous lives due to COVID-19 (APIB, 2020g).

Concerning access to information during the pandemic, the Inter-American Commission on Human Rights (IACHR) reiterates that pandemic processes produce disproportionate impacts on Indigenous Peoples. This causes more considerable difficulties in the access to health care resources and technologies (AIDA, n.d.). The IACHR reminds states of their duty to provide protection for Indigenous Peoples and the importance of issuing clear information about COVID-19 in their traditional languages.

Despite the IACHR recommendations about the dissemination of and facilitation to access information, relevant and crucial resources available in Indigenous languages on the disease and preventative measures remain scarce in Brazil. As a result of this hindrance, non-state actors have prepared and shared their efforts to provide assistance. The United Nations Refugee Agency has become a source of information on COVID-19 and has distributed pamphlets on prevention in Indigenous languages (HUGUENEY; IRNALDO, 2020). The non-profit and Indigenous-led organization, Cultural Survival, has produced radio materials, public service announcements, and translated programs into Indigenous languages (CULTURAL SURVIVAL, 2020).

2.2 Factors that can increase the spread of COVID-19 among Indigenous Peoples

2.2.1 Indigenous immunity to infectious diseases

The first factor that can increase the spread of the virus is related to Indigenous immunity to infectious diseases. Major disease outbreaks in human history have demonstrated the vulnerability of the immunity system of Indigenous Peoples. Indigenous people face a more significant disease burden across countries and populations than non-Indigenous peoples, including cardiovascular disease, HIV/AIDS, higher infant and maternal mortality, and lower life expectancies (COIMBRA, 2013). For example, the Xavante[4] infant mortality rates are more than twice those of Brazil's national average (SOUZA & SANTOS, 2001).

[4] Xavante are an Indigenous ethnic group within the eastern Mato Grosso state in Brazil.

The colonization of Indigenous territories introduced infectious diseases such as measles, influenza, smallpox, and tuberculosis[5]. Other outbreaks include the period in the 1980s when the Uru-Eu-Wau-Wau population was reduced to less than half by respiratory diseases (AMIGO, 2020). An example of a recent epidemic is the 2009 H1N1 influenza, where Indigenous Peoples' death rates were 4.5 times higher than the general population in Brazil (AMIGO, 2020). Now more than a decade later, COVID-19 certainly presents as another challenge for institutions and systems in ensuring the right to health for Indigenous Peoples.

2.2.2 Indigenous ways of living

In addition to a heightened immunological vulnerability, Indigenous ways of living is another factor that can increase the transmission of the virus. Compared with other populations with individualistic cultures and nuclear households, maintaining collective customs and traditions are integral in Indigenous communities. Remote Indigenous communities inhabit native communal territories, and local norms and living arrangements can promote virus transmission. Collectivity is a core ethos permeating multiple aspects of daily life in many Indigenous cultures, such as extended family co-residence and communal labour and production (KAPLAN, 2020). Sharing of gourds and other household utensils and food and drinks from the same bowl is customary for Indigenous Peoples. Collective activities can hinder compliance with physical distancing measures. Health officials and Indigenous leaders have recommended communities to avoid large gatherings and perform communal rituals that involve sharing tobacco pipes and other instruments.

3. Barriers to the right to health for Indigenous Peoples during COVID-19 in Brazil

This section explores the barriers to ensuring the right to health for Indigenous Peoples in Brazil during COVID-19, such as health, structural, socioeconomic, and environmental barriers.,

3.1 Healthcare system barriers

[5] The incidence of tuberculosis among Indigenous Peoples in Brazil is at least 20 times higher than that of the general population (Coimbra et al., 2013).

It is important to indicate that the inequality of the healthcare system for Indigenous Peoples in Brazil existed even before the pandemic, and that COVID-19 has only exacerbated the critical situation. In particular, the universal public health system in the State of Amazonas, where it is home to most Indigenous groups, is in a precarious condition. A critical aspect to ensuring the right to health for Indigenous Peoples in Brazil during the pandemic is the healthcare system capacity for SASI. On April 5, 2020, the mayor of Manaus, Arthur Virgílio Neto, announced the collapse and failure of the state hospital to meet the demands of COVID-19 (Neto, 2020). Many Indigenous communities, such as Manaus, lack health care units, doctors, and essential medications. There are few hospitals with intensive care units (ICUs) and ventilators, both of which are required for the most severe COVID-19 cases. In Brazil, there were 36,939 beds available in February 2020 in the ICUs, according to the *Cadastro Nacional de Estabelecimentos de Saúde* (SIMÕES; SILVA, 2020). Holding a historical occupancy of no less than 85%, this yields approximately 5500 free ICU beds (SIMÕES; SILVA, 2020).

Apart from accessing the healthcare system at state hospitals, Indigenous Peoples have access to district-level essential health services through the DSEI in Indigenous areas in Brazil. The healthcare system capacity barrier extends into Indigenous areas, as DSEI depends on SESAI for the purchasing of materials such as personal protective equipment (PPE) and diagnostic testing kits (MENDES, 2018).

Despite consistent growth in resources within SASI, there has not been a proportional improvement in Indigenous health indicators (MENDES, 2018). There is an evident shortage of essential supplies and equipment in health facilities, let alone RT-PCR for the early detection and prevention of COVID-19 transmission and symptomatic medications (CRODA, 2020). Moreover, the high provider turnover and logistical complexity in some regions have a negative impact on the quality of healthcare service delivery in Indigenous territories. Inconsistent health service delivery has limited health professionals' ability to establish rapport with patients and gain cultural competencies for specialized health care to Indigenous Peoples (CRODA, 2020).

Although DSEIs are responsible for organizing basic services, access to quality primary health care is limited for Indigenous communities. As such, there are regional inequalities in guaranteeing equitable access to appropriate basic and complex services. Data demonstrates that barriers to accessing DSEI health services, such as long distances for travel

and transportation difficulties, were higher in rural areas than in urban areas (ROCHA, 2020). The largest number of facilities and public services are concentrated in the cities, with the lowest access in Indigenous territories (COELHO; SILVA, 2007). Inadequate access to health services in Indigenous communities has also created an overload of Indigenous patients in hospitals already at full capacity in the cities (COELHO; SILVA, 2007). Despite the decentralization of SASI into SESAI, the healthcare system's fragility remains a barrier to ensuring the right to health for Indigenous Peoples.

Another healthcare system barrier is a result of DSEIs not treating Indigenous Peoples living in urban areas and, thus, must depend on the public health system or military hospital to access healthcare services (COIMBRA, 2013). The negligence of SESAI creates a barrier to ensuring the right to health for Indigenous Peoples because it leaves those residing in urban areas without access to healthcare services. According to Coimbra, the SESAI has evaded their duty and responsibility to serve and care for all Indigenous Peoples, regardless of their place of residence.

In fact, among the 379,534 Indigenous Peoples residing outside federal reserves, 78.7% (298,871) live in urban areas (COIMBRA, 2013). Furthermore, it forces Indigenous Peoples to return to Indigenous territories to access healthcare services, which puts Indigenous communities at risk of transmission. Despite being tasked as an organization solely responsible for Indigenous health, according to Coelho and Shankland, the SESAI has failed to promote coordination and facilitation among relevant stakeholders to ensure the right to health for Indigenous Peoples (COELHO; SHANKLAND, 2011).

3.2 Health and demographic data collection barriers

There is relatively scarce demographic and epidemiological data on Indigenous Peoples in Brazil. The National Survey on the Health of Indigenous Peoples was the only nationwide health survey conducted among the Indigenous Brazilian population (COIMBRA, 2013). A lack of health and demographic data on Indigenous Peoples poses a barrier to ensuring their right to health, as it becomes difficult to monitor and evaluate the impact of COVID-19 on Indigenous Peoples.

It was not until 1991 did the national decennial census include the response option "Indigenous" for the question about the "color or race" of the interviewee (DE OLIVEIRA MARTINS PEREIRA, 2020). A significant limitation of Brazilian census data is that it does

not acknowledge the nearly 200 specific Indigenous societies or ethnicities and their native languages. Despite the increase in self-reporting and identifying as Indigenous, hospital intake forms do not include the Indigenous ethnicity (COIMBRA, 2013). As a result, there is a discrepancy in official reported COVID-19 cases and deaths among Indigenous Peoples.

The *Sistema de Informações da Atenção à Saúde Indígena* (Indigenous Health Care Information System) restricts access to providers and managers, resulting in limitations on access to information, data reliability, and communication with other SUS information systems (MENDES, 2018). Moreover, the SESAI has underreported the confirmed cases of COVID-19 among Indigenous Peoples, as they do not record who do not live on Indigenous territories (APIB, 2020a). It is evident that without accurate, comprehensive, and up-to-date data, it is challenging to support the necessary measures and policies to ensure the right to health for Indigenous Peoples.

3.3 Structural barriers

The federal government has been unsuccessful in abiding by and providing coherent recommendations to mitigate COVID-19 transmission in Brazil. Various preventive measures have been debated, including appropriate physical distancing, use of facial masks, and the duration of lockdowns. However, hand hygiene seems to be enforced the most due to its low-cost behaviour for containing the pandemic (FILHO, 2020). Even so, access to water and soap for regular handwashing remains a barrier for Indigenous Peoples living in areas with poor basic sanitation and hygiene conditions. According to Silva *et al.* (2020), health authorities and government officials have not considered the vulnerability of Indigenous Peoples in contracting and spreading the virus. This public health risk will continue to perpetuate without proper hygiene measures and water availability, soap, sanitizers, and disinfects for these communities (PEREIRA; NASCIMENTO, 2020).

A study on the ethnic and regional variations in hospital mortality from COVID-19 in Brazil, Baqui *et. al.* (2020) found that sewage covers are a proxy for water availability in regions. Thus, the authors identified the availability of clean water and general sanitation as a risk factor to COVID-19 and its necessity for practising proper hand hygiene (BAQUI, 2020).

Another study investigated the relationship between sanitation indices and the rate and number of COVID-19 cases. Silva et al. (2020), observed that the north and north-east regions exhibited a higher incidence than other regions in the country. These regions also

presented with lower sanitation indices. Additionally, states in the north-east region presented with better percentages of water service and sewage treatment indices exhibited lower COVID-19 incidence and mortality rates (SILVA, 2020). Moreover, the precarious conditions of basic sanitation reflect a lack of drinking water and low hygiene standards.

3.4 Socioeconomic barriers

Access to information is crucial in ensuring the health of Indigenous Peoples during the pandemic because it can provide coverage on the evolving outbreak, health and safety recommendations and guidelines, and resources for health and social support services (BENJAMIN, 2020). Although the MS and the media provide data, information, and education for the public on the pandemic, access to and understanding of information becomes a barrier for Indigenous Peoples. The Brazilian National Household Sample Survey indicates that in the north and north-east regions of the country, 72.1% to 79% of the population is Black and Indigenous residents (MARSON; ORTEGA, 2020). The survey found that 20.2% of Brazilian households had access to the internet. However, the figures reflected an inequality of access to information from the internet. While only 8.2% of the households in the north region and 8.8% in the north-east region were connected to the internet, the south-east region had the highest percentage, with 27.4% of households connected to the internet.

Physical distancing measures that have enforced closures on the foodservice sector and transportation into the city pose another socio-economic barrier to ensuring the right to health for Indigenous Peoples (ACQUINO, 2020). The shortage of food and supplies is another obstacle for Indigenous Peoples during the pandemic, as it becomes challenging to access affordable and nutritious food under voluntary isolation. Moreover, many villages are historically dependant on the food supply coming from the city, as there are seasonal food shortages in Indigenous communities (Borges et al., 2016).

Over 90% of Indigenous communities have reported some food scarcity during the year, and more than 50% reported shortages could last longer than four months (BORGES, 2016). Moreover, Indigenous families that migrate to urban areas often experience significant changes in their dietary patterns and are at risk of anemia, stunting, and obesity due to increased consumption of easily accessible and cheap processed foods (WELCH, 2020). Commuting into and out of cities for food becomes a serious health risk during the pandemic,

but complete isolation can further food insecurity for Indigenous populations. Welch highlights that in ensuring the right to health for Indigenous Peoples, it is crucial to guarantee their food sovereignty and traditional food acquisition and production (WELCH, 2020).

Other socioeconomic barriers include having to travel to the city to receive government social welfare benefits, such as the *Bolsa Família*[6]. The recent *Auxílio Emergencial*[7] (Emergency Aid) provides households with 600 reais, as financial assistance during the pandemic. However, many Indigenous Peoples who typically receive social support no longer benefit from this aid. Community members do not want to risk travel into the cities due to the possibility of becoming infected by the virus and bringing it back to their villages.

3.5 Environmental barriers

Another barrier to ensuring the right to health for Indigenous Peoples is illegal gold mining activities. The confirmation of COVID-19 cases in Brazil had raised concerns for Indigenous Peoples and organizations on the potential of virus transmission into communities due to illegal mining activities. The gold miners are the primary vector of the virus within the territory, and cases will continue to increase due to a decrease in vector control interventions (ISA, 2020).

An example of illegal mining activities occurs in the Yanomami and Ye'kwana Indigenous territory[8]. Since the beginning of 2019, an estimated 20,000 gold mining invaders have set up illegal camps in the Yanomami and Ye'kwana Indigenous territories with permanent supply services and satellite communication systems[9]. Many factors have contributed to the gold rush in the Yanomami Indigenous territory. These include the international increase in gold prices, the weakening of policies for protecting the rights of

[6] Programa Bolsa Família was introduced in 2003 to support low-income families living in poverty (Borges et al., 2016). Over 120,000 Indigenous families receive cash transfers from Programa Bolsa Família and Programa de Aquisição de Alimentos (food security program).
[7] Auxílio Emergencial is a financial benefit for informal workers, individual microentrepreneurs (MEI), self-employed, and unemployed persons.
[8] "Formally recognized and demarcated by the Brazilian government in 1991, the Yanomami Indigenous Territory is one of Brazil's largest home to both the Yanomami and Ye'kwana people, as well as groups of isolated (uncontacted) people. With an area of 9.6 million hectares, equivalent to that of Portugal, and with a population of 27,398 people spread out in some 331 communities and groups of isolated people, the Yanomami Indigenous Territory lies between Amazonas and Roraima states (ISA, 2020a, p. 5)."
[9] The Yanomami territory is also home to the isolated Moxihatetea Indigenous group and Hakoma and Parima Indigenous communities. These populations are more vulnerable to COVID-19 due to their compromised immune systems (ISA, 2020).

Indigenous Peoples and the environment, and pressure from the current government for the legalization of mining on Indigenous lands (ISA, 2020).

Even before the pandemic started, the Jair Bolsonaro administration has taken actions that threaten the Amazon rainforest and Indigenous Peoples in Brazil. President Bolsonaro has previously stated that not a single centimetre of land will be demarcated for Indigenous Peoples (ISA, 2020). Moreover, he declared that "conservation units" and Indigenous lands should be open to agriculture and mining.

Mining activity has not been halted or prevented, as aircraft and helicopters continue carrying miners and their supplies into the Korekorema community in the Yanomami Indigenous territory. Several studies have demonstrated the relationship between population spatial mobility and disease distribution. Research indicates that illegal miners who travel between cities and remote areas facilitate the transmission of diseases like malaria (ISA, 2020), and now COVID-19[10]. The Socio-environmental Institute, University of Minas Gerais, and Oswaldo Cruz Foundation for Public Health reinforces the need for federal agencies and authorities to protect Indigenous lands from invaders to ensure the right to health for Indigenous Peoples (ISA, 2020).

Additionally, Indigenous Peoples need to be able to produce food daily during voluntary isolation (KAPLAN, 2020). Therefore, it is essential that Indigenous communities have the right and access to their traditional lands to ensure subsistence-related activities.

4. COVID-19 response and measures for Indigenous Peoples in Brazil

This section analyses the Indigenous-specific measures implemented by the Brazilian National Congress in response to COVID-19. Although the Bolsonaro administration has introduced measures for the general population, such as a welfare stimulus package and physical distancing orders, some cannot be practically implemented in many Indigenous communities (FUNAI, 2020). For this reason, Indigenous social mobilization has primarily pushed the National Congress to prepare and approve a specific law to ensure the right to health for Indigenous Peoples during the pandemic.

This section introduces Indigenous social mobilization used to create an emergency plan in subsection (4.1). It also analyzes the law n° 14021/2020, of July 8, 2020, on social protection measures to prevent the spread of COVID-19 in Indigenous territories in the face

[10] More on this topic: Souza et al., 2019.

of COVID-19 and the extent to which the recent law, once it will be implemented, can ensure the right to health for Indigenous Peoples in Brazil during COVID-19 (4.2).

4.1 Indigenous social mobilization for the creation of an emergency plan for Indigenous Peoples in COVID-19

Before the APIB publicly demanded the federal government to create an Indigenous Emergency Response Plan on April 3, 2020[11], it was evident that the government had not presented a clear strategy that took into account and ensured the right to health for Indigenous Peoples (FARIAS, 2020). Furthermore, the SESAI had not created accommodations to guarantee access to health services or protocols for health professionals in Indigenous territories (SANTOS, 2020). In the months leading up to the approval of an emergency policy for Indigenous Peoples during the pandemic, the government had not guaranteed access to drinking water, distribution of basic food baskets, hygiene and cleaning supplies, and other preventative and assistive actions (de Souza, 2020). In order for Indigenous communities to confront COVID-19 in Brazil, Indigenous leaders and Indigenous organizations (APIB and *Mobilização Nacional Indígena* (MNI)) proposed an emergency plan containing guidelines for the preparation of regional and local action plans (APIB, 2020h). Specialists from various Indigenous health civil society organizations, such as the Acampamento Terra Livre (ATL) and the ANRI, carried out participatory processes to advocate for actions that promote the right to health for Indigenous Peoples (APIB, 2020h).

The annual meeting for Indigenous Peoples in Brazil, ATL, took place online from April 27 to 30, 2020, for the first time in 16 years. The ATL is the largest Indigenous event bringing together thousands of Indigenous Peoples in Brazil to discuss the Indigenous movement's struggles and resilience in their fight for rights. This year the platform emphasized the need to support and advocate for Indigenous Peoples during the pandemic. The APIB and MNI called for the mobilization of Indigenous Peoples to hold the 16th ATL, intending to warn on the possible genocide of Indigenous Peoples in the pandemic and denounce the federal government's neglect ensuring the protection of Indigenous Peoples (APIB, 2020i).

On the last day of the event, a final document was created with an analysis of the government's failure to take proper action on safeguarding the rights of Indigenous Peoples in

[11] More on this topic: APIB, 2020d.

the pandemic and a subsequent release of demands for the government (CIMI, 2020). The document details the recall of different public policies in education, finance, environment, and health for Indigenous Peoples by the Bolsonaro government. Moreover, the document urges national and international actors to recognize their appeals, such as the demarcation of Indigenous lands, the withdrawal of invaders on Indigenous lands, implementation of actions that guarantee basic sanitation and drinking water, and the creation of adequate infrastructure and logistics for health teams.

The executive coordinator of APIB and Brazil's former vice-presidential candidate, Sonja Guajajara, affirmed that the Brazilian government needs to take concrete actions to avoid genocide due to the persistent attacks on Indigenous rights and the vulnerability of Indigenous Peoples in the pandemic (APIB, 2020j). Moreover, Joenia Wapichana, the federal deputy and Brazil's first Indigenous member of parliament, announced that an open letter signed by several organizations was addressed to the WHO on May 4 for the request that Indigenous Peoples be considered most at risk and vulnerable to COVID-19. Thus, demanding that Indigenous Peoples should receive priority assistance in the pandemic (APIB, 2020j).

4.2 Approval of bill 1.142/2020 on May 21, 2020

The dedication and commitment of Indigenous social mobilization resulted in the approval of an emergency policy for Indigenous Peoples, quilombolas, and traditional populations in the pandemic (de Souza, 2020). Rapporteur and federal deputy, Joenia Wapichana, presented bill 1.142/2020 as an effective measure to guarantee healthcare for Indigenous Peoples and strengthen the SUS (de Souza, 2020). The Chamber of Deputies approved bill 1.142/2020 on May 21, which provides the creation of an "Emergency Plan to Combat COVID-19" for Indigenous territories and indicates that the federal government should facilitate access to emergency aid in the pandemic. However, Wapichana was pressured to make concessions as other parliament members presented a substitute text altering several points in the bill (de Souza, 2020). The other bill excluded quilombolas and other traditional populations, the mandatory provision of drinking water and specific services for Indigenous Peoples in urban areas, and the removal of SESAI in the coordination of the emergency plan for Indigenous Peoples. Eventually, the bill was set to be debated at the Federal Senate without the other amendments (ISA, n.d.b).

On June 16, 2020, bill 1.142/2020 was approved before the Federal Senate (ISA, 2020b). All parties were in favour of the symbolic vote, and the momentous occasion carried no change in the content of the proposal from the Chamber of Deputies. After the approval, the law was forwarded to the presidential sanction. On July 7, 2020, President Bolsonaro sanctioned the bill that became Law 14.021/20, but put 22 vetoes towards guaranteeing access to water, the free distribution of hygiene and sanitation products, provision of hospital beds, and the proposal to ensure emergency healthcare funds for Indigenous Peoples. On August 19, 2020 Congress overturned 16 of 22 of President Jair Bolsonaro vetoes.

4.3 Analysis of Law n° 14.021 of July 7, 2020

The Law 14021/2020 consisting of 21 Articles, includes the creation of the "Emergency Plan to Combat COVID-19" for Indigenous Peoples, quilombolas, and traditional communities. This plan aims to ensure access to the prevention and treatment services for COVID-19, in compliance with human, social, territorial rights of Indigenous Peoples (ISA, 2020c).

The analysis of law 14.021/2020 follows in the order of the barriers explored in Section 3, such as the healthcare system, health and demographic data collection, structural, socioeconomic, and environmental barriers and the following parts will see if the new regulation give some tools to overcome the different obstacles to ensure the Indigenous right of health

4.3.1 Chapter 1: Preliminary Provisions

Law 14.021/2020 is organized into six chapters: preliminary provisions; the emergency plan in Indigenous territories; food security; isolated or recent contact Indigenous Peoples; supporting communities, quilombolas, and other traditional peoples and communities confronting COVID-19; and complementary and final provisions.

Article 1, 2, and 3, of law provides the foundation for the Articles that follow and future political actions to prevent the spread of COVID-19 in Indigenous territories and to ensure additional resources in emergency situations.

With regards to preliminary provisions, Article 1 establishes sanitary and epidemiological surveillance measures to prevent the spread of COVID-19 in Indigenous

territories; the creation of Emergency Plan to Confront COVID-19 in Indigenous territories; actions to guarantee food security; actions to support isolated Indigenous Peoples, quilombolas communities, and other traditional communities; the amendment of law 8.080/1990; and to ensure additional resources in emergency situations (ISA, 2020c).

Article 1 is an extended provision, covering Indigenous Peoples and other vulnerable peoples such as "V – quilombolas; VI - quilombolas who, due to studies, academic activities or the treatment of their own health or that of their families, are living outside the quilombola communities; VII - artisanal fishermen; VIII - other traditional peoples and communities (ISA, 2020c)."

Article 2 states that the above-mentioned groups should be considered a group in extreme vulnerability and of high-risk in epidemic and pandemic emergencies. This is mentioned again in the Article 5 § 2º "The measures of isolation and quarantine of suspected cases in COVID-19 should consider that indigenous peoples have greater vulnerability from the epidemiological point of view and have as a characteristic community life, with many members living in the same house (ISA, 2020c)." The express recognition of the extreme vulnerability of those groups is very important in particular for the Indigenous Peoples because, as underlined in Section 2 of this paper, major disease outbreaks in human history have demonstrated the vulnerability of their immunity system.

Article 3 reinforces that all measures and guarantees provided in the law must consider social organizations, languages, customs, traditions, and the right to land for Indigenous Peoples, quilombolas communities, and other traditional peoples and communities.

4.3.2 Law 14.021 and healthcare system barriers

Chapter 2 of law comprises Articles 4 to 8, involving creating the "Emergency Plan to Combat COVID-19 in Indigenous Territories". According to Article 5 of the law, the Federation will coordinate the emergency plan in conjunction with states, federal districts, municipalities and other public institutions (ISA, 2020c). Article 5 also specifies the inclusion and active participation of Indigenous Peoples and their representing organizations to carry out specific actions for the urgent and free-of-charge distribution of resources and services, such as qualified and COVID-19 trained health teams, adequate and sufficient PPE, and complex health service delivery in urban centres.

Concerning the healthcare system barriers analyzed in Section 3, the regulation attempts in some Articles to provide solutions. Article 5 states among other measures, that the public entities have to implement specific actions to ensure, for instance the participation of qualified and trained Multi-professional Indigenous Health Teams to face COVID-19; access to rapid tests, medicines and medical equipment suitable for identifying and fighting COVID-19 in Indigenous territories; organization of emergency provision of hospital beds and intensive care units; purchase or supply of ventilators and blood oxygenation machines; and emergency construction of field hospitals in municipalities close to villages or communities with higher numbers of cases of contamination by COVID-19.

To overcome the barrier of long distances between Indigenous territories and the hospitals, Article 5 includes the addition of necessary measures such as ambulances for transport - fluvial, land or air - of Indigenous Peoples from their villages or communities to the nearest care unit or for transfer to other units; and the elaboration and execution of emergency plans, as well as the establishment of reference protocols for specialized care, transportation, and housing of Indigenous Peoples.

Inadequate healthcare system capacity for SASI is a concern for ensuring the right to health for Indigenous Peoples in Brazil. The guarantee of health professionals, the supply of hospital beds in ICUs, and the availability of ventilators and blood oxygenation machines is a significant step in preparing and adequate provision of resources and services for Indigenous Peoples. Additionally, the availability and accessibility of culturally appropriate health services and facilities can ensure the right to health for Indigenous Peoples. The inability to acquire early detection and prevention of COVID-19 transmission can be mitigated by guaranteeing access to rapid tests and RT-PCRs, drugs, and appropriate medical equipment to identify and combat COVID-19 in Indigenous territories. This may assist in breaking the healthcare system capacity barrier that extends into DSEIs in Indigenous areas.

4.3.3 Law 14.021/2020, health and demographic data collection barriers

Concerning the demographic data collection barriers, the new law does not resolve the problem but takes some steps towards mitigation. The first steps envolves Article 1, which covers various scenarios for Indigenous peoples, “I - recently contacted Indigenous Peoples; II - Indigenous villagers; III - Indigenous Peoples who live outside indigenous lands, in urban or rural areas; IV - Indigenous Peoples and groups who are in the country in a situation of

migration or provisional transnational mobility". Article 6 provides that health care or social assistance in the public network cannot be denied to Indigenous populations due to a lack of documentation or for any other reasons.

Additionally, Article 5 reinforces transparency in the publication of contingency plans, technical notes and guidelines, and surveillance and monitoring of epidemiological data concerning COVID-19 cases in Indigenous territories. This is complemented with the guarantee of strict protocols and surveillance of entry into Indigenous lands, villages, and communities. More accurate, comprehensive, and up-to-date data can support the necessary measures and policies to ensure the right to health for Indigenous Peoples.

4.3.4 Law 14021/2020 and structural barriers

Among the structural barriers, it was point out that access to water and soap for regular hand-washing remains a barrier for Indigenous Peoples living in areas with poor basic sanitation and hygiene conditions. The first actions detailed in the emergency plan for the urgent and free-of-charge distribution of resources and services are the provision of universal access to drinking water (Art. 5, I); and free distribution of hygiene, cleaning, and disinfection supplies for Indigenous villages and communities (5, II)[12]. Article 5 clearly states that these resources and services will be provided for both officially recognized and not recognized Indigenous Peoples residing in urban areas.

All recommendations to protect the spread of COVID-19 specifies proper and appropriate hygiene measures and the availability of water, soap, and sanitizers, and disinfectants. Thus, the new law put the bases to mitigate structural barriers, with the creation of conditions that enable Indigenous Peoples to achieve their potential in health through access to water, hygiene, and sanitation is a step towards attaining a suitable standard of health equality in public health policy.

4.3.5 Law 14021/2020 and socioeconomic barriers

Some social and economic barriers are addressed in the emergency plan. The previous principle analyzed barriers are access to information, the shortage of food and the need for

[12] Article 5 (I and II) was vetted by the President, but the veto was rejected by the Congress.

the indigenous people to travel to the city in order to receive government social welfare benefits.

Concerning access to information, the law recognizes that access to the internet is a barrier for Indigenous Peoples in certain regions. Without accessible internet to obtain public health information, it can become a barrier to ensuring the right to health for Indigenous Peoples. Article 5, (VI and VIII)[13], includes extensive measures covering the elaboration and distribution of information materials on COVID-19 in different formats, such as community radio and social media. The dissemination of these resources will be in participation with Indigenous Peoples and supporting organizations. Moreover, the resources will be translated into Indigenous languages that promote accessibility and respect the linguistic diversity of Indigenous Peoples in Brazil. Article 5 identifies the provision of internet points in villages and communities to facilitate access to information and to avoid displacing Indigenous Peoples to urban centres.

Chapter 3 of law deals with food and nutrition security (ISA, 2020c). Article 9 guarantees food distribution to those in need of assistance and financial support for Indigenous Peoples. The article acknowledges the need to provide financial support to Indigenous Peoples and to provide support to those in the agricultural sector, due to the adverse effects of COVID-19 on family farming programs and infrastructure and logistics within regions.

It is important to note that Article 9 § 1º, providing that the Union will ensure the distribution of food baskets, seeds and agricultural tools directly to Indigenous families, quilombolas, artisanal fishermen, and other traditional peoples and communities was vetted by the President and not removed by the Congress, despite maintaining other parts of the Article. For instance, Article 10 specifies access to public policies that aim to create conditions to guarantee food security for Indigenous Peoples and emergency situations.

The new law takes in account COVID-19 containment measures, resulting in policy processes that include the distribution of basic food baskets, donation of school meals, and the ability to acquire and produce food on Indigenous lands.

[13] Article 5 (VI and VIII) was vetted by the President, but the veto was rejected by the Congress.

4.3.6 Law 14021/2020 and environmental barriers

Concerning environmental barriers analyzed in Section 3, Chapter 4 of the law has not directly condemned the practice of illegal mining in the Indigenous lands. Instead it has provided some indirect measures that can avoid the spread of COVID-19 in their territories (ISA, 2020c). Article 11 to 13 states that only in the case of imminent risk and under specific joint plans between SESAI and FUNAI, will certain protocols and plans protect these Peoples. Some of the measures include mandatory quarantine for all persons authorized to interact with Indigenous Peoples; the suspension of activities close to occupation areas of isolated peoples, except those who demonstrate to be of fundamental importance for the survival or well-being of Indigenous Peoples; and the availability of diagnostic tests for COVID-19 in officially recorded areas with the presence of isolated or recently contacted Indigenous Peoples.

Article 13 prohibits third parties' entry in isolated and recently contacted Peoples, except authorized persons and public agents who undergo safety precautionary measures. Moreover, missionaries who are already in Indigenous communities should be evaluated by a health team and remain subject to approval to remain in the community. Thus, the law does not explicitly state the removal of miners, loggers, land grabbers, or missionaries from Indigenous territories.

The measures provided do not guarantee the protection of Indigenous Peoples from non-Indigenous peoples entering their land and the potential to spread COVID-19 into communities. It has been substantiated that intruders in Indigenous territories and the pandemic represent a violation of a series of rights under the Federal Constitution, UNDRIP, and 1966 International Covenants (ISA, 2020). Law 14021/2020 intervenes only when the survival and socio-cultural organization of isolated and recently contacted Peoples are at risk, yet this definition and the absolute boundaries are not clear. The Brazilian law obligates the federal government to guarantee Indigenous lands' territorial integrity and to ensure the rights of Indigenous Peoples (ISA, 2020). The law fails to address the shortfall of Indigenous Peoples in attaining optimal health, as the Articles do not adequately protect them from factors that contribute to that shortfall.

Conclusion

The spread of COVID-19 is reaching and devastating Indigenous Peoples and communities in Brazil. It has been recognized that Indigenous Peoples are vulnerable to the novel virus, with a previous history of susceptibility to epidemics. COVID-19 poses a threat to Indigenous Peoples, especially given the Brazilian federal government's neglect and marginalization of the rights of Indigenous Peoples. The pandemic has had wide-ranging consequences on Indigenous Peoples, including their ability to access healthcare services, water, basic sanitation and hygiene, food and drug supplies, and PPE.

This paper explores these consequences through the analysis of different barriers that Indigenous Peoples are facing during the pandemic, and the extent to which the new Law 14021/2020 of July 8, 2020, ensures the right to health for Indigenous Peoples.

Thus, it can be said that the new Law 14021/2020, that provides urgent emergency support measures for Indigenous Peoples, is an attempt to overcome some of these barriers. Additionally, Law 14021/2020 mitigates some of the examined barriers with the creation of conditions that enable Indigenous Peoples to achieve greater health outcomes. Nevertheless, the protective measures to prevent the spread of COVID-19 in Indigenous territories, and the creation of the Emergency Plan to Confront COVID-19 is not a comprehensive strategy to safeguard the right to health for Indigenous Peoples in Brazil.

Despite that Law 14021/2020 satisfies the ethical commitment to provide the capability to achieve health for Indigenous Peoples, the regulation lacks ethical commitment to the redistribution of resources from the wealthy to those less fortunate from the well to the sick. Moreover, the law still has not been implemented at the current time of writing this paper. Every day that passes without the implementation of Law 14021/2020, more Indigenous Peoples are becoming infected and dying from COVID-19. Particularly, older Indigenous Peoples are at risk of dying from the disease. Concerning this last point and to conclude the paper, we are quoting Angela Kaxuyana[14], of the Kaxuyana ethnicity, that said “when older Indigenous Peoples die, there are two losses. The first is the pain of losing a family member, a father, and a grandfather. The second lost is losing our libraries, our memories, and our beings as Indigenous Peoples. It is like a fire at the National Museum, where everything that was recorded is on fire and turning to ashes."

[14] Executive member of the Coordination of Indigenous Organizations of the Brazilian Amazon.

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