REVISTA GEONORTE

HEALTH CARE IN ENVIRONMENTAL CONSERVATION UNITS IN AMAZONAS: CONFLICT OF COMPETENCY OR RESPONSIBILITY ISSUE?

Atenção à saúde nas unidades de conservação ambiental no Amazonas: conflitos de competência ou questão de responsabilidade?

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ABSTRACT: This article analyzes the discursive representations in the collective thinking of socio-environmentalists about the competencies and responsibilities of policies on protected areas concerning the health of riverside populations. Descriptive exploratory study with a qualitative approach based on the collective thinking of socio-environmentalists working with policy on protected areas of the Mamirauá Sustainable Development Reserve, from seven interviews collected by a semi-structured script and analyzed using the Discourse of the Collective Subject technique. Respondents express knowledge about the constitutional competencies of the municipality regarding health, but have difficulty in dialoguing with city halls on the subject; the responsibilities of the management of the conservation units (UC) and public non-state organizations that work in support of co-management are attributed to the responsibility for governing public policies and formulating scientific information to improve local health. In addition to the absence of dialogue, there is also no public agenda within the scope of environmental policy. There are experiences of access to health in rural areas adapted to the socio-environmental

context of the reserve; however, they are intermittent. The discursive representations of the collective thinking of socio-environmentalists express knowledge about municipal competencies concerning health and concerns regarding meeting these needs. The meeting of social needs is organized in a conflictual manner, due to the lack of coordination between the several institutions that operate in this territory. The decentralization of competencies and responsibilities over natural resources by the co-management of UC imposed new roles and authorities on the territories.

Keywords: Qualitative Research; Discourse of the Collective Subject; Protected Areas; Health Service Needs and Demands; Vulnerable Populations.

RESUMO: Este artigo analisa as representações discursivas no pensamento coletivo dos socioambientalistas sobre as competências e responsabilidades da política de áreas protegidas com a atenção à saúde das populações ribeirinhas. Estudo exploratório descritivo de abordagem qualitativa a partir do pensamento coletivo dos socioambientalistas atuantes na política de áreas protegidas da Reserva de Desenvolvimento Sustentável Mamirauá a partir de sete entrevistas coletadas por meio de roteiro semiestruturado e analisadas pela técnica do Discurso do Sujeito Coletivo. Os entrevistados expressam conhecimento sobre as competências constitucionais do município com a saúde, mas têm dificuldade de diálogo com as prefeituras sobre o assunto; as responsabilidades da gerência das unidades de conservação (UC) e organizações públicas não estatais que atuam no apoio à cogestão são atribuídas a responsabilidade de capitaneador das políticas públicas e de formulador de informações cientificas para melhoria da saúde local. A ausência de diálogo soma-se à falta de uma agenda pública no âmbito da política ambiental. Há experiências de acesso à saúde na zona rural adaptadas ao contexto socioambiental da reserva, contudo, essas sofrem descontinuidade. As representações discursivas do pensamento coletivo dos socioambientalistas expressam conhecimento sobre as competências municipais com a saúde e preocupações em relação ao atendimento destas necessidades. O atendimento às necessidades sociais está organizado de forma conflituosa, e isso acontece devido à falta de articulação entre as várias instituições que atuam nesse território. A descentralização das competências e das responsabilidades sobre os recursos naturais por meio da cogestão das UCs impôs novos papéis e autoridades sobre os territórios.

Palavras-chave: Pesquisa qualitativa; Discurso do Sujeito Coletivo; Áreas Protegidas; Necessidades e Demandas de Serviços de Saúde; Populações Vulneráveis.

INTRODUCTION

Conservation units (UC) are areas for the protection and conservation of biotic diversity (fauna and flora), being the oldest and most effective initiative for nature conservation in the world (GODOY; LEUZINGE, 2015).

In Brazil, there are 1,940 UC registered in the National System of Conservation Units (Snuc), corresponding to about 17% of the national territory. Regarding their distribution by large geographic regions and biomes in the country, the North Region and the Amazon biome are the most contemplated in terms of the number of protected areas, with 307 units covering 23.5% of the Legal Amazon (15.8% of the total) (AMAZONAS, 2015; BRASIL, 2011; VERÍSSIMO et al., 2011).

In the Legal Amazon, the population living in and around federal UC is of 1,345,635 people (11.3% of the state's total population), estimated from the geostatistical method of the 2007 population counting, indicating the dimension in this context (D'ANTONA et al., 2013).

Amazonas is the second state of the Legal Amazon in number of Units (71 UC, 30 federal and 41 state) and in territorial extension of UC (27% of the total area of the

state). In it, there is also an innovation in terms of the type of Conservation Unit, categorized as being of Sustainable Use (UUS), which is a Sustainable Development Region (RDS). This category and typology admit the presence of human populations in its interior, aiming to make nature conservation compatible with the sustainable use of a portion of its natural resources, unlike the category called Integral Protection Unit (UPIs), which does not allow direct human interference (AMAZONAS, 2015; VERÍSSIMO et al., 2011; MOURA, 2007).

The consolidation of the environmental and social roles of UC has been the subject of research, given the importance and difficulty of managing these areas for them to become inducers of actions aimed at local sustainable development and social equity, which may not have been occurring because multiple actors and divergent interests (biological communities, local human communities, governmental and non-governmental organizations, users, and private initiative) are involved, liable to conflict (MARTINS, 2012; GUERRA; COELHO, 2009; MEDEIROS; IRVING, 2007).

The notion of conflict has been presented in the field of environmental sociology and political ecology as an alternative to highlight the heterogeneity of interests and relationships that govern corporate processes in UC, which also translates a shift in focus, to a critical and politicized, less romantic, view of this reality (MARTINS, 2012; FERREIRA, 2005; GUIVANT, 2005).

Notably, one can identify conflict in the discursive representations of the collective thinking about the changes in the environmental and social roles of UC, being possible to talk about the attribution of multiple meanings to these spaces, or multiple territorialities, which, from the paradigmatic point of view, was conceptualized by modern scientists as preservationism, conservationism, biodiversity, and socio-environmentalism in the modern era (FRANCO, 2013; SOUZA, 2013; SANTILLI, 2005; VALLEJO, 2005; HAESBAERT, 2005).

The territorializations arising from the environmental and health policies originated from competencies and responsibilities established by the country's Magna Carta, formulated in different periods, often deriving from different public agendas. We argue that, when considering the conflicting points regarding the meeting of health-related needs in the discursive representations of socio-environmentalists, the power relations and the dynamics of territories can be revealed.

In this perspective, this study analyzes what socio-environmentalists think about the competencies and responsibilities of the policy of protected areas in meeting the health needs of riverside populations.

MATERIAL AND METHODS

The study design is exploratory and descriptive, with a qualitative approach based on the collective thinking of socio-environmentalists active in the policy of protected areas in the state of Amazonas.

The study area is the Mamirauá Sustainable Development Reserve (RDSM), which is one of the 15 UC in Amazonas organized under this typology. RDSM was created by

the non-state organization and regulated by State Decree no. 12,836/96. Since 2000, it has been considered the largest floodplain area in the world under environmental protection, and the result of this experience is awaited with great expectation regarding its sustainability discourse. (AMAZONAS, 2015).

The reserve covers an area of 1,124,000 hectares, comprising the Health Regions of the Triângulo and Alto Solimões of the state of Amazonas, specifically distributed over the municipalities of Alvarães, Fonte Boa, Japurá, Juruá, Jutaí, Maraã, Tonantins, and Uarini, where 10,867 people live in 200 communities and 1,873 households, according to the last IDSM demographic census of 2011 (MOURA et al., 2016).

The selection of RDSM was due to the fact that this UC is the only one in Amazonas that has a non-state research institute linked to the Ministry of Science, Technology, and Innovation (MCTI), which has a historical relationship with the reserve and its residents.

The group of research participants consisted of seven interviewees selected by the criterion of greater social representativeness among the representatives identified in the mapping of public state and non-state organizations. From the first interviewees, new names were requested to answer new questions. Regarding politics and protected areas, the selection criterion took place by the participants' social representation before their peers and society.

The data were collected by individual interviews, based on a semi-structured script, which contained guiding questions on the conflicts of competencies and the responsibility crisis concerning health care in the reserve area; the existence of an UC public environmental agenda; the necessary political structure to meet health needs; the legal and political implications of territorial overlaps; and the intersectorality between environmental policy and municipal health policy.

The interviews were recorded on an MP3 player and transcribed in full, respecting the anonymity of participants, identified as P1, P2, P3, etc. The presentation of the research objectives and the reading and signing of the Informed Consent Term (ICF) preceded the individual open interviews.

The data were analyzed according to the Discourse of the Collective Subject (DCS) technique, developed by Lefèvre and Lefèvre (2005). Collective thinking as a unit of analysis differs from quantitative research, which explores something that people actually have and is already given before the research, such as weight, height, income, etc. In the case of a thought, an idea, or an opinion, the "something" represented here is always what people express on a given topic that is presented in the form of a discourse.

The analysis of the discursive content is understood from the key expressions (KE), central ideas (CI), and anchoring (AC). The KEs are extracted from the more significant excerpts of the respondents' answers that divide the discursive content. The CIs are excerpts highlighted from the responses, which consist of words or linguistic expressions that reveal the meaning present in the statements in an objective and synthetic way. The AC linguistically manifests theories, ideologies, or beliefs in the condition of generic statements that define a given situation, and are not always

verified in the discourses. Each DCS was associated with the corresponding central idea (synthesis) so that it was possible to analyze the collected interviews. Thus, it became feasible to unite testimonies (DCS) with a similar meaning, but identified in their uniqueness, and to analyze them in the light of available knowledge. (NICOLAU et al., 2015; LEFÈVRE; LEFÉVRE, 2005).

DCSs were grouped into the following categories:

a) Conflicts of competency and the responsibility crisis concerning health:

For the purposes of definitions, constitutional competencies can be understood as the legal capacity of a federated entity or public body to act in a given matter (MACHADO, 2016); while constitutional responsibilities encompass the duties and obligations of all federated entities or public bodies to ensure, in favor of the citizen and the community, effective access to their rights (PAIM, 2002).

b) Public environmental agenda of UC to ensure health care:

The public agenda can be understood as the process of including or registering a theme in the local political debate. In short, it is the first step in building the bridge between society and government, regarding the search for answers to the needs or solutions to society's problems by appropriate measures of the Executive Power (as well as the Legislative and Judiciary Powers) (GOTTEMS et al., 2013; KINGDON, 2003).

c) Thinking about the health care policy of the riverside population:

The notion that policy encompasses is the one that guides decision and action; this is the most used meaning to define and understand public policies, which is also the notion explored by scientific research. In general, its analysis allows complementing and going beyond the study of the State as entity, legal and bureaucratic roles and apparatus, to verify how it acts, decides, interferes, and affects problems by public policies (SECCHI, 2010; MULLER; SUREL, 2004).

The term "health care" is a notion that comprises the form of organization and action strategies of a society in response to the health needs of the population, being expressed in an articulated way with the unique demographic and epidemiological situations in force (MENDES, 2011; MATTA; MOROSINI, 2009).

d) Interinstitutional and intersectoral partnerships to meet health needs in the Mamirauá Reserve:

This category sought to identify the existence of intersectorality between environmental policy and municipal health policy in the context of RDSM, based on the identification of projects developed in partnership between UC management and municipal management.

The Federal Constitution of 1988 brought great challenges to the management of public policies, regarding the recognition of fundamental rights and guarantees and the realization of social rights prescribed as universal, including the democratization of power. Integrated action, that is, intersectorality, aims to overcome fragmented management models; share resources and goals; and develop joint strategies based on experiences already carried out, bringing to the scene a greater participation of all actors involved in social policies, including the recipients of such policies (CARMO; GUIZARDI, 2017).

The project was approved by Opinion no. 1,667,857 of the Research Ethics Committee of the Aggeu Magalhães Research Center (CPqAM) of Oswaldo Cruz Foundation.

RESULTS AND DISCUSSION

Among the seven respondents, five were male and two female. Most respondents have higher education (six) with a Master's degree in biology (three), fisheries engineering (two), and anthropology (one), and only one respondent had primary education. Only four of them live in the reserve.

Conflicts of competency and responsibility with health

The DCSs of the first three central ideas show the interviewees' knowledge about some constitutional aspects that guide the organization of public health and education services. On the other hand, they point out different ways of dialoguing with the managers of these social services within the scope of UC management. Although the interviewees highlighted the financial limitation of the management and the challenges imposed by the territorial extension of the Reserve, they claim to be able to dialogue more with the education sector at the state level, which is in the same administrative level of government as the UC management (Table 1).

The fourth central idea recognizes the UC management responsibility for health and attributes the role of "governor of public policies" to UC management. Another responsibility attributed is related to the production of scientific knowledge. According to them, it would be up to these social organizations "to show through research how fragile the health issue is in all aspects; such research can subsidize us for many things" (Chart 1).

Chart 1 – Competencies and responsibility of the UC with health. RDSM, 2016.

CI (synthesis)	DCS
(1) UC management is not responsible for health	I understand that each sector of the government has a mandate to act on a theme. The health part does not depend much on the reserve. You know that education and health occur via municipality.
(2) UC management has no structure or financial resources	I find it difficult for such an entity to encompass this. The Mamirauá reserve, in addition to being large, is a land that spreads over several municipalities. UC management does not have the resources to do this, does not even have the resources to solve issues related to UC organization and to the protection of surveillance and monitoring of biodiversity.
(3) UC management enters as the governor of public policies	UC management enters as the governor of public policies. The needs of the communities arrive through the council, but are not directly carried out by the UC manager. I think that the mission of Mamirauá IDSM or the entities that support UC management is to show through research how fragile the health issue is in all aspects; such a research can subsidize us for many things.
(4) The responsibility of UC management with education is different	Education is different, today, for example, I had an agenda with the education personnel. But this depends a lot on the manager and the level of government; in some conservation units there is a state school, sustainability nucleus of the Sustainable Amazon Foundation (FAS).

Source: prepared by the authors

The guarantee of rights to health and to a healthy and balanced environment, within the scope of our society, is the responsibility of different institutions that act according to their competencies, according to the constitutional interpretation. The typical competencies of the Brazilian federalist constitutional model still provide for the decentralization of Power in several autonomous centers coordinated by a central power; the peculiarity of the Brazilian model is the inclusion of Municipalities as members (MACHADO, 2016).

In terms of health, the idea of decentralization prevailed in the Federal Constitution of 1988, with reference to the municipalization of public services that guided the Brazilian Unified Health System. In addition to attributing competencies common to the Union, the States, and the Federal District, the Constitution attributes 12 competencies to the Municipalities in the management of the public health system, regarding the formulation of policies at the local level, planning, organization, execution, evaluation, and control of health actions and services (PAIM, 2002).

The political agenda that culminated in Bill no. 2,892/1992, which later created Snuc, was based on the Plans for the System of Conservation Units in Brazil of the Brazilian Institute for Forestry Development (IBDF) of 1979 and 1982, whose work was taken

over by the Brazilian Institute of the Environment and Renewable Natural Resources (IBAMA) in 1989, under the name of the National Conservation Unit System (SISNAMA), which was processed for almost a decade to be approved by the National Congress (WALLAUER, 1998).

In a critical analysis, we can say that the philosophical and political orientations of the actors involved in the establishment of a National System of Conservation Units were almost all conservationists, coming from the South and Southeast of the country. They were represented in the figures of Paulo Nogueira Neto, who created the category of full protection reserve, and Maria Tereza Jorge Pádua, first director of the Brazilian Institute for Forestry Development (IBDF) and Pro-Nature Foundation (FUNATURA), who had strong presence on the Green Front of the National Constituent Assembly, which brought together more than 80 Deputies and Senators from all political parties, whose leadership was Deputy Fábio Feldmann, from São Paulo (GODOY; LEUZINGE, 2015).

Santilli (2005) notes that the emphasis of the legislation produced in this period was on control through the repression of practices harmful to the environment, carried out mainly by IBAMA, created in 1989 and linked to SISNAMA. The laws were intended to safeguard ecosystem species, with a strong conservationist orientation, without a clearly incorporated social dimension, which began to change with the unfolding of the alliance between forest peoples, social and environmental movements during the country's re-democratization period, called socio-environmentalism, explains the author.

Since 2004, Bill no. 4,573/2004, which regulates the selection criteria and the duties and responsibilities of civil society organizations of public interest (Oscips) in the management of UC, has been underway in the National Congress. For the Bill, shared management is a way to take advantage of the technical capacity of non-governmental entities linked to the environment.

Political and environmental agenda of UC to ensure health care for Mamirauá peoples and communities

In the central idea (1), the interviewees blame the environmental legislation, which does not allow the development of initiatives to solve health complaints and problems of access to health services in riverside communities. In the central idea (2), the interviewees recognize the lack of health services in the Mamirauá Reserve area, however, they admit that the problem is not clear in the work agenda of the environmental institutions in which they work, which may mean lack of knowledge on the organization and functioning of the health sector (Chart 2).

Bentes (2006) explains that Snuc, under the Sustainable Development Reserve (RDS) typology, alludes to making preservation compatible with the survival of its residents, giving this policy a sustainability character. In the interpretation of the jurist, whose idea we also share, it is up to the State (at the Federal, State, and Municipal levels) and the institution responsible for the management of the Reserve to offer the necessary

means for an individual to live in society and, thus, promote sustainable development, which is the greatest goal of RDS.

However, Calegare et al. (2013) found, in two federal UC, also in Amazonas, the use of ethnicity as a means to guarantee access to health and education services. In this context, the situation was also verified by a research in the community of São Francisco do Aiucá, in the Uarini Area of the Mamirauá Reserve.

Chart 2 – Political agenda of UC to ensure health care for the Mamirauá peoples and communities. RDSM, 2016.

CI (synthesis)	DCS
(1) Health is not a prerogative of the environment secretariat.	There is no planning, no agenda, nothing to do with it so far. An annual RDSM general meeting is held, where I raise priorities and discuss social issues, but the activity plan is not linked to this issue of public health policies. Because the state secretariat for the environment does not understand this as an obligation of the manager and management is very hampered, it has no funds and the laws do not allow it.
(2) The health agenda is strategic	Last year, FAS addressed a lot this health issue, to find a solution. As I am 24 hours in the communities, I know the need for and incredible lack of health. There should be a lot more. Our tendency is to seek solutions to solve. But this issue is also not clear on the agenda. Health is a strategic agenda.

Source: prepared by the authors

Recently, the Amazonas State Court of Auditors (2015), in an assessment of the Amazonas Conservation Units System (SEUC-AM), listed nine problems that compromise the desired future of the environmental protection policy, among which we highlight: problems of reclassification, redefinition, and adequacy of UC; low effectiveness for land tenure regularization of UC; insufficient human and financial resources for the management and operation of UC; political weakening and even extinction of state agencies in the context of the reform of the current State Government; and low access by state UC to public policies. The document also points out that the adoption of environmental protection agendas was not accompanied by other social policies, which has negatively contributed to the low quality of life of the populations living in the vicinity of UC, deterioration of ecosystems, and proliferation of endemics (AMAZONAS, 2015).

Thinking about the structuring of the policy to meet the health needs of the Mamirauá RDSM Reserve populations.

In the discourse of central idea (1), the notion of health is expanded, and the monitoring of socio-environmental conditions, described in the UC management plan, could reduce the vulnerability of local populations. This perception tries to overcome the idea

of health as the absence of disease, which corroborates central idea (2), when the interviewees attribute to the UC management the responsibility of raising and knowing the most frequent health complaints, as well as mobilizing, articulating, and cooperating in a technical and financial way to the health protection actions of the riverside population. Especially because, it is worth mentioning, the interviewees know about which health strategies and technologies (a*mbulancha* (motorboat ambulance); health boat; river health unit) are better suited to their geographical conditions; these initiatives, unfortunately, are intermittent (Chart 3).

Chart 3 – Thinking about the structuring of actions to meet the health needs of the Mamirauá peoples and communities. RDSM, 2016.

CI (synthesis)	DCS
It will depend on what we are talking about health	I think it also depends on what I am defining as health, in a very broad sense. If UC managers take the trouble to raise the main health complaints and understand the most frequent diseases that are affecting the population, they will end up arriving very quickly in an environmental issue; they will obviously not deal with health issues as their agenda, but they can articulate and facilitate important processes.
The UC management could mobilize, articulate, and cooperate in a technical and financial way with health actions.	UC managers must ensure that the population residing within their protected area has access to health. They have to carry out a survey, consult the communities, deepen the understanding of the main health complaints attributed to environmental issues. An agenda needs to be drawn up, as well as a working group that addresses this specific health issue within the Association of Residents and Users of the Antônio Martins Mamirauá Reserve (Amurmam) and within the reserve council. Amurmam has strength, it represents all associations, it only has less strength than the general reserve council. There must be a technical cooperation agreement with the municipality, and the UC management must bear the burden of health responsibility. I remember that, in 2003, there was an itinerant motorboat, with a doctor and nurse who went through the communities doing health work, collecting laboratory supplies, dental care, but that stopped. I know that the municipality of Tonantins has a river unit that is stopped there at the port, because there is no doctor or nurse to work. It is what I said, what's the use of setting up a policy if you don't create that other part that is the structure?

Source: prepared by the authors

According to the latest survey by the National Program for Improving Access and Quality in Primary Care (PMAQ, 2012), two strategies for municipal health management in Amazonas were identified to ensure care for their rural populations, as provided for in PNAB. The first was the designation of a basic health unit located at the

headquarters as a reference for meeting the rural population; the second strategy was to offer itinerant health care services by visits to communities (GARNELO et al., 2013).

There are also two other strategies that we have identified in the State to ensure care to rural peoples and communities: *ambulanchas* and river basic health units (UBSF). *Ambulanchas* are a type of vessel adapted for the emergency removal of patients, which were acquired by an agreement between the municipalities and the Sustainable Amazon Foundation, one of the non-state organizations that works to support the co-management of the Mamirauá Reserve. They helped health agents to remove the patients, and the agents are also responsible for guarding the equipment. In communities where health agents do not reside, they are under the responsibility of community leaders who do not always have fuel, as the agreement ensured that the municipality would pay for the operation of the equipment (fuel and maintenance), which, in practice, does not work. Very often, the patient has to pay for the fuel to be cared for. The river basic health units (UBSF) were inaugurated by the Ministry of Health by Ordinance no. 2,490, of October 21, 2011, and aim to expand the access of the riverside population of the Legal Amazon to primary health care. The UBSFs operate 20 days a month in an area delimited for operation, and each unit is composed, at least, by a doctor, a nurse, an oral health technician, and a biochemist or laboratory technician. It is estimated that its operational capacity is at 80%, given that they are equipped with a satellite transmission resource, which can ensure, by telehealth actions, support for remote service.

These initiatives are important, given that the riverside mobility and health care are also affected by hydrological dynamics, especially during the drought period, when access to the community is further away from the river channel that remained perennial.

Interinstitutional and intersectoral partnerships to meet health needs in the Mamirauá Reserve

The elaboration of this category sought to identify the existence of intersectorality between the environmental policy and the municipal health policy in the context of RDSM. Thus, the interviewees were asked about the development of projects in partnership between UC management and municipal management.

Chart 4 describes the discourses that pointed out three central ideas: (1) The partnership has improved health; (2) There is difficulty in making things operational; and (3) We are not handling this issue properly.

The first central idea refers to the initiatives promoted by the social organizations involved in supporting the co-management of the UC to improve infrastructure, which positively impacted the reduction of waterborne diseases and the decision of some families not to migrate to the city, since rural exodus was intense.

The last two central ideas show the difficulty of dialogue and partnerships between the two sectors, which is due to “political issues” and the lack of understanding about the health responsibility of managers.

Chart 4 – Interinstitutional and intersectoral partnerships to meet health needs. RDSM, 2016.

CI (synthesis)	DCS
(1) The partnership improved health	As far as I know, at the beginning, IDSM worked a lot in the Uarini Area of the Reserve. They worked in all sectors of Uarini on these health issues. For example, the cesspit issue, of drinking water, was a very beautiful job, it improved health. Then, with the changes that have taken place, I don't know. But in this upper part of the subsidiary area, it has very little influence. Only now that there has been more things.
(2) There are difficulties in making things operational.	There are problems in the political relationship, the municipality is very strong, and now it seems that it has changed, lost resources. There is no issue in the role with Amurmam. There are issues with FAS, which is the management support entity. The partnership only happens after a lot of fighting. We also hear a lot of complaints from UC managers that mayors promise, but do not keep their word.
(3) We are not handling this problem properly	I don't have much experience with that, what I have are some observational reports outside the government. The program for the acquisition of food for school meals has moved some of the UC' production chains on a municipal scale. But I think that we are not treating this health problem correctly.

Source: prepared by the authors

During the 1980-1990s, the main reference of the rural populations of RDSM in meeting their health and education problems were the philanthropic missionary actions of Prelature of Tefé, with the implementation of the Basic Education Movement (MEB); and of Pastoral da Saúde, whose origins date back to the consortium of the Congregation of the Holy Spirit in Tefé (current Prelature of Tefé) with the Sanitation and Rural Prophylaxis Service of the National Health Department in 1921 (MOURA, 2007; HOCHMAN, 1998).

The health improvements existing in some communities in the Uarini Area of the RDSM were initiatives not by the State, but by IDSM and Prelazia de Tefé. Among these, the following were cited: (i) hand pumps for capturing groundwater, installed in the early 1980s, later abandoned for technical (low potability) and financial (high cost) reasons; (ii) simplified pumping systems; and (iii) capture and distribution of water by photovoltaic solar energy and rain, which started in 2000, covering 200 households in 2014 (IDSM initiative), whose resources were from the Program for Technologies Appropriate to Floodplains, in partnership with other institutions (MOURA et al., 2016; MOURA, 2007).

However, these initiatives were pilot projects that are intermittent and almost always do not receive support from the municipal level, as was the case of the 11th Meeting of Midwives in the Middle Solimões in 2015, in which the participation of the municipalities was insignificant and the participation of the State Health Secretariat of Amazonas (Susam) was funded by IDSM. In addition, the great flood of 2015 paralyzed

the simplified network. But there are also stoppages due to technical and operational problems related to the responsibility for maintaining the equipment.

It should also be noted that the social determination of the health of populations is not limited to health and environmental policies. For the effectiveness of social protection, other policies of social, economic, and political nature are needed, which should be planned in an integrated way.

We understand that the National Policy for Comprehensive Health of the Populations of the Countryside, Forest, and Waters (PNSIPCFA) (Ordinance no. 2,866/GM/MS, of December 2, 2011) has a strong component of transversality and intersectorality that, since its origin, was oriented towards guaranteeing the right to health. Its formulation resulted from the agendas of social movements within the scope of the National Health Council, being organized by Grupo Terra (collegiate created from Ordinance no. 2,460, of December 12, 2005, within the Secretariat of Strategic and Participative Management of the Ministry of Health) in partnership with the councils of health secretariats (CONASEMS and CONASS), which promoted Grito da Terra in 2007.

In the State of Amazonas, to date, the only policy discussion initiative has been promoted by project “Itinerant Listening: access of rural and forest populations to SUS,” in the municipality of Borba, in February 2013. According to the evaluation of the SUS Ombudsman Department and the National Confederation of Agricultural Workers (CONTAG), responsible for the research funded by the Pan American Health Organization (PAHO), there was no mobilization by the health sector and workers to build a work agenda to discuss it (BRASIL, 2013).

FINAL CONSIDERATIONS

The discursive representations of the collective thinking of the socio-environmentalists interviewed in the research express concerns regarding meeting health needs. They also express the existing knowledge about municipal competencies concerning health, as well as the lack of dialogue between health policy and environmental policy.

The meeting of social demands is organized in a conflictual manner, and this is due to the lack of coordination between the various institutions that operate in this territory.

The decentralization of competencies and responsibilities over natural resources by the co-management of UC imposed new roles and authorities on the territories, which ignore pre-existing municipal institutions.

The research continues to empower municipalities on the National Policy for the Comprehensive Health of the Populations of the Countryside, Forest, and Waters, whose process is being conceived by a broad political project that will enable the structuring of a system of guarantees of rights, which aims to make available the development of integrated actions, to promote greater access by the riverside population to the social goods and services recommended by the Federal Constitution of 1988.

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