Relations within the Health System among the Yanomamɨ in the Upper Orinoco, Venezuela.

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Preface

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration.

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in the Upper Orinoco, Venezuela.**

Abstract

This thesis is an analysis of the relationships between doctors and Yanomamɨ, and between the latter themselves, that converge around the operation of the health system. On the one hand, the health system is the prism through which we analyse an inter-ethnic relationship between Yanomamɨ and Whites. Related to this, the health system becomes a network of sites and people through which to analyse a wider issue: an aspect of the Yanomamɨ experiences of the Venezuelan state. Two other alternatives were available but rejected: relations converging on missionary schools or within the context of indigenous movements and party politics. Thirdly, this is an ethnography of the health system and how it is incorporated into daily life in the Upper Orinoco. All these matters are interrelated to give us a picture of transformations occurring among the Yanomamɨ, products of multiplied exchanges with agents of national society. The health system in this thesis is, then, mainly a function of a political anthropology of Yanomamɨ-White relations: at once the angle, the connecting network, and the object of study.

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Introduction

I arrived in Ocamo, a Yanomamɨ village in the Upper Orinoco, in August 2000 with the intention of studying Yanomamɨ political transformations. I wanted to see what had happened as their integration into the Venezuelan state had become more intense and complex. State presences have multiplied from mainly missionaries to a political field that involved missionaries, political parties and indigenous organisations. How did these institutions of supra-local influence blend in with Yanomamɨ community and inter-community political relations? At the time I thought this was a good strategy to analyse what I envisioned as 'Yanomamɨ experiences of integration into the Venezuelan state.'

I dropped this orientation almost as soon as I got to Amazonas state and the Upper Orinoco. As a means of integration, and to be of some practical use, I established a collaborative relation with a tropical medical research centre in Puerto Ayacucho, CAICET, with long experience among the Yanomamɨ. When I arrived in Ocamo to negotiate my permits with the community, I stayed in the doctors' house. It was only late in this initial three-week period, after I had had informal chats with influential Yanomamɨ in Ocamo, that a meeting was held. By this time, hearing the doctors' accounts and watching their work in the health post, the health system was my exclusive subject of analysis. This choice seemed much more applicable, more consonant with the problems facing the Yanomamɨ and the doctors working with them. I spent most of the next 17 months in the Upper Orinoco helping in the health post, accompanying doctors in their visits to communities along the Ocamo river, attending meetings about health and other community issues.

The problem in the field

In Ocamo it soon became evident that the relationship between doctors, Venezuelan urban middle class graduates on their year's service to the state, and Yanomamɨ, both in medical and non-medical situations, was extremely complex and fraught with latent friction. This struck me as rather bizarre. Doctors, I thought, in an area with such poor health standards (see Appendix A) should be unambiguously welcomed, a redeeming feature of the engulfing dominant society. Why was this relationship so problematic?

It became apparent that what was most relevant in this relation was that doctors, more than doctors were, '*napë*' or '*criollos*,' non-Yanomamɨ, and that Yanomamɨ, more than 'patients' were Yanomamɨ. This set up the problem for this thesis.

This thesis is an analysis of the relationships between doctors and Yanomamɨ, and between the latter themselves, that converge around the operation of the health system. On the one hand, the health system is the prism through which we analyse an inter-ethnic relationship between Yanomamɨ and *criollos*. Related to this, the health system becomes a network of sites and people through which to analyse a wider issue: an aspect of the Yanomamɨ experiences of the Venezuelan state. Two other alternatives were available but rejected: relations converging on missionary schools or my initial political line. Thirdly, this is an ethnography of the health system and how it is incorporated into daily life in the Upper Orinoco. All these matters are interrelated to give us a picture of transformations occurring among the Yanomamɨ, products of multiplied exchanges with agents of national society. My change from 'politics' to 'health' was a change in the site, but not the kind, of analysis. The health system in this thesis is partly a function of a political anthropology of *criollo*-Yanomamɨ relations where the health system is at once the angle, the connecting network, and the object of study.

The anthropological problem

It was some time ago that Turner (1987) suggested a provocative field of enquiry for Amazonian anthropologists suggested in the following dichotomy:

> '[referring to anthropological work in the Amazon]…To write about the struggles of indigenous peoples with the national society or international capitalism has usually meant to exclude serious attention to native cultural or social forms, and a focus on the latter has usually seemed possible only by excluding from theoretical consideration the political-economic and cultural realities of inter-ethnic contact.' (1)

The problem is how to convey, in a single analysis, both aspects of most Amerindians' contemporary lives. Ocamo people, for example, might be speaking

about so an so's illness, an attack from an enemy shaman, then switch to discussing the writing of a 'project' requesting an outboard motor from one or another state agent. The 'pure' or 'struggle with national society' orientations are producing 'half pictures' of life in the Amazon. Now Turner's observation, and his subsequent analysis of the Kayapó case, may be seen as a development on Cardoso de Oliveira's (1972) earlier cues on the need to consider contemporary Amerindians in a system of interdependence with Whites – specially those who live in daily or frequent interaction with Indians. This he called an 'interethnic system' that unites distinct populations with opposite interests (Ibid.:87). Turner's point reflects the persistence of this issue in anthropological writing, but also an important tilting of the balance of power between indigenous peoples and the state which finds the former evermore effective in negotiating their rights and agendas. Such developments continue to merit more anthropological attention.

Let us discuss how the issue has been treated in subsequent Amazonian literature summarising some of the main lines and styles of enquiry regarding Indian-White relations or relations with the state. This is not a comprehensive list but rather a sampling of exemplary works serving to place the thesis in the wider context of Amazonian research. Clearly many of these works overlap or crosscut the artificial groupings I have made solely for clarity of exposition.

One line of enquiry has studied the reflection of relations with national society in different forms of discourse: mythical, historical or political (Hugh-Jones, 1988; Hill 1988; Albert, 1993; Ramos, 1988; Gallois, 2000; Gow, 2001; Graham, 2002). This prolific field has underlined the agency of indigenous people in their responses to novel circumstances. Mythical readjustments accompany the changing relations with Whites furnishing contemporary events with meaning once put into relation with traditional cosmology, thus transforming it. Political discourse often draws from mythical narratives as justification of particular demands, for example, to land or public services (Gallois, 2000). Other times, myth is updated but deemed inadequate for political purposes, even when it explains the structural power relations with Whites (Hugh-Jones, 1988). Shamanism has also revealed itself as a prime means of incorporating and reacting to the White world in both strong and mild colonial

situations becoming a relevant field of inter-ethnic, symbolic and real, commerce (Hugh-Jones, 1994; Gow, 1994; Taussig, 1987; Townsley, 1987; Buchillet, 1991c).

Closely related are those who describe new senses of identity and self-representation resulting from increasing awareness of being part of nation-states (Turner, 1987;1991; Urban & Sherzer, 1991; Warren & Jackson, 2002). The analysis of processes of 'ethnification' and the new field of 'identity politics' often underscore the appropriation and re-deployment of Western categories such as 'Indian,' (Ramos, 1998) 'territory,' 'environment' (Albert, 1993) or 'culture,' (Jackson, 1991;1995; Hugh-Jones, 1997) imposed on Indians by both White allies and detractors. Such notions, often with new and eclectic (White-Indian) connotations, are then used by Indian leaders to strategic political effect in their own struggles with the state or private institutions. Many of these works focus primarily on 'inter-ethnic politics': indigenous movements and organisations, political discourse, official meetings with state representatives, and the influence of Western institutions like NGOs, anthropologists or state officials in indigenous political organisation and self-representation (Turner, 1987; Albert, 1993; Jackson, 1995; Hugh-Jones, 1997; Conklin, 1997; Graham, 2002).

A third emphasis from which I have taken much inspiration places prominent emphasis on the blending social organisational forms, discourses, imagery of Whites and Indians and the symbolic incorporation of Whites and their most commonly selected companions: objects and disease (Albert, 1988; Albert & Ramos, 2000; Gow, 1993;1994;2001; Hugh-Jones, 1992; Taussig, 1987). Many of these works have historically and/or geographically traced the migration of disease, objects, Whites and images trying to grasp the indigenous perspective on events and processes of inter-ethnic contact. Gow (1993) analyses Piro people's deployment of images of 'wild Indians' and '*gringos*,' constructed in the historical juncture of the North Western Amazon debt-credit chains, and how these categories contribute to define Piro people's sense of identity as a historical mixture of different peoples. Hugh-Jones (1992) traces the trajectories of manufactured objects that link, through debt-peonage relations, White bosses with Indians. He analyses the multiple significance of objects in the inter-ethnic context. White and Indian valuations become intertwined as the 'morality of the market' and that of kinship blend into each other. Both these analysis

benefit from going beyond the White-Indian interface, emphasising the relevance of imported objects or images in relations among Indians themselves. Tracing a historical rather than geographical network, Albert (1988), with reference to the Brazilian Yanomam, details the trajectory of Whites, manufactured objects and epidemic diseases through their political theory of pathogenic powers, in this way privileging the indigenous means of interpretation and selection of relevant events of contact. All these examples place the weight of analysis on the indigenous lived world trespassing the boundaries of mythical or political discourse, often prompted by the anthropologist's interest, paying closer attention to Indian's regular engagements with Whites, its consequences and their valuations.

As Hugh-Jones (1992) notes, the often brutal circumstances of contact with Whites should not detract our attention from scrutiny of the significance these relations have for Indians as well as their often active engagement in seemingly undesirable power imbalances. Two recent ethnographies exemplify the importance of this shift of attention. Gow (2001:6) comments on his surprise at how Piro people, who had been enslaved by rubber bosses and forced into labour in White's haciendas, '[i]nstead of recounting their past and present circumstances as a litany of exploitation, brutality and injustice, they seemed to talk about it as an onwards-and-upwards tale of progress from the historic low-point of the world of the ancient people to the sunny futures beckoning to their children and grandchildren.' Equally Rival (2002:155) recounts her analytical shift in analysing Ecuadorian state schools among the Huaroani. At first she focused on how this educational system was 'creating around itself a community in which social relations, subsistence activities, the very mode of existence and identity were being restructured in ways that undermined the reproduction of core local, kin-based social forms and cultural meanings.' Schools were then sites of 'struggle' and 'negotiation.' Without negating the validity of her initial analysis, she continues to recognise how that emphasis 'now appears to me as lacking an indigenous perspective…[r]ather than being unduly impressed by the hegemonic power of centralized and impersonal institution, I would pay more attention today to the fact that local people use schools as part of their long-term strategies to ensure the reproduction of their kindreds and alliance networks' (156). The shift is from the somewhat ironic privileging of the state's perspective in trying to illuminate its lack of

attention to the Indians' socio-cultural context, to giving equal attention to the parties involved in this encounter.

Once this step is taken, an number of continuities, of constancies, flourish between 'old' and 'new' institutions that challenge ideas of structural deterioration prominent in Cardoso de Oliveira's concept of interethnic friction – loss by attrition. In this light we find interesting cases of role or functional 'transformative substitutions' which adopt characteristic indigenous forms. Hugh-Jones (1994) suggests the disaggregation of different shamanic roles between the new figures of Christian priests and pastors in North Western Amazonia. Rival (2002:170) finds school festivals replacing traditional manioc drinking ceremonies. Gow (2001:170) finds the 'modern' community feasts centred around the school as transformations of women's initiation rituals. In this view, instead of 'opposed interests' meeting at points of political, religious or economic friction we find Indians embracing the foreign institutions, attempting to 'indigenise' them, interested in them but on their own terms and putting them to the service of their own agendas.[1]

Finally, crosscutting Turner's divide, we find political-economic transformations like changes in settlement patterns, leadership structures and styles, insertion in market economies (Arvelo-Jimenez, 1972; Brown, 1993; Saffirio & Hames, 1981; Mansutti, 1986;1992; Ferguson, 1995; Chagnon, 1997: chap. 8; Descola, 1981) normally treated separately from the symbolic incorporation of Whites and corresponding cosmological adaptations.

For the most, the above approaches have placed little emphasis on practical, everyday engagements with Whites in comparison with the detailed analysis of cosmological transformation. The everyday is also diluted in more generalised assertions about political-economic structural change.

- o -

[1] See McCallum's (2001:117-27) analysis of the dynamic surrounding the operation of a village co-operative among the Cashinahua; Rival's (2002: chap. 7) discussion of the Huaorani's efforts to make the school a naturalised source of wealth; Vivieros de Castro (2002:195-212) on 16th century Tupinamba efforts to subject European priests and their religion to their warfare agendas.

This thesis overcomes Turner's dichotomy in three ways, drawing from and adding to the main styles of enquiry just mentioned in another number of ways. First, by focusing on a public service within an indigenous group, we access the realm of everyday relations with *criollos*, seeing the political character of the inter-ethnic relationship as it occurs most of the time: in the rural clinic, the village plaza, the doctor's house, the hammock of a patient. In other words, an important part of our thesis is dedicated to 'the political' outside of politics, beyond meetings or indigenous organisations, in this way departing from the topical site of literature on 'inter-ethnic politics.' In Ocamo, relations with resident and other *criollos* are bound up in things of the everyday functioning of the health system or the missionaries' school. Meetings with doctors or other higher level officials occur and are important but these constitute a fraction of Ocamo Yanomamɨ's experience of *criollos*. Our thesis, moreover, shows that the significance of public events with *criollos* cannot be fully grasped if not contrasted with quotidian relations with *criollos* and with other Yanomamɨ with different historical experience of *criollos*. Just as an anthropological study of ritual benefits from its contrast to the secular aspects of life from which its symbols and significance may be drawn, so does a study of inter-ethnic politics when contrasted with those not-evidently-political engagements of the quotidian.

This orientation also redresses the ethnographic and theoretical imbalance between cosmological transformations and symbolic incorporations, on the one hand, and practical engagements, on the other. Our analysis will show the real and the symbolic complementing and sustaining each other. For instance, examining the roles of political leaders and shamans in the management of *criollos*, or seeing how doctor's *criollo* outsider status is practically sustained, when Yanomamɨ address them strongly, pressing them into action.

Second, the health service defines in itself a network of sites that connect upriver Yanomamɨ communities with down-river mission/health post communities like Ocamo, *criollo* towns further down river and cities in different parts of Venezuela. By analysing doctors and Yanomamɨ working at different points of this network, from medical provision in an upriver community to Yanomamɨ participating in a meeting in the Capital of Amazonas state, we can trace how images, discourses and performances

are deployed in practical engagements between *criollos* and Yanomamɨ. This network describes not only a graded socio-political space that includes different types of *criollos* and Yanomamɨ but also its constitution through experiences in different places (city hospital, upriver community) and circumstances (treating patients, exchanging items with doctors in Ocamo). This approach describes the articulation of Yanomamɨ and *criollo* worlds not as a 'front' or 'contact,' but rather a superimposition of contexts that feed into, and transform each other.

Third, our analysis puts the health service in a historical and synchronic context of relations with *criollos*. But the terms for the 'historical' and 'synchronic' context I try to extract from Yanomamɨ's own perception of their historical experience. In this respect I was profitably inspired by Gow's (2001) analysis of Piro historical relations with Whites.

Fourth, by considering doctors in our analysis we counterbalance the greater emphasis on missionaries (Taylor, 1981; Rivière, 1981; Hvalkof & Aaby, 1981; Lizot, 1976; Jackson, 1991;1995; Vilaça, 1997) or teachers and education (Hugh-Jones, 1997; Rival, 2002) as the more prominent emissaries of the state in Amazonian literature. The circumstance of Upper Orinoco doctors, who normally attend a post for one year, is simultaneously an oblique analysis of anthropologists' own position in fieldwork.

Finally, I worked on the interface between *criollo* doctors and Yanomamɨ. As Thomas (1994) has noted, the emphasis of most analysis of inter-ethnic or colonial relationships is on the colonised rather than coloniser. Examinations of contemporary Amazonia are, by and large, not exempt from this bias. This thesis seeks to conduct a symmetric exercise, exploring both actors' perspectives. Not just because the articulation of indigenous and Whites worlds takes a substantially different form from *criollo* and Yanomamɨ points of view. As mentioned above, several anthropologists have dwelt on the reverberation of images of Others in inter-ethnic situations (Taussig, 1987; Gow, 1993). Going beyond the migration of images, we will analyse how *criollo* and Yanomamɨ mutual perceptions are incorporated into action as both motivation and form. Only through the consideration of both perspectives will the two simultaneous pictures of articulation emerge. As Hugh-Jones (1992:54) illustrates in

the context of exchange, Whites and Indians may be immersed in two different 'regimes of value' (Appadurai, 1986) and enter into relations with entirely different understandings. Such is often the case between doctors and Yanomamɨ: failure to see how they misunderstand each other and build two different realities, would also be a 'half picture' obscuring an essential component of 'inter-ethnic' life in the Upper Orinoco.

Summarising, an emphasis on coupling the everyday with more extraordinary events (e.g. meetings with officials); on seeing 'the political' outside of politics; on networks; on a symmetric analysis of *criollo* and Yanomamɨ perspectives; on describing historical change from Yanomamɨ perspectives, all contribute to bring together Yanomamɨ 'socio-cosmology' and 'relations with the state' as it is expressed in a variety of practical engagements, sites and discourses.

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Our approach in this thesis implies a lateral entry into issues more typically treated by medical anthropology. Emphasising that this thesis is not about medical anthropology, our approach nonetheless yields something for this field as it has been explored in Amazonia. Several authors have dealt with the theme of the articulation of bio-medical and indigenous medical systems in Amazonia (Buchillet, 1991; Santos & Coimbra Jr., 1994; Chiappino & Alès, 1997; Kroeger & Barbira-Freedmann, 1992). By and large, these works have placed considerable emphasis on indigenous notions of illness, healing, and the body and its metabolism, to explain Amerindians' reactions to formal bio-medical systems. Correspondingly themes like ethnomedicine, aetiology, therapy and its itineraries are explored in order to highlight their discrepancies with bio-medical tenets on these regards. Although not exclusively, the issue of the articulation of medical systems is kept within the realm of 'the medical,' just as 'the political' mostly keeps to politics.

What does our lateral approach add? First, it considers relations with doctors as inscribed into a wider Yanomamɨ 'project' of political management of *criollos*. *Criollos* and their resources (objects, education, healthcare) are necessary components of a 'civilised' lifestyle that Ocamo Yanomamɨ sustain. The health system and its

doctors are put to the service of a historical trajectory of 'becoming *napë*' or 'becoming civilised.' In this way, we trespass the limits of 'the medical' to explain relations with doctors. Second, many of the concerns of Yanomamɨ and doctors in Ocamo had little to do with medical issues. Issues about the management of the rural clinic's resources (boat, motor, gasoline), trickery, scolding people (doctors or Yanomamɨ), 'organising' the clinic and its functioning, theft, had more weight in determining the character of the health system in Ocamo than the also relevant, but more sporadic, issues of medical treatment itself.

In short, we will consider the non-medical contexts of relations between doctors and the indigenous population served. Failure to do this would place undue emphasis on the discrepancies on medical beliefs and misrepresent the lived experience of both doctors and Yanomamɨ in the Upper Orinoco.

The importance of inter-ethnic relations in the medical articulation has been mentioned before. Langdon comments that '[i]n Colombia, Indians are considered as under aged. Whites in general consider the Indian as an animal and dirty ignorant.' (1991:220) This importantly impinges on Siona and Sibundoy Indians' preference for 'popular medicine' at the expense of the official health system. Kroeger & Barbira-Freedmann (1992), referring to different health services operating in the Peruvian and Ecuadorian Amazon, also note the relevance of pejorative views of White service-providers of Indian receivers and of discriminatory practices. Briggs (2003) also reveals a concerning picture of a racialised Indian-*criollo* scenario, evidencing the differential treatment of Warao and *criollos* in the Orinoco delta in the health system's (local, regional and national) reaction to a cholera epidemic in 1992-3.

The Upper Orinoco inter-ethnic context differs from those discussed by these authors. Rural doctors in places like Ocamo are working in Yanomamɨ-only communities. Ocamo counted most of the year with only four *criollos* (two nuns, a doctor and a medical student) amid some 370 Yanomamɨ. The situation in the other three posts within Yanomamɨ territory is similar. *Criollo* entry to the Upper Orinoco is severely restricted for those who don't work there. This local inter-ethnic scenario often inverts the expected power relations between Whites and Indians. Yanomamɨ experience discrimination mostly beyond their land, in the mixed ethnic town of La

Esmeralda – 1 ½ hours down river form Ocamo – (see Figure I.3. pp. 28) or the predominantly *criollo* capital of Amazonas, Puerto Ayacucho (2 hours flight). In Ocamo, however, beyond how Yanomamɨ are seen by doctors and the former's reaction to that, the inverse is equally important, the place doctors as *criollos* have from the Yanomamɨ perspective, and how the former react to that.

Finally, let me touch on the way the provision of healthcare in the Upper Orinoco has been treated. Throughout the years many articles have provided report-like descriptions of the health system, highlighting different aspects of its operational difficulties (the list includes Semba, 1985; Fuentes, 1983; Lizot, 1998). Alès & Chiappino (1985) must be credited for their analysis of healthcare being used by NTM missionaries in Parima to legitimise their presence in the area in the eyes of the Yanomamɨ, the Venezuelan authorities and international allies/donors. They highlight the use of 'health' as an instrument of power among the Yanomamɨ, consequently becoming the object of competition between institutions with an interest in the Yanomamɨ. Salesian missionaries have also participated significantly in the provision of healthcare in their areas of influence (including Ocamo). However, since the permanent presence of rural doctors (1985), these have taken up the central role in this regard. The power relation I witnessed in Ocamo was, then, of a different nature to that which Alès & Chiappino describe. The health system doesn't need to legitimise its presence among the Yanomamɨ, neither are rural doctors particularly able to impose their agendas on the Yanomamɨ. Inter-institutional debate and often friction, including missionaries, health system, municipality and different levels within these institutions as to the running of the health system does, nonetheless, continue to be a significant factor to consider in the Upper Orinoco context.

If at one level of analysis the health system must be considered in political terms because of its insertion in the Yanomamɨ political management of *criollos*, at another level, this is necessary because of the various aspects of the *criollo* politics of healthcare. This politics has different facets. First, it is a disputed field of intervention that has historically involved not only missionaries but also the local municipality, different organisations within the Ministry of Health and bio-medical researchers. Second, at regional and national levels, the administration of healthcare finds health objectives competing with political ones. As sources of employment, managers of

financial resources, and definers of policy, the Ministry of Health at regional and national level is embedded in wider political processes involving party politics and the sustenance of the interests of particular sectors of society – historically to the exclusion of Indians.

Finally, the health sector is one of the areas where significant change has been recently promoted by the current government, some of which reflects a parallel and historical change in Venezuela's indigenist policy. The new 1999 constitution declares Venezuela to be a multi-ethnic and pluri-cultural nation. This constitution guarantees indigenous peoples' rights to culturally sensitive healthcare, correspondingly the new draft of the health law treats indigenous people as ethnic minorities with special needs. In Amazonas in particular, sensitivity to these issues has been growing for some time, influenced by a strong indigenous movement and a handful of professionals particularly concerned with indigenous peoples, their health and rights.

Given all these facets of healthcare provision, a political analysis stretching from Yanomamɨ, to different levels of *criollo* politics is justified. The range attempts to include Yanomamɨ and *criollo* 'political perspectives,' reflecting the simultaneity of these 'forces' as factors to account for in inter-ethnic scenarios.

What kind of theory?

A consequence of the separation of 'identity politics' from 'tradition' is the development of distinct analytical categories for one case or the other. The former may speak of ethnic identity, modernity, resistance, colonialism, the latter of kinship systems, rituals of social reproduction, personhood. What kind of theory should be used to portray the superposition of these contexts from both the indigenous and White perspectives? We need a theoretical framework allowing us to treat a diversity of actors (doctors, Ocamo Yanomamɨ, upriver Yanomamɨ) in a diversity of circumstances (medical and non-medical relations, individual and collective events) with the same language, elucidating continuity, contrast and complementarity within the health system's network.

Wagner's (1981) *The Invention of Culture* came, in this respect, as a formidable solution to meet this theoretical requirement. I draw heavily on his distinctions between the conventional and the inventional, 'the innate' and the 'artificial,' collectivising and differentiating action, and the symbolic ecology that follows from the mutual constitution of these concepts. A crucial move in comparing doctors' and Yanomamɨ perspectives is to distinguish the former's ideological commitment to locate the realm of convention to that which is available to human agency, or in this sense 'artificial,' relegating 'the particular,' 'incidental' or inventional to the 'innate' or 'given' component of the phenomenological totality. In this respect Yanomamɨ make a fundamental inversion, assigning to the conventional the quality of 'innate' or 'given' and leaving invention or 'the particular' as what is accessible to normal human agency. In the case of doctors and *criollos* in general, nature epitomises the realm of the innate and 'culture' – a gamut of social and cultural conventions – is then seen as the product of human activity. Yanomamɨ and many Amerindians generally find in culture (again as social/cultural convention) the 'innate' or 'given' component of lived experience and hence dedicate time and effort to making 'the particular.' In this way, while doctors' daily life is motivated by a need to organise and establish conventions with the Yanomamɨ, the latter, subscribing to another 'order' which is 'given' and places doctors/*criollos* in certain web of understandings, constantly mark themselves off from doctors' collectivising efforts.

Whites' need to make convention among Indians underlies much of the character of this encounter in contemporary and historical Amazonia. Missionaries' attempts to 'civilise' are in essence efforts to make stable rules, organisations, predictable behaviour, etc. Indians on their part often show a remarkable desire for self-transformation (see Gow, 2001; Rival, 2002; Vilaça, 1999) of 'becoming civilised' or 'becoming *napë*/White,' elevating to the level of a 'form of being' a commitment to differentiating action. I will argue that this inverse distribution of what is 'given' and what should be actively 'made' underlies much of doctor-Yanomamɨ relations in a diversity of contexts: treating patients, exchange, public discussions, negotiating where and how to treat patients.

The *criollo* commitment to an 'innate' nature and Yanomamɨ commitment to an 'innate' culture brings us directly to Viveiros de Castro's (1998) theory of

Amerindian perspectivism as a multi-naturalist ontology in contrast with the Western multi-cultural thesis. The multi-natural vs. multicultural contrast will aid this thesis in the analysis of Yanomamɨ and doctors' interpretation of each other's roles and practices within the general discussion of the articulation of bio-medicine and shamanism.

Wagner's and Vivieros de Castro's theorising allow us to discuss *criollo* and Yanomamɨ understandings of each other within the same framework. It also brings together and contrasts the quotidian and the extraordinary, the 'traditional' and the 'modern,' providing the continuities we want to analyse in relations with *criollos* in terms of the relations with other alters of Yanomamɨ socio-cosmology.

We shall show how the 'radical' changing of perspectives, normally found in myth or shamanism, is in a continuum with the everyday activities that constitute communities of kin. This continuum becomes clear when we consider 'a perspective' as a gamut of attributes with important moral connotations. This is the stepping stone to then see how relations with *criollos*, what we shall the 'domestication of outsiders,' is in a continuum with the 'making of kinship.' This points to the necessity of apprehending the articulation of White and Indian worlds as non-distinct from the indigenous process of making themselves. This is crucial for understanding Ocamo peoples' historical self-appraisal in terms of 'becoming *napë*' and the place *criollos* take in the sustenance of a 'civilised' life in Ocamo. This is the historical and synchronic substrate in which the health system is integrated into the Yanomamɨ lived world.

This substrate is historical and synchronic because 'becoming *napë*' is a transformation that has occurred in the context of a 'gradient of contact' with *criollos*. In Ocamo, people have lived with *criollo* missionaries and more recently doctors for half a century. As we go upriver along the Ocamo, access to healthcare, education, manufactured objects and *criollo*-style politics decreases. This graded landscape forms what we shall call a '*napë* transformational axis' as a context of relations with different categories of Yanomamɨ and *criollos*. The former defined by their degree of historical transformation into *criollos*, the latter by the intensity with which they can affect life in the Upper Orinoco. I shall show that this '*napë* transformational axis,' as

a context of relations, is congruent with the Yanomamɨ socio-political space described masterfully by Albert (1985). The one is an innovation upon the other.

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Our emphasis on continuity between the quotidian and the extraordinary adds to a growing effort in Amazonian anthropology to bring together into a single picture two distinct analytical inclinations. Conscious of the reductive nature of summary classifications, for the purposes of exposition, I shall outline some distinctive features of these 'schools.'[2]

One has privileged the analysis of relations with 'the outside,' supra-local relations that include affines, enemies, the dead and spirits. Alterity here is prominent in its fundamental role in the reproduction of society and full persons and in making the 'inside' or identity. Privileged sites of analysis are warfare, ritual and shamanism, finding in affinity and predation the underlying socio-cosmological symbols of relationality (see Viveiros de Castro, 1992; Vilaça, 1992; Albert, 1985). Another trend has focused on 'the local' in the production of persons and kin. Relations of care, feeding and co-residence that foster the development of affect and memory take centre stage. Peoples' quotidian making of each other is promoted as the performative making of kin that occupies most of Amazonians' daily life (see Gow, 1991; Overing, 1999; Overing & Passes, 2000).

More recently, however, it has become increasingly clear that these styles are more different in appearance than substance. In the realm of kinship recent publications (e.g. Vilaça, 2002; Vivieros de Castro, 2001) have persuasively shown how the 'in' and 'outside' traverse the whole field of relationality – already evident in Vivieros de Castro's (1993) synthesis of Amerindian kinship. Two recent ethnographies (Gow, 2001; McCallum, 2001) successfully blend insights from both styles of analysis showing how, in the end, the everyday is quite extraordinary, pervaded with 'the

[2] For a more detailed discussion of these different 'schools' of analysis see Vivieros de Castro (1996) and Overing & Passes (2000).

outside' and, conversely, how the extraordinary is not so surprising after all, part and parcel of the everyday.[3]

This thesis adds to this trend in combination with the effort to analyse the articulation of White and indigenous worlds. Our analysis is fully congruent with Gow's (2001) insightful conclusion that Whites enter the Piro world filling a space already available to outsiders as 'potential affines' (Vivieros de Castro, 1993). Potential affinity 'qualifies relations between generic categories: compatriots and enemies, living and dead, humans and animals, humans and spirits…Potential affinity is a politico-ritual phenomenon, exterior and superior to the plane encompassed by kinship.' (Vivieros de Castro, 2002:159). As generic Others, *criollos* like doctors in Ocamo, fulfil this role of potential affines. We shall analyse what it is to be a potential affine in a place like Ocamo, for 'potential affinity' is that 'innate' place *criollos* have in the Yanomamɨ lived world, so strongly impinging on relations in medical and non-medical contexts (cf. Rival, 2002:176). Following Gow's lead, we shall analyse Ocamo peoples' historical transformations whilst elucidating the subordination of the local health system to the Yanomamɨ management of *criollos* in their process of 'becoming *napë*.'

Use of, and contribution to, Yanomamɨ ethnography

As is well known, the Yanomamɨ are perhaps the most thoroughly studied Amerindians in both social and physical anthropological terms. Leaving physical anthropology aside, there is still a vast literature which I cannot cover here for reasons of space. Considering a substantial set of 'traditional' analyses, that have not dealt directly with the issue of 'change,' I draw on a few works filtered by the need to ground analysis of transformations on well-described aspects of Yanomamɨ sociality. On the other hand, given that my fieldwork and this analysis both occur on the *criollo*-Yanomamɨ interface, these works will also substantiate aspects of Yanomamɨ sociality I myself was not in a position to observe thoroughly. I mostly draw on Albert

[3] On an entirely different subject, the arrival of Europeans in Melanesia, Strathern (1990:30-1) makes this point that is nonetheless here pertinent. Melanesians, she argues, are constantly surprising themselves by disguising and revealing their appearances. In such a context, to take Europeans as spirits was indeed surprising, but a surprise of the kind they must have been used to. Hence, the

(1985) taking two things. One: the description of Yanomam socio-political space as a socio-geographical landscape of increasing alterity, defined from each community in a socio-centric manner. Two: the analysis of the circuits of real and symbolic exchange that bind this space. These links immediately correlate socio-politics with disease, for Yanomamɨ etiological theory points to human and non-human alters as agents of disease. Lizot (1997; Unp.) complements this analysis. Reference to Yanomamɨ kinship and village dynamics is drawn mainly from Albert (1985), Lizot (1977;1985;1994; Unp.), Alès (1990) and Chagnon (1997).

Another set of works are directly concerned with the issue of change or relations with the Whites/the state from a variety of angles (among others Lizot, 1971; 1976; 1998; 1998-9; Albert, 1988; 1992; 1993; Chagnon, 1997: chap. 8; Ramos & Taylor, 1979; Ramos, 1995: part 3; Saffirio & Hames, 1983; Ferguson, 1995; Colchester, 1995; Alès, 1995; Chiappino, 1997; Alès & Chiappino, 1985). From this spectrum I again draw on Albert's (1988) work on the symbolic trajectories of Whites, manufactured objects and disease across the Yanomamɨ socio-political space. This sets the ground for the discussion of a '*napë* transformational axis' and a 'Yanomamɨ morality of being human' as innovations and guiding principles that have historically determined the quality of relations with *criollos*.

Our analysis contributes mainly to this set of works in the ways already mentioned above. First, adopting Ocamo peoples' perspectives on historical change, we break with the emphasis of most of the analysis on socio-economic change (Lizot, 1971; Chagnon, 1997; Ferguson, 1995; Saffirio & Hames, 1983). Second, with a thorough inspection of the health system, we add to the little that has been said in that regard. Third, in emphasising the practical aspects of relations, the everyday in conjunction the extraordinary, the political aspects of non-political contexts, we complement Albert's (1998;1993) work on the articulation of White and Yanomam worlds. Fourth, by focusing on the health system's articulation with shamanism, we complement Alès & Chiappino's (1981-2;1985) analysis, incorporating doctor's perspectives and making a more nuanced discrimination between the case-specific distribution of healing roles between doctor and shaman.

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encounter is not as radical as our historical orientation would have it. The extraordinary of the everyday and vice-versa in Amazonia is well captured in this discussion on the generation of surprise.

Last but not least, beyond the anthropological and theoretical interest in studying the health system, there are practical reasons for this study, of interest to those working with the Yanomamɨ and the health system – mainly doctors and higher health officials but also anthropologists, activists, etc. Much of insight can be drawn from this thesis for the training of *criollo* health personnel and as input in the definition of a coherent health policy for the Upper Orinoco Yanomamɨ. My general intention is an effort to put anthropological knowledge to practical application in a hopefully long-term relationship with the Yanomamɨ and the health system. At a time when anthropology in the Upper Orinoco has been questioned on ethical terms (Tierney, 2000), this work hopes to exemplify how anthropology has a place in what must be a multidisciplinary approach to address the Yanomamɨ health situation.

Fieldwork and its limitations

I originally planned to stay in the Upper Orinoco for 18 months separated in three six-month terms, the first in Ocamo, the next in a mid-river community, and the last in an upriver one. Fieldwork, however, proved more cumbersome. Lacking resources (boat, motor) that would enable me to respond to grave health situations when no doctor was around, I couldn't come to terms with long-term residence in upriver communities. My visits to these communities were plentiful, yet most of the time with a health team. Our analysis here would benefit from more long-term stays in these communities.

I spent most of the time in Ocamo, and along the Ocamo river, and short periods in the Mavaca rural clinic (see Figure I.3. pp. 28). My knowledge of the working of the health system in the Parima highlands, where there is another official health post, is limited to interviews and informal conversations. So, whereas many of the situations I describe for the Ocamo Yanomamɨ are reasonably extendable to the two other posts along the Orinoco (Mavaca and Platanal) where river travel and the presence of Salesian missions is shared, a more cautious extension is due when considering the Parima area.

Although I visited the hospital in Puerto Ayacucho several times whilst helping Yanomamɨ patients and held interviews with hospital health personnel, more fieldwork is necessary to fully integrate this aspect of Yanomamɨ's experiences into the thesis. Given the different ethnic environment – *criollo* dominance – the distance from their homeland and relatives, often mistreatment and discrimination, the different profile of the health personnel, this experience differs substantially from that in the rural clinics in the Upper Orinoco. For these reasons, further research in the hospital would complement our analysis.

As mentioned above, inter-institutional relations are an important factor to consider in the politics of healthcare in the Upper Orinoco. This is an overly sensitive issue for all parties involved. The Upper Orinoco is a politically volatile area as the recent debate surrounding the publication of *Darkness in El Dorado* (Tierney, 2000) has made clear. Due to this sensitivity, I have chosen to limit the analysis of inter-institutional relations to delineating the main institutional agendas, alliances and frictions. A more thorough inspection of the impingement of international actors on the life of Yanomamɨ in Venezuela has also been foregone in favour of a more detailed description of regional and national-level influences. All names (Yanomamɨ and *criollo*) mentioned in the thesis have also been changed.

In terms of language, I have benefited enormously from Lizot's *Introducción a Lengua Yanomamɨ* (1996) and his unpublished dictionary. The orthography used in this thesis follows these works.[4] Some of my interviews were held in Yanomamɨ, others in a mixture of Yanomamɨ and Spanish, and yet others in Spanish. Throughout the thesis, Yanomamɨ texts have been translated to benefit from linguistic analysis. This detail immediately makes the thesis more comprehensively comparable with other Amerindian ethnographies. Citing Yanomamɨ texts also allows the scrutiny of more experienced Yanomamɨ speakers that may then refine the translations provided. In this regard, some of the cited texts have been translated with the aid of Yanomamɨ assistants; when this was not possible, I have done so myself with the aid of Lizot's works.

[4] This is also the orthography Yanomamɨ learn in the Salesian inter-cultural schools.

The extensive citation of both Yanomamɨ and *criollo* statements also responds to an emphasis on language and its use throughout the thesis. Many of the cues as to the analogies and contrasts doctors and Yanomamɨ make of each other are reflected in key words and language use. For example, a young, educated Yanomamɨ might refer to his status as holder of *criollo* knowledge as being '*capacitado*,' 'with capacity/ability,' the same term he would use in explaining how a shaman's helper spirits enable him to cure, thus establishing a correspondence between the *criollo* and the spirit worlds (see Chapter IV). A doctor's use of Yanomamɨ or Spanish in treating gravely-ill patients might make all the difference in establishing (or not) good doctor-patient rapport (see Chapter VI).

I wish finally to warn the reader about what this thesis is not about. First, it does not attempt a comparative study of health systems operating in Amazonia or beyond. Whilst such an exercise would be enriching, the approach I have here taken is normally absent from the report-like manner in which descriptions of other comparable systems are available. I have added Appendix B to compare, in the broadest of terms, our material with the available reports on the Yanomami in Brazil. At other points throughout the thesis, punctual regional comparison is made. Second, this thesis is not an analysis of bio-medicine or shamanism, nor of their underlying 'belief systems,' neither does it attempt a historical epidemiology of the area.[5] The health system here defines a network of people and contexts guiding us through a wider enquiry into the articulation of *criollo* and Yanomamɨ worlds.

Structure of the thesis

This thesis has three parts but they are not consecutive. One part (for exposition purposes Part I), formed by Chapters II and IX, addresses the health system as an organisation: its functioning, its operational and structural problems, internal relations

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[5] For general epidemiological profiles of the Venezuelan Yanomami see Yarzábal & Lairisse (1983), Cardozo & Caballero (1994), Colchester (1985), Hames & Kuzara (in press), MSDS (2000). Epidemiological profiles for the Brazilian Yanomami can be found in Alves Francisco & Esteves de Oliveira (1995;1999); more recent data can be found in www.urihi.org.br. More detailed analysis of specific diseases include Torres *et al.* (1997) on malaria in the Upper Orinoco; Yarzábal *et al.* (1985) and Escalona & Botto (1999) on onchocerciasis in the Parima highlands and Upper Orinoco respectively; Sousa *et al.* (1997) on tuberculosis among the Yanomami in Brazil; Holmes (1983) on the nutritional status in the Parima highlands. For demographic studies among the Xiliana Yanomami in Brazil see Early & Peters (1990; 2000).

between different levels or organisation, internal politics and its relation to regional and national politics and policy. Its focus is the ethnographic exploration of the *criollo* component of the health system. These two chapters help particularise the health system, on the one hand, and give us a reflection of the position of Yanomamɨ and indigenous people in Amazonas and Venezuela, on the other.

Part II, including Chapters III and IV, is devoted to the historical and synchronic contexts of which the health system and doctors are integral parts. These chapters are a background for understanding current relations within the health system and the general argument of the thesis. Chapter III, follows Albert's (1988) analysis of the symbolic trajectory of Whites, manufactured objects and disease through the Yanomamɨ socio-political space. Among other discussions, we shall see how the native category of *shawara* – a type of 'war sorcery' (Albert, 1985) – is transformed, in the context of relations with *criollos*, into a category of infecto-contagious diseases typical of epidemics whose origin and character is eminently *criollo*. *Shawara* is a crucial pivot linking *criollos* and Yanomamɨ. Chapter IV complements that analysis, exploring how the passage of *criollos* through the Yanomamɨ socio-political space transforms the constituent categories of this space themselves. This transformation yields the '*napë* transformational axis' as a context of relations where extended or transformed meanings of social categories become relevant.

Throughout Chapters III and IV, part of the analysis is purposefully left incomplete to be treated altogether in a theoretical discussion in Chapter V. A middle point in the thesis, Chapter V completes the analysis done thus far, and sets the theoretical ground for the following three chapters.

Part III of the thesis, Chapters VI, VII and VIII, is the analysis of current relations within the health system. Chapter VI explores what it is to be a doctor 'potential affine' in Ocamo and its concomitant social dynamic. Non-medical relations are explored in terms of general doctor-community relations. Next, medical contexts are explored, seeing how the potential affine quality of doctors impinges on these relations, from mundane situations like requesting medicine in the rural clinic through to negotiating treatment with patients and relatives, and finally in the context of treating gravely-ill patients. The last part of the chapter sees how the health system

contributes to the sustenance of the 'civilised' being of Ocamo Yanomamɨ through what we shall call 'upriver differentiation' – a series of conventional actions that separate them from upriver 'real Yanomamɨ.'

Chapter VII deals with the issue of the practical and conceptual 'fit' of doctors and bio-medicine in its articulation with shamanism, complementing the previous chapter in several respects. An analysis of two case examples reveals an inverse distribution of two aspects of the healing process we may call 'cure' and 'care,' from Yanomamɨ and doctors' perspectives. The differential efficacy ascribed to doctors in the cases of *shawara* is also discussed. At the end of these two chapters, having considered Yanomamɨ and doctors' perspectives, a clearer picture of two distinct 'realities' in practical and conceptual terms arises.

Chapter VIII escapes the everyday running of the health system to analyse a series of meetings between higher institutional officials and the Yanomamɨ. Two examples, a protest in the capital of the Upper Orinoco municipality, and a historical Yanomamɨ conference in Mavaca, are considered. The analysis emphasises the continuity between quotidian relations with doctors and the more singular meetings and protests. The complementarity between 'upriver differentiation' against 'real Yanomamɨ' and the 'down-river' differentiation against *criollos* is also stressed. As a middle point between Yanomamɨ political management of *criollos*, and the *criollo* politics of healthcare, important contrasts are also made signalling Yanomamɨ's fading efficacy on getting *criollos* to do what they want.

Finally, Chapter I is the stepping stone for the body of the thesis. A brief history of Ocamo and health delivery in the area, the major institutional actors in the Upper Orinoco, and a description of the 'daily round' of doctors and the rural clinic in Ocamo constitute the obligatory initial ingredients to proceed with the rest of the text.

Two appendices complement the thesis. Appendix A provides a picture of the health situation in Ocamo through demographic and epidemiological data. Appendix B is a brief comparison of the Venezuelan health system with healthcare provision among the Brazilian Yanomami.

Chapter I: Ocamo, the health system and the daily round

This chapter provides general background information for the rest of the thesis. It is divided in four parts. First we describe Ocamo and the network of communities that make up the area of influence of the Ocamo health post, including important *criollo* locations that have become part of Ocamo Yanomamɨ's normal life. Second we give an overview of the historical provision of healthcare leading to a description of the current health system. Third we briefly describe the inter-institutional political panorama in the Upper Orinoco together with a summary of the important changes in Venezuela's indigenous policy. Finally, we present a succinct account of doctor's daily life in Ocamo.

I. 1. *The Yanomamɨ and Ocamo*

The Yanomamɨ inhabit an area that falls on the western section of the Venezuelan/Brazilian frontier. Ethnographers have traditionally distinguished four linguistic sub-groups: Ninam, Sanema, Yanomam and Yanomamɨ, the term 'Yanomami' normally used as an umbrella classification. The total Yanomami population in Venezuela, based on the 1992 indigenous census, approximates 15.000. Of these, some 13.500 Yanomami (Yanomamɨ and to a much lesser extent Sanema) inhabit the state of Amazonas, most of these in the Upper Orinoco municipality.[6]

The Yanomami ancestral territory is the Parima Highlands lying in a relatively inaccessible area between the watersheds of the Orinoco, Negro and Branco rivers which were the major trade routes and avenues of slave raiding during the advance of European colonisation between the 16th and 19th centuries. This geographical location allowed the Yanomami to undergo a population expansion that makes them a large and scattered group – above 25,000 people in approximately 180.000 km^2.[7]

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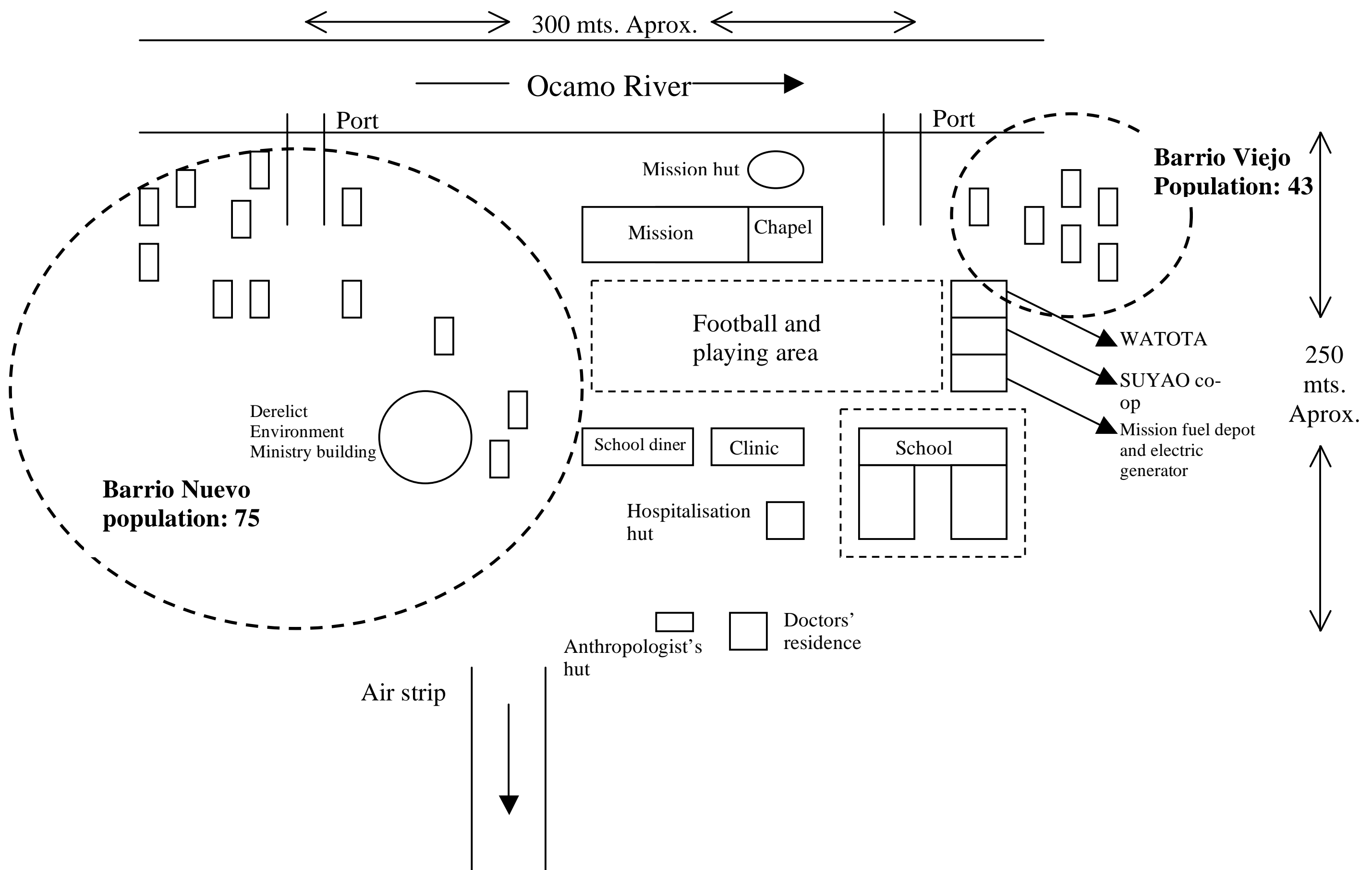
[6] This census counts 13.347 Yanomami in Amazonas state (Colchester & Watson, 1995:8). However, 5.882 were not counted but estimated. A new census was done in 2001 the results of which were unavailable at the time of writing.

[7] See Lizot (1984) for a detailed description of historical trajectories of the Yanomamɨ in Venezuela; Albert (1985) for the Yanomam; Ramos (1995:20-1) for the Sanema; Ferguson (1995: part II) for an overview of the movements of all the subgroups. The area is estimated on the bases of the two legal figures that encompass most of Yanomami land in Venezuela and Brazil. The 83,000 km^2 Orinoco-Casiquiare Biosphere Reserve in Venezuela and the 94,000 km^2 reserve in Brazil. This figure doesn't include the areas occupied by Sanema and Ninam in Bolivar state, Venezuela.

Ocamo itself was founded upon the encounter and settling, in 1957, of the Salesian priests Father Cocco and Bonvecchio with two Yanomamɨ groups – the Iyëwei t^{h}eri and a bit further upriver, the Rihu una t^{h}eri – at the confluence of the Ocamo and the Orinoco. The then headman of the Iyëwei recounts a series of westward movements of his people both due to conflict with other groups and the appeal of exchange with neighbouring Yekuana who had more manufactured objects (Cocco, 1972:111-14). The establishment of the Iyëwei on the mouth of the Ocamo around 1955 was a deliberate strategy to make themselves visible to *criollos* travelling on the Orinoco. The original population of both groups totalled 59 Yanomamɨ. The massive provision of manufactured products persuaded the Iyëwei to stay at this location and fostered the accretion of many relatives that were living up the Ocamo and along the Padamo and its main tributaries. By 1972 the population of Ocamo had grown to 139 Yanomamɨ.

Today 'Ocamo' refers to a conglomerate of 10 communities in the close vicinity (up to 10 minutes by boat) of the Salesian mission and the health post, most of which are the product of internal fission of the original communities. Community size ranges from 7 to 75 people and total approximately 370 people. Among these communities, Barrio Nuevo and Barrio Viejo stand out for actually being within metres of the mission and health post, meaning they are who most relate to doctors and missionaries. All other communities must walk or travel by boat, albeit short distances.[8]

Figure I.1: Ocamo village layout.[9]



Ocamo counts with a permanent health service and Salesian's intercultural bilingual school that runs up to 6th grade. A thin few Ocamo youngsters continue their education in the inter-ethnic high school Salesians run in the town of La Esmeralda, the capital of the Upper Orinoco municipality. Apart from the primary school and the health post, Ocamo hosts the 'local branch' of SUYAO, the Yanomamɨ economic co-operative. SUYAO's main area of influence is along the Orinoco and up some of its tributaries (Ocamo, Mavaca, Manaviche). Here you can exchange indigenous products like baskets and arrows for machetes, pots, cloth, fishing nylon and hooks, soap, lamps, etc. Yanomamɨ items are then sold externally in Puerto Ayacucho or Caracas. All these items can also be bought with cash, an option available to only a

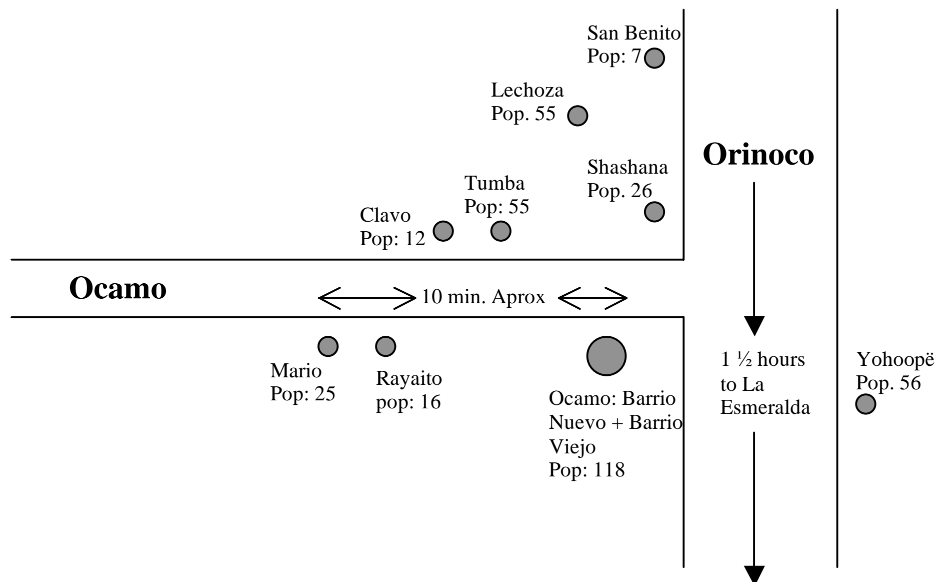
[8] Henceforth I will use the term 'greater Ocamo' when necessary to distinguish Barrio Nuevo and Barrio Viejo from the rest of the 'satellite' communities. Otherwise 'Ocamo' refers to people living in any of the communities of the conglomerate.

[9] I have been informed that since my departure, Barrio Nuevo has moved 15 minutes walk upriver. It no longer can be considered to be next to the mission as is still the case of Barrio Viejo.

few Yanomamɨ who have fixed salaries.[10] Some women of Ocamo also work sewing cloth to make shorts, T-shirts or weaving nylon hammocks in the WATOTA, a kind of ‘female side’ of the co-operative. Ocamo also has an airstrip currently used mainly for flights related to the health system – taking patients to the capital Puerto Ayacucho or flying personnel and/or supplies into Ocamo.

This pattern, with the presence of the Salesian mission, health post, SUYAO and WATOTA, is shared by the Mavaca and Platanal conglomerates.

Figure I.2: Layout of Greater Ocamo.[11]



I. 2. *A river network from the health service’s point of view*

The health post’s area of action stretches mostly up the Ocamo river itself. Along the Ocamo watershed there is a large number of communities stretching well beyond the reach of the health system. One area stretches Northeast-ward into the Parima

[10] A summary of the job offer in Ocamo: A handful of Yanomamɨ (men and women) work teaching in the school. Three officially get salaries from the health system (nurse, microscopist and motorist). One works for the Ministry of Environment measuring daily the level of the river. Another post is offered by the Ministry of Infrastructure for the maintenance of a communication antenna which has been out of use for several years. Some Yanomamɨ get paid for doing odd jobs for the mission and finally another handful are paid by the municipality for local political posts like ‘sport promoter’ or for being members of the *Junta Parroquial*.

highlands; other communities connect the Ocamo watershed with that of the Padamo (Northwest-wards) and a third area bends down towards the Orinoco again connecting with the Manaviche river, on the one hand, and with the Orinoquito area, on the other (see figure I.3).

About 1½ hours upriver is *Caño Henita*, a tributary with communities infrequently visited by Ocamo health crews. Then come a group of five communities between 2 and 3½ hours upriver known as the 'intermediate' communities. Altogether they amount to approximately 150 people. The next set of communities visited by the health team include two communities on the *Puut*^{h}*a kë u* 'river of honey' and one higher up the Ocamo. These are the only 'distant' communities in the area of influence that are visited with a minimum of regularity, adding another 120 people approximately.

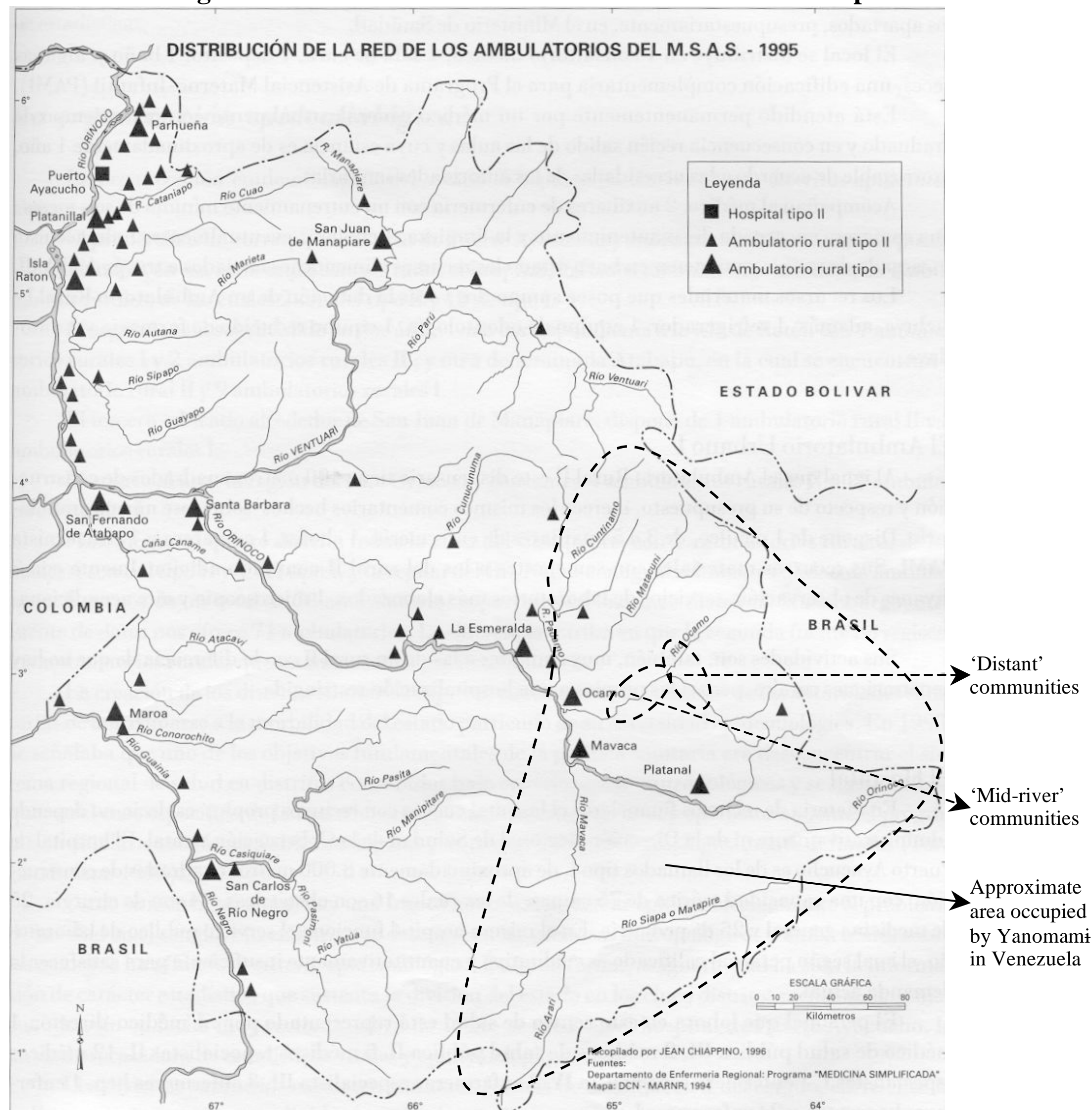
We shall be analysing the health system within this river network. Let me illustrate the internal gradient of difference between these communities in relation to their degree of exchange with *criollos* and the 'outside' world.

An upriver community like Pashopeka has no shotguns, no outboard motors and no Spanish speakers. In a survey I did, only two of 36 people had been as far down-river as La Esmeralda (closest *criollo* style town), only a few had been to Ocamo, Koshirowë or Mavaca – Yanomamɨ communities with permanent missions – none had been beyond the Upper Orinoco. In comparison, among the communities of greater Ocamo (6 hours down river) there were 36 shotguns and 16 motors, most children go to the mission school and most young people speak Spanish to different degrees of competency. Most, if not all men have gone to La Esmeralda, many do so regularly. A considerable number have been to Puerto Ayacucho or other cities in the north of the country. Many Yanomamɨ also participate in local party and indigenous politics, others have been trained as nurses and microscopists, and so on.

[11] The census data is from November 2000. All figures are approximate because a number of people tend to move from one community to another for a variety of reasons: marriage, conflict, wanting to be with closer relatives, etc.

A mid-river community like Maweti (3 hours upriver from Ocamo) has a motor and boat, two shotguns and a radio among 52 people. Several here have been to Puerto Ayacucho; one had gone to Caracas. Many youngsters have gone to La Esmeralda and several know other mission/clinic conglomerates. They have no daily school and only a few (very limited) Spanish speakers.[12]

Figure I.3: Amazonas state with the locations of health posts.[13]



At the other end of the river network is La Esmeralda. It is the closest *criollo* style town with a population of over 300 people of mixed ethnic origin. La Esmeralda is about 1 ½ hours from Ocamo (2 ½ from Mavaca and 4 from Platanal). It is a long town next to the Orinoco, distributed on both sides of the huge runway that makes it

[12] Education here is limited to fortnightly visits by the two nuns of Ocamo.

the main entry/exit point of the Upper Orinoco *via* the regular flights that connect it with the capital of Amazonas, Puerto Ayacucho – these can vary from two to four per week. One side of the village is predominantly occupied by Yekuana Indians, the other by a number of other ethnic groups – Warekena, Bare, Baniva, Kurripaco, and Guahibo – and some *criollos*. This spatial distribution reflects the internal friction between the Yekuana and the rest, grouped as 'the Arawaks.' La Esmeralda is frequently visited by Orinoco Yanomamɨ to buy gasoline, *criollo* food and some manufactured objects.[14] Being the seat of the municipality, several political meetings are also held in the capital. Some Yanomamɨ also spend variable lengths of time working in official constructions or doing odd jobs for people in La Esmeralda. There is also a military post, the Salesian multi-ethnic high school and a rural clinic.

Puerto Ayacucho is the capital of the state of Amazonas and seat of the regional government and ministries. It is reachable from La Esmeralda by small aircraft (2 hours). Alternatively, and much less frequently, Yanomamɨ may travel two days by river to reach the capital. A sector of Orinoco Yanomamɨ – mainly local government workers, teachers, health personnel and other people with salaries – travel frequently to Puerto Ayacucho. These people come to collect pay cheques, negotiate contracts, participate in regional indigenous gatherings, missionary events or buy *criollo* products. Here lies the state hospital, where patients from the Upper Orinoco are flown if needed.

I. 3. *Indigenous organisations*

Along the Orinoco the only supra-local indigenous organisation is SUYAO.[15] Created by the Salesians in 1986 as a small commercial co-operative facilitating the flow of manufactured goods whilst promoting productive activities, SUYAO has also grown into the political sphere representing Yanomamɨ interests in regional indigenous affairs. It also serves as the Yanomamɨ counterpart to outsiders who come with community projects. The Indigenous Affairs Direction in Caracas, for example, requires explicit SUYAO authorisation for anthropological research. Still 'coached'

[13] Map taken from Toro (1997:321).
[14] Henceforth I will use the term 'Orinoco Yanomamɨ' to designate all the Yanomamɨ who live in the mission/health posts conglomerates of Ocamo, Mavaca and Platanal.

by the Salesians, SUYAO's everyday running is in the hands of Yanomamɨ. A Puerto Ayacucho-based NGO and the missionaries link the Upper Orinoco with outside markets commercialising their products and sending manufactured goods into Yanomamɨ land.

SUYAO is part of the state-wide indigenous organisation ORPIA,[16] created in 1993, representing 19 ethnic groups in Amazonas. The organisation's objectives look both inward, through promotion and assistance to community-level organisations and self management initiatives, as well as outward, through the defence of indigenous rights, the representation of communities in regional, national and international institutions and the promotion of indigenous identity and values (Oldham, 1995:109; Plonczak, 1995:131).

ORPIA is perhaps the most effective Venezuelan indigenous organisation. Today it is influential in its interface role with state institutions like the health authorities in Amazonas. They participate in national and international indigenous congregations and continuously publish in the Salesian newsletter *La Iglesia en Amazonas* and the human rights office publication SENDAS. ORPIA has so far successfully challenged the regional and national government when in 1995 they managed to reverse the geo-political ordering that followed the declaration of Amazonas as a state in 1992. In 1999 ORPIA also included one of its members in the national assembly that drafted the new constitution's indigenous rights. Guillermo Guevara continues to be one of the three indigenous representatives in this assembly. In 1997 from ORPIA a new political party (PUAMA)[17] was born, quickly becoming a major regional political force.

Finally, the Yanomamɨ of the Upper Orinoco have no current pressure from encroaching settlers or large scale development projects on their land due to the creation, in 1991, of the 83.000 km^2 Alto Orinoco-Casiquiare Biosphere reserve which encompasses Yanomamɨ and part of Yekuana territories. Although the biosphere reserve is mostly an environmental legal figure with conservationist emphasis, it has

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[15] *Shaponos Unidos del Alto Orinoco*, 'United *Shaponos* of the Upper Orinoco.'
[16] *Organización Regional de Pueblos Indígenas de Amazonas*, 'Regional Organisation of Indigenous Peoples of Amazonas.'

kept outsider settling, tourism, and extractivist activities (mining, logging) at bay. Having said this, the presence of illegal wildcat Brazilian gold miners along the frontier with Brazil is an on-going problem even though the Venezuelan military have two bases near the foci of these incursions (Parima B and Delgado Chalbaud).

It was this situation that favoured the killing of sixteen Yanomamɨ by gold miners in 1993. This well-reported episode circulated through national and international media, generating a renewed wave of pressure on national governments (Brazil and Venezuela) to deal with the mining issue.[18] In Venezuela, through the Office of Human Rights in Puerto Ayacucho, a demand was introduced at the Inter American Human Rights Office in Washington. Responding to the latter's pressure, in December 1999, the Venezuelan state agreed to redeem this situation, amongst other ways, by providing a dedicated health plan to attend the dramatic health standards of the population and the still incipient health system (see Appendix A and below).

This 'Yanomamɨ Health Plan' was discussed by a number of institutions from 1999 to 2001. A document (outlined in Chapter IX) now exists which has served to secure an important state-provided annual budget but has yet to be implemented.

I. 4. *Historical health-related presences and the current health system*

The first institutions involved in providing different kinds of medical assistance in the Upper Orinoco were the missionaries (Salesian and NTM) and the malaria, dermatology and infirmary services of the health ministry. Due to their permanence I will briefly outline the role of Salesians and the malaria and dermatology services.

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[17] *Pueblo Unido Multietnico del Estado Amazonas*, 'United Multiethnic People of the Amazonas State.'
[18] For reports and analysis on the situation of gold mining and the Hashimu case see, amongst others, Ramos (1995: chapter 11); Albert (1992); Rabben (1998) and Rocha (1999). On the situation in Venezuela see Colchester & Watson (1995). The Brazilian NGO CCPY keeps an updated web site www.proyanomami.org.br and regular newsletters reporting on these issues. In Venezuela the Office of Human Rights in Puerto Ayacucho also publishes regularly on human rights issues involving the Yanomamɨ and other indigenous groups of Amazonas in their newsletter SENDAS or in the Salesian newsletter *La Iglesia en Amazonas*.

The malaria service began attending the area in the late 1950's.[19] It began with a base in the mouth of the Mavaca river but has been relocated several times, initially to Platanal, next back to Mavaca, next in the vicinity of La Esmeralda. Today the malaria service continues to attend the area from Puerto Ayacucho. It visits the Yanomamɨ on the Orinoco and larger tributaries ideally every four months or when deemed necessary (e.g. epidemics).

The service of sanitary dermatology set up a base in Mavaca in 1975-6 as a result of reports of onchocerciasis foci in the Parima highlands (Razzi *et al.*, 1978). Permanent presence was terminated in early to mid 80's when the control programme was taken over by CAICET,[20] a tropical disease research centre based in Puerto Ayacucho. Today control of onchocerciasis is run by CAICET as part of a national programme.

Finally, since their arrival, the Salesian mission has provided basic medical assistance mainly through the Sisters of *Maria Auxiliadora*. Although each of these services had a specific task – malaria, onchocerciasis, primary care – and were run independently, in the field they have all had a part to play in primary care and have functioned in a similar way. All had one or more bases visiting nearby communities depending on programme schedules and different kinds of emergencies. Intermittent visits were also done to upriver communities from the Orinoco. The Salesian mission, having outlasted the Health Ministry's permanent presences up to 1985, also played an important role in treating malaria, vaccinations and record keeping. Previous to 1985, with isolated exceptions (Ocamo and Platanal), there were no resident doctors in the area. Researchers and itinerant doctors based elsewhere in Amazonas were the only professional doctors available.[21]

In 1985 the Parima-Culebra Programme, implemented by a group of young graduate doctors, began regularly serving the Upper Orinoco with rural doctors spending one

[19] The XIX malaria zone begins operating in Amazonas from Puerto Ayacucho in 1954 (Armada, 1997:297).
[20] *Centro Amazónico para la Investigación y Control de Enfermedades Tropicales*, 'Amazon Centre for Research and Control of Tropical Diseases.'
[21] Armada (1997:296) refers to the existence of three rural clinics in Amazonas in 1961, in Maroa, San Carlos de Rio Negro, and San Fernando de Atabapo. Semba, in his assessment of the health system in 1980, reports the presence of foreign doctors revalidating their medical licenses. Their stay was most commonly limited to three month periods (1985:35).

year in the area as their compulsory year's service to the state.[22] Soon afterwards these doctors took over the primary care role from Salesians along the Orinoco working from rural clinics in La Esmeralda, Ocamo, Mavaca and Platanal and visiting nearby communities on a regular basis and other ones accessible within a few hours by boat or foot. In 1993 the Upper Orinoco Health District was created, meaning that the Regional Health Direction of Amazonas would assume full responsibility of health provision in the area (medical and logistical supplies, salaries, etc.)[23]

Other important developments include:

1976: Training of the first Yanomamɨ nurse under the scheme of the Simplified Medicine Programme.

Early 90's: Final-year medical students begin to regularly work for two months in each of the rural clinics in the Upper Orinoco. Dentistry services have functioned under the same scheme although in more irregular fashion and mostly based in La Esmeralda from where they visit the rest of the rural clinics in Yanomamɨ land. This is part of a state-wide project, *Proyecto Amazonas*, which is a collaborative agreement between the Amazonas regional government and the Central University of Venezuela which includes this scheme of training/assistance, and a basic and applied research component, among others.

1995: Training of the first group of Yanomamɨ microscopists.

2001: Building of the Health Centre in La Esmeralda. This is a health unit that, without being a fully-fledged hospital, is planned to have more resolutive capacity than a rural clinic (e.g. oxygen, X-rays, blood transfusion capabilities, clinical laboratory). It is only being used as a rural clinic due to lack of equipment and staff.

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[22] The compulsory rural year system is a policy oriented to counter the shortage of doctors in rural areas that has been implemented by a number of Latin American countries including Venezuela, Colombia, Peru, Ecuador, Bolivia, Cuba and Mexico (Marquez, 2002; Kroeger & Barbira-Freedmann, 1992).

[23] Previously supplies of medicine and equipment and some salaries were provided to the Sisters by the Regional Health Direction. During the Parima-Culebra programme, doctors operated under the figure of a foundation that, through diverse fundraising activities, added medicines and equipment to the vaccines, medicines and gasoline supplied by the Regional Health Direction.

I. 5. ***Current functioning of the health system***

Today the Yanomamɨ of the Upper Orinoco count with a state-run health service with four rural 'AR II' clinics (Parima, Ocamo, Mavaca and Platanal) tending exclusively to Yanomamɨ communities and one just beyond Yanomamɨ land of which Yanomamɨ make a lot of use in La Esmeralda.[24] Each clinic is ideally staffed by a rural doctor, a Yanomamɨ nurse, a Yanomamɨ malaria microscopist and a motorist (to drive and maintain the clinic's small boat). There are two 'AR I'[25] clinics run by Yanomamɨ nurses, one in the Mavaca area (Warapana) and one in the Casiquiare canal (Cejal). Every ten weeks a medical student adds to this group during 8 weeks. All these health posts work alongside mission bases, Salesians along the Orinoco, and NTM in Parima. Each health post is assigned communities classified according to their distance by boat (foot in Parima) from the health post. Roughly the classification is as follows:[26]

Table I.1: Distance classification of Yanomamɨ communities.

Classification	Distance
'Close'	up to 30 minutes by boat
'Intermediate'	up to 5 hours by boat
'Distant'	more than 5-6 hours by boat

There are six Yanomamɨ nurses and five relatively active malaria microscopists.[27] Nurses are trained in the Simplified Medicine Programme, a course given in the

[24] From 1999 to 2001 a rural clinic staffed by a doctor and a Yekuana nurse functioned in Toki, a mixed Yekuana-Yanomamɨ community on the Padamo river. A doctor is no longer maintained in this post which continues to be supplied with medicines administered by the nurse.
[25] The main difference between a AR II and a AR I rural clinic is that the former is staffed by a doctor and the latter by a nurse trained in the Simplified Medicine Scheme. In their regular functioning AR I nurses maintain radio contact with an AR II and are coached by rural doctors when in doubt of how to proceed. AR Is are organisationally one level below, and co-ordinated by, AR IIs.
[26] Aware of the artificial nature of these classifications, I will continue to talk about 'close,' 'intermediate' and 'far' communities for clarity of exposition. My knowledge of the area of Parima is limited, a similar classification is held there but visits are by foot and involve longer periods than those I have mentioned above.
[27] Two more Yanomami began the Simplified Medicine course in early 2002 (one from Parima and the other from Mavaca). Some trained malaria microscopists are not currently active. To the best of my knowledge there is one microscopist in each of the following areas: Parima B, Koyowë, Platanal, Mavaca and Ocamo.

Amazonas capital Puerto Ayacucho lasting 6-7 months.[28] Microscopists have been trained in La Esmeralda or Puerto Ayacucho in shorter courses.

Rural clinics constitute the operative level of the health system performing a) daily, mostly curative, primary care activities, b) the implementation of nation/state-wide disease control programmes, the most relevant in the area being: malaria, onchocerciasis, tuberculosis, immunisations programmes and intestinal helminths control activities, c) epidemiological registering (weekly and monthly reports) and d) referral of patients to the hospital in Puerto Ayacucho.[29]

The rural clinic, in ideal circumstances, opens everyday during the mornings and in the afternoon the doctor visits a number of the 'close' communities that surround each post in such a way that they are actively visited at least once a week. 'Intermediate' communities should be visited every 2 weeks and the more distant ones, once a month. Upriver visits normally last anywhere between 1 and 4 days. The time spent at each community varies according to the health situation encountered but normally ranges between half and two or three hours. Patients requiring supervised treatment are taken to the health post down-river.

The malaria programme involves early detection, diagnosis and treatment by the staff of the health posts. Nearby communities are the ones with a more strict epidemiological surveillance. In the Ocamo and Mavaca 'close' communities, an impregnated mosquito-net project was evaluated during 1999-2001 as a vector control measure. The preliminary results of this project are encouraging (significant reduction of mortality due to malaria and improvement of indices of splenomegaly and haemoglobin levels (Dr. Magris pers. comm.) and may lead to its wide-spread use in the future. These activities are complemented by the malaria service's quarterly visits which fumigate and fog in 'close,' 'intermediate' and some 'distant' communities as well as diagnose and treat as they go. 'Intermediate' and 'distant' communities, then, are treated for malaria during the health teams' visits, leaving the treatment for suspected or identified malaria cases with patients or relatives.

[28] Avoiding the complicated term 'Simplified Medicine Auxiliary' I shall be using the term 'nurse' to refer to this health personnel throughout the thesis.

The onchocerciasis programme involves the delivery of Ivermectine (antifilaric, antihelminthic) two times a year to all 'close,' 'intermediate' and 'distant' communities and an annual evaluation of sentinel communities to monitor progress. Due to an inadequate cold chain, immunisation activities are limited to national and regional campaigns twice or three times a year. The TBC programme consists of continuous surveillance (i.e. passive and active case detection) and supervised treatment of active cases (by local health personnel, missionaries or relatives).

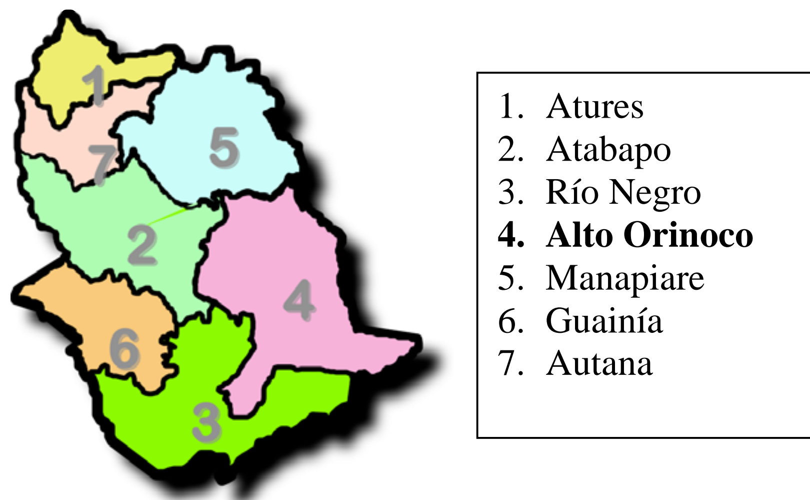
Finally, intestinal helminths control involves periodical mass treatment of school-age children at the health posts. 'Intermediate' and 'distant' communities are not normally mass treated, however, the six-monthly Ivermectine treatment means that all communities are treated for some helminths at least twice a year.

In addition to these activities communities beyond the 'distant' category are occasionally visited by helicopter either in response to news of epidemics or as part of vaccination campaigns. Salesian missionaries continue to hold some medicines they receive through donations. In Ocamo they visit 'intermediate' communities fortnightly, combining education with some medical attention.

In organisational terms most of the Yanomamɨ communities in Amazonas fall into a single health district (Upper Orinoco). Health districts are mapped onto the Amazonas' geo-political divisions (figure I.4). The Upper Orinoco health district is co-ordinated by a Head of District who is the link between rural doctors, Yanomamɨ nurses and communities, and the Regional Health Direction.

[29] There are airstrips in Ocamo, Platanal, Parima B. All are regularly used in response to emergency calls.

Figure I.4: Health districts in Amazonas state.[30]



I. 6. *Area of coverage*

The most important deficiency of this health system is its limited area of coverage. Lack of adequate updated censuses make it impossible to precisely ascertain the percentage of communities with access to the health system, however, on the basis of the 1992 census and on a series of censuses made by the health posts we can give some estimates. According to this composite data, regular health services are available to approximately 14% of the Yanomamɨ.[31] These communities have access to medicines, rural doctors and Yanomamɨ nurses and are regularly vaccinated in national and regional campaigns and according to vaccination schedules managed by the rural doctors. Due to poor record keeping and high turnover rates of rural doctors it is hard to know the precise vaccination coverage of all the population for each immunopreventable disease.

'Intermediate' communities are supposed to be visited fortnightly, but in reality this frequency depends on the logistical constraints of the health post (functioning boats and motors and gasoline supply), the number of doctors in the area and the general

[30] Map from the Amazonas Regional Health Direction. It is worth noting that the Upper Orinoco is the largest health district in the state covering an area of 50.000 km^2.
[31] These figures include only the Ministry's health posts. If we consider the contribution of NTM missionaries in Koyowë and Padamo this figure ascends to approximately 19%.

state of health in ‘close’ communities.[32] These communities may be visited anywhere between once every two weeks to once a month. Some of these communities can call for a doctor or bring a patient to the health post, having either radios or boats of their own. Including ‘intermediate’ communities, tended Yanomamɨ population grows to approximately 25%.

‘Distant’ communities are visited anywhere between 1 to 4 times a year. The programme with reaches most Yanomamɨ is the onchocerciasis control programme which reports (CAICET, 2001) to have visited communities, amounting to a population of 3,845 Yanomamɨs in 2001 representing approximately 29% of the total estimated population. Crudely this means that roughly 70% of Yanomami population is beyond the reach of the current health system. These areas are those most distant from the Orinoco and its larger tributaries and from the Parima B health post in the Parima Highlands (e.g. Unturan ridge, Kobari, Delgado Chalbaud, Siapa basin). Table I.2 resumes the current coverage and activities of the health system.

[32] Trips upriver may be affected by arriving at empty communities either because they are visiting a more remote community or because they are in long-term fruit collecting in the forest (Y. *wayumi*) – sometimes the crew is advised of this on the way upriver. It is also frequent to have trips upriver thwarted by the encounter of one or more gravely-ill patients in ‘intermediate’ communities forcing the immediate return to the health post.

Table I.2: Coverage and activities of the health system in the Upper Orinoco.

	'Close'	**'Intermediate'**	**'Distant'**	**Remaining 70%**
Primary Care	Regular	Irregular and on demand	Irregular to sporadic	Very sporadic or nothing
Malaria Control	• Regular early detection and relatively supervised treatment • Vector control: Mosquito nets (Ocamo and Mavaca)[33] and quarterly malaria service visits	• Irregular early detection and unsupervised treatment • Vector control: quarterly malaria service visits • Exchanged mosquito nets (see ff. 33)	• Irregular to sporadic detection and unsupervised treatment • Vector control: malaria service visits • Exchanged mosquito nets (see ff. 33)	Very sporadic or nothing
Onchocerciasis Control	Twice a year: onchocerciasis treatment with Ivermectine	Twice a year: onchocerciasis treatment with Ivermectine	Twice a year: onchocerciasis treatment with Ivermectine	Very sporadic or nothing
Immunisations	High but unspecific coverage	Irregular and incomplete coverage (insufficient doses of different types of vaccine)	Irregular to sporadic and incomplete coverage (insufficient doses of different types of vaccine)	Very sporadic or nothing

- o -

To understand the supra-local forces that impinge on the provision of healthcare for the Yanomamɨ we need to grasp the institutional context in which the health system is embedded. Institutions operating in the Upper Orinoco have a history of accommodating newcomers, shifting alliances, contradictory agendas and conflict. Institutions that stand together on one issue oppose each other on others; help may be followed by bitter critique.

[33] This evaluation lasted only between 1999-2001 but a large number of mosquito nets remain in these communities. These nets have also become an important exchange item. A survey I did along the Ocamo river yielded that 42% (15 of 36 inhabitants) of Pashopeka, a community classified as 'distant,' had mosquito nets obtained from exchange with different communities, the sources being Parima B (upriver) and Ocamo (down-river). In Maveti, an 'intermediate' community about 3 hours up river

I. 7. ***Institutional ideologies and inter-institutional relations***

There are multiple interests and agendas that have 'the Yanomamɨ' as targets of institutional services and attention, forming a political arena in which any health or other development intervention is immersed. The Upper Orinoco is simultaneously a politico-administrative entity (municipality), a health district, a biosphere reserve, a boarder with Brazil, an educational zone, an indigenous area and a target of religious evangelisation. At least the Ministries of Defense, Education, Health, Environment, local government, and missionaries, the Direction of Indigenous Affairs and the regional indigenous organisation (ORPIA) have special interests here. As a point of convergence of so many 'special interests,' a coherent policy (health or otherwise) of engagement with the Yanomamɨ is difficult to achieve. To illustrate the divergence of policies let me delineate the most relevant conflicting ideologies of intervention I witnessed.

By far the most important institutional divergence was that which found Salesians, health authorities, ORPIA and National Guard (GN) on one side, and the municipality on the other.

The Upper Orinoco mayor is a Yekuana Indian member of the Acción Democrática (AD) nation-wide political party. AD is one of the two important traditional Venezuelan political parties that has shared government for most of the country's democratic history (since 1958). Currently, however, it is cast by the new government of President Chavez as the chief culprit for the country's demise and the spread of corruption. Before the regional elections in 2000, Amazonas had been an AD stronghold for several years. The Upper Orinoco continues to be so.

In terms of health the Mayor had a series of disputes with the Head of District (HD) and the health system in general. The municipality had signed an agreement to provide fixed salaries for Yanomamɨ health personnel only to fall short on its obligations. At one point it also wanted to build a rural clinic based on the political support of a Yanomamɨ community in the Mavaca area. The HD objected because it

from Ocamo, 56% (29 of 52 inhabitants) had mosquito nets obtained by exchange, the main source being Ocamo.

was only ten minutes away from an existing health post. The municipality had also fallen back on bonuses offered to rural doctors. Finally, the HD and others were critical of the municipality's expenditure, specially in the face of La Esmeralda's lack of basic sanitary infrastructure – garbage disposal and waterworks.

Legal action against the Mayor on counts of corruption has been advanced for several years. He was finally jailed in mid 2002 but released not long afterwards. All institutions mentioned above believe the Mayor is corrupt and are vocally against his clientelistic-paternalistic policies. The municipality also appeared to be the most vocal promoter of 'progress,' accusing the Salesians of keeping the Yanomamɨ away from it with their emphasis on cultural sensitivity (e.g. inter-cultural bilingual schools; support for a Yanomamɨ-only special municipality).

Another important influence was the National Guard through intervention of the *Plan Casiquiare*. This plan is the Amazonas version of a nation-wide social programme involving the armed forces in deploying community development schemes (e.g. setting up low cost markets, rebuilding rundown health centres). Even when the GN's social development interest was welcome, some of its most visible actions in the Upper Orinoco – initially, distribution of food and tools and then of boats and motors – were seen as retrograde paternalism (mainly by Salesian missionaries who have been for a long time reforming their own paternalistic policies.) The renovated importance of the GN was seen as uncoordinated with the principles of existing institutions, who were then 'sending mixed messages': some promoting achievement of goals through work (missionaries) and others countering this efforts with gifts (GN, municipality). The HD at the time echoed this criticism. ORPIA was also critical of this aspect of the *Plan Casiquare* paternalism.

In other respects *Plan Casiquiare* was recognised as a positive influence. In and around La Esmeralda, it allocated substantial funds for the design and implementation of a number of community development projects. In contrast with its relation to the Yanomamɨ, in this case, all initiatives were drawn up together with the sectors of the communities involved, a side-by-side process lasting more than a year replete with talks, workshops, etc. The GN also provided a weekly flight, connecting La

Esmeralda to Puerto Ayacucho, for less than a third of the price that regular commercial services provided.

In terms of general projects of integration into the nation-state there were clear institutional divergences.

Municipality: promoter of 'progress' operating mainly in a party-clientelistic fashion.

Salesians: 'accompanying the Yanomamɨ historical process,'[34] fostering grass-root economic and political activity through SUYAO, and inter-cultural bilingual education.

Plan Casiquiare: 'social development' with a paternalistic character in the Upper Orinoco, adopting a more grass-root guidance role in other areas.

A crucial implication of these diverse ideologies of intervention is that, as Yanomamɨ become progressively involved in the operative level of several institutions (e.g. health system, SUYAO, local government), they participate in inter-institutional rivalries. Party political divides were strongly visible in Ocamo where Barrio Nuevo's main leader supported the AD Mayor, whilst the Barrio Viejo's most vocal leader sided with SUYAO and ORPIA. Several Yanomamɨ health personnel were also supporters of the AD Mayor which intensified their criticism of doctors and the HD. The multi-layered political character of relations in the Upper Orinoco and their impingement on the health system will become evident in Chapter VIII.

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Stepping beyond the Upper Orinoco onto the national stage, Venezuela has undergone the most important change in its recent history regarding indigenous peoples and their rights with the writing of a new constitution in 1999. We shall now briefly discuss this and other developments in the state's indigenist policies.

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[34] This is their own wording.

I. 8. *Changing tides*

The assimilationist character of the 1915 Missions Law (see Arvelo-Jimenez, 1972b) that entrusted several Catholic denominations with the task of ‘civilising’ Indians, making them an indistinguishable part of the nation-state, came to an end in 1999. Venezuela has officially become a multicultural and pluri-ethnic country with a new constitution that dedicates eight articles to the rights of indigenous peoples. The most important areas covered are: a) Recognition of indigenous peoples, their languages, religion, and social, economic and political organisation; b) Right to communal ownership of inalienable land; c) Exploitation of natural resources in indigenous habitats may not harm the cultural, social and economic integrity of the indigenous people and is subject to consultation; d) Right to maintain and develop their ethnic and cultural identity, and to intercultural and bilingual education; e) Right to integral health services sensitive to local beliefs and practices; e) Right to maintain economic practices based on reciprocity and solidarity without precluding participation in the national economy; f) Right to participate in the design, execution, and management of programmes in the framework of sustainable development; g) Right to political participation at regional and national levels. (Venezuela, 1999:6)

The government has also shown commitment to addressing the ‘Indian issue’ in several ways. Venezuela has incorporated itself to the 169 ILO agreement on Tribal and Indigenous Peoples (in December 2000). The National Assembly has now three elected Indigenous representatives. Descending down the legal apparatus, the new draft health law contemplates indigenous peoples as ethnic minorities who require culturally sensitive policies. It also emphasises community participation in the design and implementation of health policies. In the wake of the publication of *Darkness in El Dorado*, an inter-institutional commission was designated by the government to investigate its allegations. This commission also prompted the organisation of an unprecedented Yanomamɨ conference in Mavaca in November 2001 (Chapter VIII). Within this context an ambitious intervention like the Yanomamɨ Health Plan finds itself backed not only by international, but also, constitutional and organic legal instruments.

To close this chapter I provide a succinct description of doctor's daily life in Ocamo in this way completing all the ingredients needed to get a general knowledge and feel for the health system in the Upper Orinoco.

I. 9. ***Daily life of doctors in Ocamo***

In all health posts in the Upper Orinoco doctors and medical student share a house. In Ocamo this house lies at the most inland part of the community, on the edge where the forest begins and beside the airstrip. Being at a distance to both Barrio Nuevo and Barrio Viejo and at the fringes of the community, its location is 'neutral' and peripheral, a spatial equivalent of doctors' general relation with the community.

At a distance doctors enjoy some privacy and can live to some degree a life of their own. The daily life of the community – eating, fishing, hunting, *yopo* sessions, family life and some community gatherings – unfolds at a remove and doctors learn what is happening mainly through the mediation of those Yanomamɨ who visit them on a daily basis. In Ocamo, where the 'two sides' of the community were politically opposed, news was highly biased by the interests and position of these visitors.

Doctors' engagement with the Ocamo people is mostly limited to the clinic, their house and some other public sites like the mission, the river or attendance in a community meeting if 'health' is to be discussed. Beyond this it is relatively rare for doctors to spend time in peoples' houses if not visiting a specific patient. Depending on their interest and time spent in the community, doctors may be invited to attend *reahu* funerary ceremonies. Students are always keen to attend. This seemed unproblematic for Yanomamɨ so long as no photographs were taken. Doctors appreciated these invitations and welcome them as signs of community acceptance. An important aspect of this living arrangement is that doctors construct their anthropology of the Yanomamɨ from this partial perspective. What they mostly see of Yanomamɨ life is pre-configured by the mainly *criollo* contexts of their encounters.

The daily routine normally begins with someone coming to the house to advise the doctor that people are accumulating at the clinic. During the children's school periods people begin to arrive around 7 a.m. because those who feel ill can use the mission's

‘river school boat’ to go to Ocamo. Some doctors go to the clinic as patients arrive, others, on the contrary, make little effort to adjust to this schedule.

Most of the morning is spent treating patients with minor disturbances: head aches, body pains, conjunctivitis, diarrhoea, asthma, fever, parasites, skin diseases, etc. for which either a number of pills, syrups or injections are provided. All fevers are treated as possible malaria cases and need a blood sample taken, diagnosed and adequate treatment provided if the result is positive. Respiratory issues often involve several sessions in a nebuliser – an electric device used for treating breathing difficulties. It creates a fog of broncho-expansive medicine that is inhaled by the patient for several minutes using a mouth piece. Both these cases (malaria and respiratory issues) require the patient stay a longer period in the clinic.

There being people from all the surrounding communities, the clinic becomes a social space where people meet and exchange news or gossip. Hence a visit to the clinic is, for those who don’t live in Barrio Nuevo or Barrio Viejo, also an opportunity to visit a relative, chat, eat, etc. In bringing together people who would otherwise not meet so frequently, the clinic acquires a special social dimension. The clinic is also a particularly female setting since, for the most, it is mothers or female relatives who bring the children. Another important sector is that of young men, many unmarried, some of whom spend plenty of time in the clinic either listening to radio calls, entertained by gossip or helping the doctor with translation. Being a crowded place, subtle exchanges between lovers can also be disguised. In this most simple way the health system’s physical structure is integrated into the everyday life of greater Ocamo as a kind of centre, a place where time is spent sharing with others. Moreover, since transport with the mission is ‘free’ i.e. it doesn’t require an investment in gasoline, sometimes people claim to be ill to go visiting. Similarly, every time the doctor hops on the boat to visit a community, someone will want to come along.

Seeing patients in Ocamo is, by urban hospital standards, disorganised. Even when there is a ‘waiting room’ the space where patients are examined and treated is, more often than not, open and visible to the others in the clinic. Relatives or friends are usually present, simply observing what is done to the patient or helping out in explaining his/her problem. A visually impacting patient (e.g. a large wound) or grave

circumstances always attracts a small crowd of commentators. The doctors' procedures and the illness of the person are normally commented upon: the possible diagnosis, blames, suggested ways forward, etc. All of this happens in Yanomamɨ excluding the doctor from understanding.

During the first part of the morning there are always several simultaneous activities: people talking on the radio, the doctor tending a patient, others translating, mothers having the children nebulised, malaria slides being examined. The degree of hecticness varies, but in Ocamo it tends to decrease by 11 a.m.

Most of the work in the clinic is done by the doctor, the student and an unofficial nurse, David, who has worked with the doctors for several years and has learned several nursing activities, but hasn't done the Simplified Medicine course. The official nurse, Jose, is one of the community leaders and is erratic in his appearance at the clinic for several reasons. He is tired of his job which he has done for 25 years, he had also moved to a community beyond Ocamo itself (10 min.), and in the process of establishing a new community for which he needed to organise the making of a new garden. His involvement in party and indigenous politics occasionally saw him occupied campaigning for himself or others, or assisting indigenous congresses. It is also the case that, having both a doctor and a student in the clinic, there is little for him to do other than translate and do other minor jobs that are not terribly motivating. This is an important problem because it can displace Yanomamɨ personnel from the clinic.

Jose is nonetheless an important voice of the community in relation to the running of the clinic and his opinions and decisions bear considerable weight. The microscopist is a youngster who, whilst valued as a good microscopist, due to problems of misconduct is repeatedly suspended. This is a problematic relationship that has been compounded by the inability of the health system to provide him with a regular salary. Several years of makeshift contracts and delayed payments are the main arguments he expounds when criticised for his unruly behaviour.

The morning routine in the clinic is affected by the school periods and by the epidemiological conditions of the moment. When there are vacations, people come

more spread out through the morning because there is no school boat. Certain affections like diarrhoea and respiratory diseases can easily spread among the community, making some periods considerably more hectic than others. These variations are obviously emphasised to extremes in the case of epidemic outbreaks.

In normal circumstances, at midday the doctor would go to the house and prepare her/his lunch together with the medical student, occasionally joined by some Yanomamɨ. The preparation of food and eating are a favoured spectacle for young Yanomamɨ who peer into the house through its extensive open windows. Some doctors dismiss this; kids leave on their own once their curiosity is satisfied. Others cannot tolerate being observed and scrutinised in this way and ask people to leave or shout at them. They don't like being 'a television' for the Yanomamɨ. To strong reactions youngsters leave laughing only to come back again the next day. The group of onlookers is always rotating, sometimes Ocamo youngsters bringing upriver visitors to see.

When the clinic motor is functioning well and there is gasoline, the afternoon is used to visit several communities of greater Ocamo. These are also opportunities where some doctors get more involved with the communities and might choose to stay conversing with friends. Medical students arrange exchanges of arrows or ornaments or pay for the next *paca* killed to be taken to the doctors' house to eat.

By nightfall doctors are back home preparing dinner. Evenings have a cosy air to them, doctors and student converse about the day's medical cases, the gossip from the community, Upper Orinoco anecdotes, etc. Yanomamɨ anthropology is also a common subject where doctors assume the role of 'knowledgeable sources' when students ask about different Yanomamɨ practices: illness beliefs, warfare, sexuality, naming taboos.

Another night activity for doctors is communicating with relatives or the other doctors in the Upper Orinoco *via* radio. Salesians have a fixed time at night to communicate with each other. After the missionaries talk their frequency is made available to doctors and students to speak to their relatives in Caracas. The latter, in the Salesian house in Caracas, get then a chance to speak to their children: 'are you

having a good time?' 'Are you eating well?' 'Are you not ill?' 'So an so sends you her love; the dog at home is missing you…'

During the night there is always the possibility of being called upon urgently to see a patient, and it is not unusual to spend long hours in the clinic dealing with gravely-ill children with respiratory diseases, fevers or very dehydrated. It is also usual for there to be patients that require medicine (normally antibiotics) over the night. Doctor and student will take turns on these shifts to go to particular houses with their torch and stick in hand to fend the angry dogs away and locate the patient in her/his hammock.

From morning to night, varying periodically with school activity and unpredictably with epidemic outbreaks, this constitutes the daily round of life for doctors in Ocamo. Having detailed the general setting of the fieldwork we are now ready to progress into the rest of the thesis.

Chapter II: Particularising the health system's 'front end'

This chapter is devoted to knowing the doctors and part of the system they work in. I want to particularise the situation of Venezuelan urban middle class graduate doctors working for a year in the health system of the Upper Orinoco. This effort particularises the taken-for-granted category of 'the doctor' or more generally 'White' in the analysis of inter-ethnic encounters, which by and large, invest most analytical effort on the indigenous side (cf. Thomas, 1994:13). I will proceed in three steps. First, exploring doctors' motivations reveals an imagined 'Amazonas' as a composite of cultural, environmental and professional otherness which, in collusion with a dominant state discourse of *mestizaje*, eclipses indigenous people themselves as motivations. Next, we explore 'first impression' accounts that reveal two opposed sets of proclivities and discourses about the Yanomamɨ: the naturalised Indian and the 'difficult' Yanomamɨ. We shall keep track of these 'doctor perspectives' throughout the thesis as they intermingle with 'Yanomamɨ perspectives.' Step three describes the ever-changing 'front end' of the health system. Differences in personal policies regarding the running of the clinic make the 'front end' a discontinuous process towards the Yanomamɨ. Finally, I shall argue that the health system as lived in Ocamo is an ahistorical 'cold' system repeating itself over time with a limited capacity to expand or improve. Progressing through the thesis, the incompatibility of the rural year scheme with the Yanomamɨ conditions for creating relations of trust with outsiders – that *criollos* epitomise – will become apparent, hence the importance of this part of our discussion.

II. 1. *Getting to the Upper Orinoco*

The following are accounts of how and why rural doctors reached the Upper Orinoco.

One doctor:

> 'I had graduated 16 days ago. Well, ever since I was in med school I have been attracted by Amazonas, not because of / not a clue of what the hell Indians were, indigenous people, [I had] heard of the Yanomamɨ but not / I mean the real context of the ethnic group as such / neither of any other. A was attracted by

Amazonas because of its farness, the jungle, the animals because of [my]... contact with INPARQUES [National Park Service where he worked for a period] …that ecological aspect, to know things that no one / the things you see on TV. But actually there is a great gap between what you see on TV and what you now see here…[speaking of how he learned of the job options in Amazonas] well, I was at my graduation party and a woman came to me with a newspaper clip saying Amazonas was requiring 6 doctors.'

Another:

'Then after my graduation event…I went to Caracas to do all the paperwork related to registering the title, whilst I was doing this I saw on a billboard, over there in the Ministry that doctors were needed for the areas of Upper Orinoco / Amazonas in general…

[once in Puerto Ayacucho] I came all ready with my things, without knowing much of 'the reality,' I looked in a map where La Esmeralda was…Well I came thinking that it was going to be in 'the complete jungle'[35] a camp like one of those, I don't know, of one of those African films…when I got here the Regional Health Director told me there was also the possibility of working in Ocamo … that I should think about it…I said 'well I have no problem, I really don't know either place, it's the same for me'

[on motivation] 'I was not into meditation…neither ecologist, nor spiritualist, nothing of the sort, I was going there because I had a vocation of service because I thought…that if I could serve in a rural community where it was really needed I was going to be able to fulfil my legal requirement [rural year] as it should be done.'

Another:

'Well, it all began ever since I was studying medicine I had the wish of doing my last rotary internship in Amazonas a bit for the experience of knowing another culture, knowing another geographical area, more for knowing other

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[35] This doctor has been working in Amazonas for several years now. The reference to '*la selva total*' 'a complete jungle' expresses how she thought of it then in relation to how nowadays, she sees it differently with less connotations of remote wilderness.

things and how medicine at a rural level is managed [so he wanted to do his work]…in a really rural place, hence I had the wish to go to Amazonas.'

Another:

> '[in university he was part of an outdoors group that organised excursions] Well one of those trips was to Amazonas to a community not too far from Puerto Ayacucho, it is a *Guahibo* [ethnic group] community…Of course I saw that as a jungle, as 'The jungle'[36]…we were almost two weeks there, relations with the people were very special, so considering that I have always liked the outdoors… I thought the best place to do the rural year was in Amazonas.'

Exploring these motivations, reference to Amerindians or the Yanomamɨ is a telling absence. No-one spoke of a prior interest in indigenous peoples, be it their health situation or otherwise. There are references to culture, but 'other' in 'other cultures' is an unknown 'other,' part of an otherness attached to Amazonas as a place in Venezuelan urban middle class imaginations. It is to 'Amazonas,' rather than to Amerindians that doctors go. Given the continuous growth of the indigenist movement in Latin America and elsewhere; the evermore conspicuous presence of indigenous peoples in international forums (see Ramos, 2002); the newly gained visibility of Venezuelan indigenous peoples in the constitution; the prominence of the Yanomamɨ within international circuits of defense of Amerindians' rights; it was surprising to learn how doctors were all but completely oblivious to Yanomamɨ or indigenous affairs. This absence speaks of Venezuelan Amerindians in the urban middle class imagination, the demographic locus of rural doctors. It is the invisibility of Indians that needs to be explained (a point made by Arvelo-Jimenez (1972b:39) more than 30 years ago). In contrast, Ramos (1998:3) introduces her book on indigenism in Brazil: 'The question that prompted me to write this book is why Brazilian Indians, being so few, have such a prominent place in the national consciousness.'

First, Amerindians live in areas, for the most, poorly connected with the more developed north of the country; 'far outreaches' from that perspective. Urban middle

class of the north or Andean regions of Venezuela and Amerindians (with the exception of the Wayuu in the city of Maracaibo – see Fig. 2.1) do not meet, hence the 'reality of Amazonas' that doctors comment of not having known.

Second, contrary to the Andean countries of South or Central America, Venezuela has comparatively little in terms of Indian cultural features as part of its recognised folklore or architecture. There are significantly few signs of Indian heritage and identity. Where there are (Amazonas, Zulia, Bolivar), they are constituent of regional, not national, identity.

Figure II.1: Distribution of indigenous groups in Venezuela and location of main cities.[37]

Third, Venezuela's indigenist policy for most of this century has been assimilationist, oriented at making indigenous peoples an undifferentiated part of the nation-state. The delegation of the task of 'civilising Indians' to different Catholic

[36] 'The jungle' here is both a recapitulation of how this doctor saw that community then, and how, in context, he realised the Upper Orinoco, where he worked later on, was much more of 'a jungle.'
[37] Source: www.a-venezuela.com (accessed 25/7/03).

denominations in 1915 is testament to the peripheral importance which the state bothered to attach to the 'Indian issue.' An agrarian reform in the 1960's that forced Indians to become peasants and a massive development project, CODESUR, aimed at developing Venezuela's 'empty' Amazon region, are well documented references to the neglect and invisibility of Indians as people with social and cultural ways of their own (Arvelo-Jimenez, 1972, 1992; Oldham, 1995; Heinen & Seijas, 1998). But the Venezuelan urban middle class is quite unaware of Venezuela's indigenist history, a reflection of what is more profoundly determining: for the invisibility of Indians to be made possible, something else had to conceal them (cf. Hendricks, 1991 for the Ecuadorian case). Venezuelan identity is predicated upon the notion of *meztizaje*, the mixing of Indian, Black and White (Spanish) blood. An indigenous component of national identity is celebrated not as a living aspect of today's multicultural scenario but as a historical component of nation building. Indians are not ethnic minorities but historical forebearers. One only has to recall how history was taught in schools: the comparatively short space in books devoted to pre-Columbian history indicated that history started with the arrival of Europeans.[38] Indians were portrayed as lazy or feeble, this being the reason for seeking the muscle of African slaves. Roughly speaking, given that Indians had little of good in themselves, the process of colonisation is cast in terms of an operation of welfare not conquest (Thomas, 1994:124), conversion to Christianity being the vehicle and symbol of improvement.

As noted in Chapter I, the 1999 constitution is a substantial change in tides. But, as most of the radical changes the current government has attempted, the new indigenist policy has been met with resistance, not least because it is caught up amidst the most bitter political battle of Venezuela's democratic history. In any case, as the invisibility of the Yanomamɨ in doctors' motivation accounts makes clear, the refashioning of Venezuela's national identity and implementation of constitutional principles will take time even in the most favourable political circumstances. Venezuela is in the delay period between legal reform and on-the-ground change.

[38] This parallel with the Argentine situation is telling: 'To the great majority of the inhabitants of the Republic of Argentina, the Indians represent a mere remembrance from their school books that narrated episodes of Conquest and national expansion' (Bartolomé in Ramos, Ibid.:4).

Returning to doctors' statements, the specific absence of Indians is also due to the general appeal of Amazonas as an imagined composite of Otherness. Reference to 'the far awayness of the jungle,' or wanting to work in a 'really rural' place, reflect how Amazonas is considered an underdeveloped, backward frontier of civilisation, an unknown wilderness, mostly a natural space only referable to the mediated experience that TV enables.

The way going to Amazonas is often met with either objection or concern by doctors' parents reflects how bold this choice is considered. It is also common to find two or more friends going together to Amazonas boosting each others' determination to take this plunge into the unknown, creating a small safety net to better cope with the difficulties expected. This boldness is compounded by the fact that, for some, it is the first time they spend any prolonged period away from their families and urban environments.

> 'When I arrived…crying because our parents didn't agree, our parents don't agree! We were [saying] 'we are going!, we are going! we are going!'…we are really like children of Mom and Dad very delicate we don't know anything of, for example, cooking, of having to wash, or anything, none of those things, this is a reality we are going to live here...However, we took the step.'

This statement is from an interview with six newly arrived female doctors. 'We are children of Mom and Dad' is a common way of saying 'well off, pampered.' They considered this 'year away' as a passage to adulthood, a matter of entering into 'real life.' Briggs (2003:182) interviews a rural doctor caught up in the cholera epidemic in the Orinoco Delta coming to a similar conclusion: 'Campins tells his story…in terms of a coming of age as a professional.'

Another friend was offered posts in Bolivar, Sucre and Amazonas after graduation, all of which sounded too far; he preferred not leave his home region but there was no option. He was interviewed by a psychologist after having been persuaded into choosing Amazonas:

> ‘ [Talking to the psychologist] ‘Ok’ I said, ‘things put in those terms I think I will pick Amazonas but very conscious that I think that I will not like it, I mean, I am going to the jungle this has nothing to do with me, I mean, my comfort, my television, my things’…and she said to me ‘try it out and if not [if you don’t like it] well we’ll see what we can do. Quit.’
>
> [psychologist asking] ‘how do you picture yourself in that area?’ and I said ‘well I see myself eating weird things, I see myself on a *chalana* [flat boat to cross rivers], I see myself bathing in a river’ P: ‘and what does that make you feel?’ ‘well fear! [Sp. *miedo*]…I mean I never / what's more I don’t know Amazonas state.’

Another doctor after a month’s stay affirmed:

> ‘…I have lived in one month everything that in 27 years I did not live. I had never been in an aeroplane, never been in a helicopter, I had never been in an aluminium motor boat. I had never walked in a jungle, never in my life…’

For many the passage through the Upper Orinoco constitutes a dramatic ‘coming of age’ in many more than professional ways. Working in Amazonas is an experimental experience, emotionally charged with a mix of fear, insecurity and challenge. ‘Try it out, and if not...quit’; this decision is a trial.

The possibilities afforded by Amazonas extend into the professional realm. A common appeal was the opportunity of practising ‘another type of medicine’: health promotion and prevention, epidemiology, disease control programmes, and a host of public health activities not part of graduates’ previous hospital-centred experience. For some working ‘away from the hospital’ was a requirement, not just an inclination. In other cases it was a matter of rejecting the ‘hospital regime’ – sometimes a rejection of the medical internal power structures, others a desire to exercise that power oneself.

Another friend returned to Amazonas after having spent several months working in private clinics, disgusted with the way private medicine worked.

> '…the first day I arrived to work in a clinic I was horrified when I heard these things…these are normal commentaries like 'gee! I hope to receive people with insurance so I can hospitalise them straight away and get the commission'…its awful to receive a patient and to have to ask if s/he is insured.'

Wanting to be in a 'really rural place' also encodes a socially-oriented vocation varying in degree and character from one doctor to another.

But we must place these doctors within the total population of graduate doctors in Venezuela. A taste for public health, curiosity about other places and cultures, wanting to serve in 'backward' areas, willingness to live for a year far away, makes of these doctors a thin minority, a counter current among their peers. Most fresh graduates, it seems, prefer to do their rural year close to home minimising disturbances to their normal lives. In several cities of the north of the country there are hospital-based posts that 'count' for rural years, defeating the purpose of the compulsory rural service policy.

Another 'complication' that students bring up, is that a year in places like the Upper Orinoco is, in terms of a medical career, a form of stagnation (Sp. *'te estancas'*). You cannot keep up to date in a highly competitive race for post-graduate courses and the common pathologies of the area are considered boring and unchallenging.[39] These are symptoms of a more profound issue, I can only mention in passing, regarding how university curricula in medicine are geared towards a curativist, hospital-centred health delivery system.[40] Correspondingly, public health and other less clinical aspects of the medical sciences occupy a marginal place in curricula and are poorly regarded amongst students (Castellanos, 1986; Barreto, 1992; cf. Kroeger & Barbira-Freedman, 1992:90 for Ecuador and Peru). Most students in the Upper Orinoco spoke derisively about public health courses. One doctor, having realised that the only real

[39] The inability to treat 'complicated cases' in the rural clinic – these must be sent to the hospital in Puerto Ayacucho – corroborating clinical observations with para-clinical tests, and the fact that some see themselves as little more than 'distributors of medicine' are all counter incentives. These are common features of work in the primary care network that discourage doctors from this option not only in the Upper Orinoco but country-wide (Dr. Gregorio Sanchez pers. comm.).
[40] For brief reviews of the historical development of the Ministry of Health see Gonzalez (2001) and Armada (1997).

impact possible in a place like the Upper Orinoco is through disease control programmes, recalled her experience in the university:

> 'I don't know why but to be honest the majority [of public health teachers] are very bad, but bad in the sense that they don't transmit anything, and not only do they not transmit but also they are bad in the sense of not knowing…hence everybody hates public health [courses] and they call it 'public bull shit'…but really everybody hates it, its something you have to do because if not you don't graduate…we are very badly trained [in public health].'[41]

Finally, getting to the Upper Orinoco is often a matter of 'ending up.' Several of the above doctors were responding to newspaper advertisements or information on billboards: 'doctors for Amazonas required.' It is only in Puerto Ayacucho that options are discussed, considering the 'fit' between the persons' desires and the available health posts. Apart from these postings, health officials rely heavily on informal word-of-mouth recruiting, contacting students that have worked in the area or friends of outgoing doctors. Students make good candidates because they know what they are getting into. In ideal conditions 25 students work in the Upper Orinoco per year – 5 per each of the 5 health posts. Although there is the occasional period of 'competition,' during my stay the opposite was true. Of the four doctors that worked in Ocamo during Jan 2000 – Apr 2002 none had been students in Amazonas. Out of the 20-25 students of 2000 only one returned as rural doctor. During the 2001 'generation' again only one returned. The reasons for this low return-ratio are beyond the scope of this chapter; it suffices to say that a passive recruitment process contributes to temporary shortages of doctors and also precludes adequate selection of personnel.

II. 2. *Last year medical students: 'pasantes'*

Last year medical students (6th year), *pasantes*, from the Central University of Venezuela arrive every 10 weeks to each health post in the Upper Orinoco, spending 8 weeks at a time as part of their last year rotary internship. The circumstance of their

arrival to the Upper Orinoco is different to that of doctors. Contrary to the latter, most students have their mind set on going specifically to the Upper Orinoco. There is an effective transmission of 'the experience' from higher to lower year students. During my stay, Amazonas and the Upper Orinoco were highly coveted. Students' eagerness is such that, on top of a small financial support provided by the university, they spend cash of their own – often substantial amounts – to complete food and other expenses like appropriate waterproofs or boots.

Students' motivations were more focused on the appeal of the Yanomamɨ and the jungle, based on the fantastic stories elder students tell on return from 'life changing' experiences.

> 'Well, basically all the people they have come here [Upper Orinoco] have told me this experience has changed their lives, everybody…all the people that have come to the Upper Orinoco have told me: my life before and after…and I wanted to live that, live what ever there is here that divides everybody's life into a 'before' and an 'after.''

Although they also speak about the less romantic aspects of the Upper Orinoco, and some students cast their experience as a catalogue of environmental, social and medical hardships, most always have plenty of stories. Beautiful places, particular friendships with Yanomamɨ, shamanic curing, fishing, specific medical cases, all portray living with the Yanomamɨ in exotic and challenging terms.

These tales create an imagined Upper Orinoco that almost becomes a checklist of 'musts' to exploit the full potential of 'the experience.' Correspondingly, once there, students are normally very eager to engage in all medical and non-medical activities. Specially men tend to be keen on joining the Yanomamɨ on fishing or hunting or trying *yopo*. Exchanging or buying arrows, feather ornaments, baskets and taking pictures gives student stays an important element of cultural tourism. A strong eagerness to visit the upriver, more traditional communities is also very common. I noted in several students a sense of exchange: expectations and efforts in coming to

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[41] This situation might be most representative of the Central University where the students and this doctor come from. It was clear from other doctors trained in other universities that public health's

the Upper Orinoco should be compensated with upriver trips and other activities of the 'full package.'[42]

As with doctors, for many students the experience is a self-test: 'will I survive eight weeks in the jungle? Will I manage to relate well with the Yanomamɨ?' Those who go to the Upper Orinoco, again specially the men, gain a reputation of 'rough goers' to which some prestige is attached within university circles. As one friend put it:

> 'There is a reputation that going to Amazonas is like an elite of the students, those who are most 'rough goers' [Sp. *guerreros*]…the most adventurous, that is, if you are really *macho* you go to Amazonas, or if a woman is really *macha* she goes to Amazonas. Now if the ones who go to Amazonas are tough, then those of us who go to the Upper Orinoco are like the highest elite…'

Only a minority of students choose the Upper Orinoco as a trial for their rural year. Normally they see this as 'an opportunity of a life time.' A matter of 'been there, done that.'

> '…that is why I wanted to come here...it's a unique opportunity, unless you come here as a rural doctor it is highly unlikely that you will have the chance to come here in other circumstances.'

The Upper Orinoco is a passage point, a side step, as opposed to a first step, in doctors' careers.

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We have so far particularised 'the doctor' by discussing the motivations of both rural doctors and students. In doing so we have gained a perspective on the plurality of interests that bring people to the Upper Orinoco. In 'Amazonas,' a diffuse sense of Otherness, in geographical, environmental, cultural, professional terms, is found in different blends from one doctor to another. Students on the other hand, are attracted

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status varies.

[42] It must be stressed that I am in no way questioning their dedication or the quality of their medical work.

to specific ideas of place and people constructed by the circulation of accounts giving their experience a character of adventure travel. For both doctors and students the Upper Orinoco constitutes a passage point of professional and personal maturation. For both, the experience – a year or two months – has a variable experimental component which adds to the normal insecurities of new or soon-to-be graduates, specific fears, senses of challenge and curiosity regarding the unknown.

II. 3. *First impression accounts*

In the second part of this chapter I will explore accounts of first impressions of the Upper Orinoco. I will discuss two opposed views of Yanomamɨ, as positively valued naturalised Indians and negatively valued petty thieves and irresponsible patients. The naturalised Indian is evident in a set of interpretative proclivities, aligned with the notion of Amazonas as a natural space, attributable to the mediated knowledge reproduced in 'the West' about 'primitives.' The other view is part of the circulating discourse that doctors learn through contact with those who have worked in the area in the process of getting to the Upper Orinoco. It is important that we dwell on these ideas for several reasons: a) we will follow them, examining doctors' views, throughout the thesis (Chapters VI-VIII); b) Doctors' discourses about the Yanomamɨ differ from those of local *criollos* or more 'acculturated' Indians, allowing us to dissect, at least minimally, an often too generic 'popular perception' or 'national society' found in anthropological literature; c) Because they reflect preoccupying parallels with colonial situations which should be corrected to avoid making doctors the unwitting sustenance of these types of relations.

II. 3. 1. The naturalised Indian

There is a proclivity to positively evaluate initial situations, sometimes associated with a proximity to nature, other times phrased in terms of the negative self-evaluation of all things Western. The propensity is more commonly articulated when Yanomamɨ practices, like dressing with western clothes, smoking, or eating tinned food, are assumed almost always as 'our contamination.' The sometimes incessant request for clothes or food is explained as the result of missionary or political paternalism, something from outside, not a 'Yanomamɨ thing.' The 'simplicity of life'

as opposed to the hectic city is frequently admired. The following student's statement reflects some of these points:

> 'You see how the Yanomamɨ see the world and you realise that the strangers here are us, the ones that are seriously mistaken here are us. It is not them that are mistaken, it is us that are mistaken, it is us that wear clothes. Hence, the belief that we have of greatness, that we are the unique beings of the universe, changes, we are completely mistaken!'

One doctor was familiar with Guajiro (Wayuu) Indians; he expected something similar in the Yanomamɨ. The following is an account of his arrival at the port in Ocamo, where it is common to find a small gathering of Yanomamɨ summoned by the noise of an approaching motor:

> '…the motorist…was the first Yanomamɨ I met but he appeared / since he was dressed and all, I mean nothing like / well he had his indigenous features…because the Guajiros don't dress like Guajiros anymore but rather as anyone of us…they are Indian because they have Indian features and come from their ethnic group…they are already part of a totality and probably that was what I was / what I expected to find…But when I saw that [people in the port]…I was impressed by the fact of finding Indians in that way, women without their thing [no shirts]…'gee how good! with their children.'

Being in the city and not wearing traditional clothes makes the Guajiros less Indian more like 'anyone of us' than the Yanomamɨ. The image of the semi-naked women carrying their children after a journey into the jungle is the image of nature itself. The positive valuation is revealed in the exclamation: 'how good with their children.'[43]

In general, the us/them divide is an axis of interpretation, placing Indian and Western at opposite ends of a continuum with static/good/nature at the Indian pole. Movement is only possible in one direction (worse/West/future). Nature is the source of what is good in Indians, part of nature themselves. Departure from the source –

[43] The salience of the body as a marker of authenticity has been recently treated by Conklin (1997) and others. I will touch on the more general subject of Western aesthetics and it relation to indigenous action in Chapter VIII.

geographical or in terms of increased mediation (clothes, manufactured objects) – is an index of degradation in the Western direction. Moreover, to become more Western is to lose something Indian; cultural change is cultural loss.

The common usage of temporal makers like 'still' or 'not yet' in expressions like 'they still do X or Y' is sometimes an expression of a belief in the inexorable westernisation of Indians, other times an assumption of a social evolution making Indians 'contemporary ancestors.' Those who have a chance to socialise with the neighbouring Yekuana often compare them and see the former as less Indian and closer to us than the Yanomamɨ 'who still…'

The primitivism and evolutionism evident in these statements is problematic. First, as others have discussed (Thomas, 1994; Slater, 1996) the naturalised Indian works to the exclusion of those who don't easily fit into this image. The exclusionist effect of the imposition of Western aesthetic values found in some expressions of the environmental and indigenist movement, allies of the Amerindian cause, has also been discussed (Ramos, 1998; Conklin, 1997). It is this same essentialised naturalisation that, in the negative guise of 'savages' – sub-humans better extinct or assimilated – is ammunition against Amerindians (Ramos, 1998:48; Albert, 2000:256). Second, an evolutionist discourse, however sympathetic to indigenous life, implicitly places the commentator at a different time and stage in an imagined route of universal progress, a well known self-critique within anthropology itself (Fabian, 1983). Third, primitivism, as a positive valuation of a 'simple' life (Thomas, 1994), also implies the superiority of a more complex commentator normally biased by his/her own notion of culture (books, edifices, technologies, etc.). Encountering little of this, the 'simple life' encodes a lack of potential for human achievement. On this regard, I remember a student's report – produced at the end of the two-month stay in the field – which labelled the Yanomamɨ spirit world an 'embryonary religiosity.'[44] Fourth, the essential good natural Indian is deprived of agency. In this view Indians adapt to nature and, in the case of modernity, the only option is maladapted Indians (cf. Briggs, 2003:156-7).

[44] These reports have a standard format. They normally include brief descriptions of the geography, climate, people/culture before describing the student's activities in the field and presenting epidemiological summaries of the health situation among the population where they worked.

Some doctors' initial positive disposition also takes the form of making room for cultural differences. In the following example two new doctors were treating a baby that required an intravenous solution. Met with the mother's refusal they only performed part of the treatment. In the morning one went to remove the clinical tapes from the child's arm.

> 'This morning when I removed it, she didn't let me again, she put water on it first…and she took it off…it was stuck – the tape is very strong – so she poured water on [the arm]… she let me do the last part.
>
> [other doctor]: 'She is giving me an example, I mean [paraphrasing the mother's thoughts] 'you must realize that its hurting, there are other ways of doing it, lets pour some water on it, lets rub lightly, ok?'…in the city one is used to doing everything fast…so undoubtedly I think of the richness I am going to take [from here]…'

A potential 'difficult mother' becomes as a caring mother who, through the delicate treatment of her child, teaches them that there is no need to be coarse. If avoiding pain takes more time and gentleness, then so be it. The loss of humanity of the bustling urban hospital is made evident by an unwitting cultural critique.

It is important to note that the essentialist naturalisation of Yanomamɨ doesn't exist in isolation within new doctors' imaginations. It is patent all over Puerto Ayacucho where Yanomamɨ are the prime image of the Indian in nature. In the airport, some restaurants and sites of tourist concentration, Yanomamɨ are depicted in paintings as naked bodies with traditional adornment, often with a bird in the same frame.

Figure II.2: Paintings of naturalised Yanomamɨ.

II. 3. 1. The difficult Yanomamɨ

When doctors arrive in Amazonas they are put through a relatively standard induction process during which they learn the general functioning of the regional health system (regional epidemiology; diagnosis and treatment of malaria; anthropological orientation.) This induction tends to last anywhere between one and three weeks, curtailed or extended by the logistical constraints of getting people into the field. Efforts are made for outgoing doctors to overlap for a few weeks in the field with incoming ones. In any case, it is often delegated to people that have worked in the Upper Orinoco to instruct new personnel in the more practical aspects of the job. It is here that most doctors get their first references of the Yanomamɨ. I asked several doctors what they remembered of this informal instruction with regard to the Yanomamɨ. This friend had spent some time with an outgoing group of students:

> '…everybody [students] would tell me: 'Ocamo is China town, its *malandro*'[45] 'but *malandro* in what sense?'…I would ask them why, they would laugh…'but what do they do to you? Do they steal your food?'
>
> Student: 'well sometimes.'
>
> Doctor: 'Do they steal your clothes?'
>
> Student: 'yes, I had some underwear stolen' [another student] 'I had a tiger skin stolen…'

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[45] Venezuelan Spanish term designating petty thieves, low lives, or thugs. It is associated with urban shanty towns.

Doctor: 'but what else?'

Student: 'they leave and they don't follow the treatment [take all the pills they have to]…'

All new doctors and students, keen to know what to expect, receive this practical information on how the Yanomamɨ are and how to deal with them. Thieves, deceivers, or 'difficult' are rarely absent adjectives. As patients Yanomamɨ are typified as 'difficult,' not fulfilling complete treatments and hence 'irresponsible.'

'Petty thieves' or 'irresponsible patients' is clearly not the only 'data' passed down on the Yanomamɨ, but it is frequent enough to be a stereotype and in this sense, regardless of its experiential foundations (Chapter VI), is no less problematic than the naturalised Indian. They are produced in similar conditions of imbalance in the production of knowledge about others. Yanomamɨ don't participate in this induction process, they are talked about and not with, having no say over the representations that circulate about them. Outgoing doctors, students and the anthropologist, at the expense of Yanomamɨ themselves, are credited with the role of 'the expert,' who can speak of others who can't speak for themselves.

Primitivism, evolutionism and stereotyping resonate with colonial situations even when the operation of the health system is far from being an instrument of oppression, or Yanomamɨs' use of it a form of resistance. On the other hand, Yanomamɨ also produce and circulate discourses of *criollos* and doctors to great effect (see Chapters VI, VII). I found that some assign this knowledge with the authority that a seasoned, experienced person confers and are initially at a heightened state of alert, vigilant not let him/herself be fooled. Others, on the contrary, tend to disregard these comments in an effort to make up their own minds about the people.

This is clearly not an exhaustive list of what is transmitted among students and doctors. A lot of effort is invested in teaching the 'art of medicine' in the field: the appropriate malaria treatments, specific ways of dealing with dehydrated children, appropriate use of antibiotics, key Yanomamɨ words, etc. A crucial void in this

induction is historical accounts of the development of the health service and other state presences within the Upper Orinoco. There are no aids like a doctor's manual.

Before continuing to our third section let me make one observation. We must note the absences, in these accounts, of words like 'irrational' or 'civilised' to refer to Indians or *criollos* respectively. This vocabulary, so entrenched in *criollo* Amazonas and internalised by 'acculturated' Indians, is not found in doctors' accounts. It did come up in interviews with long-time *criollo* 'regional' health personnel (e.g. malaria crews) who had worked with the Yanomamɨ and some conversations in the hospital in Puerto Ayacucho with *criollo* nurses. This suggests an important distinction between discourses and valuations of middle class urban doctors and other health workers of Amazonas.

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We have so far particularised the doctors by exploring their motivations and 'first impression' accounts. In these two ways we have advanced in sharpening the focus of the 'front end' of the health system towards the Yanomamɨ. Our third and last step is to discuss some of the implications of having the rural year scheme among the Yanomamɨ.

II. 4. *The rural year scheme among the Yanomamɨ*

II. 4. 1. A discontinuous 'front end'

The yearly rotation of doctors and bimonthly rotation of students engenders a system whereby the on-the-ground operative level is most of the time in a slow learning curve. Each new doctor spends several months learning how to run the clinic, manage people, treat patients, speak a language. Doctors normally say it was towards their final months when they managed to 'have things under control.' As soon as a new person arrives relations must be made anew, the way of doing things changes, the same mistakes reappear, personal methods are tested and finally some way of working stabilises, but not for long. High turnover rates make of the health system a

discontinuous process towards the receivers of this service.[46] This discontinuity cannot be underestimated because it is incompatible with the importance Yanomamɨ place on co-residence (and other forms of mutuality) in the construction of affect and trust. This will be discussed later in the thesis. The discontinuity I will discuss here consists of ever-changing personal policies in running the clinic and other aspects of relations with the Yanomamɨ that, in themselves, contribute to a more confrontational relationship with doctors.

The management of clinic resources (motor, gasoline, boat) provides an example. One year a doctor might be relaxed in the management of these resources, typically lending them to a group of privileged friends, helpers or influential people. The next doctor may attempt a strict control over resources and monitoring of Yanomamɨ health personnel. I will discuss the dynamics of these changes in Chapter VI, for now suffice it to say that these changes of this kind had a profound impact on relations with the doctors that traversed Ocamo during my stay.

Another common shift relates to the doctors' residence. One doctor might be inclined to share with Yanomamɨ and encourage friends to join in meals, chat, etc. The next might want more privacy cutting these reunions to a minimum. I knew of one case of a doctor who adopted a 'no Yanomamɨs in the house' attitude. In La Esmeralda, some made a habit of speaking to Yanomamɨ through the bars of a closed door.

A crucial difference is also found in the administration of treatments. One doctor will personally administer every dose of a malaria treatment (7-14 days) or other long-term treatment to ensure it is completed. The next might think it is necessary to instil responsibility, giving patients whole sets of pills to take home without supervising the medication. One doctor will love to visit upriver communities as regularly as possible, the next might not be so inclined, making less effort to comply with the ideal visitation scheme.

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[46] There are areas of Amazonas in other health districts where Simplified Medicine Auxiliaries occupy a more central role in the rural clinic providing more continuity *vis a vis* the communities than is the case in the Upper Orinoco.

In short, important aspects of the health system like the frequency of visits, area of coverage, resource management and administration of medicine are (not exclusively) subject to the particular styles of running the clinic. These short-term changes add to the more long-term policy discontinuities related to the lack of a coherent health policy for the Yanomamɨ and the variability of dedication and priorities set by different Regional authorities (Chapter IX).

II. 4. 2. Inexperience and anxiety

We cannot underestimate the fact that these doctors have little experience of unsupervised medical practice. Specially in 'life or death' situations, inexperience in terms of handling ethical decisions when negotiating with Yanomamɨ relatives is the source of much anxiety and desperation. It is hard to imagine a more radical change from a supervised university environment, where life-death responsibility is not on you, to assume this responsibility in such unfamiliar circumstances. On the other hand, rural doctors' educational background prepares them poorly in terms of public health and personnel management, key features of work in rural areas (cf. Marquez, 2002:28). Add the fluctuating feelings of loneliness, the loss of urban facilities, the frequent sense of abandonment within the health system itself, and the oppositional character of *criollo* – Yanomamɨ relations, and one can see how the Upper Orinoco can become overwhelming. Although most doctors I spoke to remember their time with the Yanomamɨ in a positive light, none would deny the extreme emotional wear of periods of anxiety, insecurity, despair, depression and frustration. Taking all into account it is a hard step into the 'real world.'

II. 4. 3. Non-corporeality and a 'cold system'

Because both doctors and students are transient and in passage, a sense of belonging – to a system; a project with a goal – is often hard to maintain and progressively erodes in time. Students, in particular, sometimes neglect the consequences of their actions, a possibility afforded by the brevity of their stay. Here Salesians afford us a comparison. When missionaries talk about their institution they do so as members of a corporate body. Doctors' sense of corporeality is weaker, often criticising the health system as if not belonging to it. This high turnover rate of doctors and students compounded by a

lack of historical information (medical and otherwise) gives a degree of timelessness to the health system. Each doctor passes on aspects of his/her year's experience but important events, people and changes of the past 50 years are often ignored. As a result the health system, in its regular repetition, remains in constant infancy among a people who, in contrast, grow old and face the same episodes over and over. In this sense the health service takes on the 'cold' qualities of a system without history or change,[47] this being an in-built limitation to expand and/or improve. Repeating its incipience, it is the Yanomamɨ who can see the system as a historical process that normally doctors ignore.

Of course the health system has evolved in time but it is only when a minimum, stable network of people have remained as part of a single project that these changes have occurred. In 1985 the Parima–Culebra project managed, in a matter of 3 or 4 years, an infrastructure, logistics, a way of working in the field, of obtaining medicines from Caracas, of recruiting personnel. This involved a collective effort of a few doctors linked to this project for several years. Further important advances like the training of Yanomamɨ malaria microscopists, or the construction of a 'health centre' in La Esmeralda are all examples of progress made possible only by a minuscule number of people who have maintained an interest in the health system throughout the years.

Concluding remarks

In this chapter we have progressed, in three ways, in characterising the doctors and the health system in the Upper Orinoco. In doing so we have also learned about the rural year scheme and some aspects of recruitment and 'ending up in the Upper Orinoco.' A few comments in this regard.

First, the rural year scheme, with its high rotation of doctors, is incompatible with the inherent importance of permanence and co-residence for the carving of affect and trust with outsiders in Yanomamɨ sociality (cf. Kroeger & Barbira-Freedmann, 1992:100). This is, however, a structural problem. The lack of incentives for medical professionals to assist in rural areas is a nation-wide and Latin American problem

[47] I use this Lévi-Straussian terminology conscious of the misinterpretation it has been subject to. For critiques of this misreading of Levi-Strauss's 'cold' and 'hot' terminology see Hugh-Jones (1988) and

(Marquez, 2002). Some measures are planned in the Yanomamɨ Health Plan to make the Upper Orinoco more appealing for graduates, like more training and special treatment for entry in postgraduate courses (MSDS, 2000:31). The addition of specialised university courses on traditional indigenous medicine is also an option promoted within the Ministry of Health (Rivero *et al*. 2002) as well as the Pan-American Health Organisation (PAHO, 1998).

Another parallel and necessary step is to increase the training of Yanomamɨ health personnel (nurses and microscopists) which is in keeping with Yanomamɨ expressed desires for greater autonomy in managing their health problems (Chapter VIII). Ideally, both because of the structural limitation of having doctors reside long-term in the Upper Orinoco, and because it is aligned with Yanomamɨ's desire for greater control, the system should progressively move from being 'doctor intensive' to being 'Yanomamɨ intensive,' offering the latter alternatives for more training and in-depth knowledge in all aspects of the health system. The inclusion of more technical-level health professionals as opposed to doctors would also counter the discrepancies between young doctors' career expectations and the possibilities offered by the Upper Orinoco.

Second, subsequent chapters will reveal that newcomers' assumptions of encountering a static 'ancestral' culture stand in stark contrast with a historical process of 'becoming *napë*,' a collective self-transformation Ocamo Yanomamɨ cast in terms of an ongoing trajectory of becoming 'civilised.' The interpretation of the acquisition of *criollo* habits as 'cultural loss' is equally at odds with this 'civilised' self-appraisal.

In our next six chapters our analysis turns more to the Yanomamɨ themselves, using interspersed aspects of 'the doctors' side of the story' as a counterpoint to the analysis. In our final Chapter IX we will retake the analysis of the health system itself as part of a regional and national organisation.

Gow (2001).

Chapter III: Epidemic diseases, *criollos*, and the morality of being human

This chapter explores some aspects of the historical relations between Yanomamɨ and *criollos* with a particular emphasis on epidemic diseases. Drawing on Albert's (1988) analysis, we follow the innovative transformation of the Yanomamɨ conception of *shawara* from a type of 'war sorcery' to an ontologically *criollo* form of disease. This conceptual shift corresponds with the redefinition of *criollos* from ghosts, to enemies, to friends/allies according to Yanomamɨ socio-political space as described by Albert (1985). This discussion will compare engagements with early extractivists and missionaries as relations of opposite quality – negative and positive respectively – determined by the degree of conformity to a Yanomamɨ 'morality of being human.'

III. 1. *A baseline*

Before entering this analysis we must provide some base material that will allow us to understand this and the subsequent discussions. Given that these topics have been treated extensively in the literature, risking excessive reduction, I will limit myself to summary descriptions without attempting detail.

III. 1. 1. Constituent parts of the person

A major distinction made in Yanomamɨ conceptions of personhood is an external-material/internal-immaterial dichotomy: *pei sikɨ* 'skin, any envelope' and *pei hushomi* 'inside'[48] or *pei mɨ amo* (*mɨ amo* meaning the centre of something, the middle) (cf. Albert, 1985:139; Lizot, Unp.:220). The *pei mɨ amo* is a vital immaterial aspect of the person you cannot live long without. It is subject to be devoured or stolen by supernatural agents; if the latter, shamans must recapture and reinsert it into the person.

[48] *Pei* is a term used to designate all parts of the body or its products (urine, saliva, etc.). It is also used in reference to parts of a whole, like branches of trees or streams of a river system (Lizot, Unp.:320). *Hushomi*, means 'inside, bottom of a container' (Ibid.:125).

Pei no uhutɨpɨ: A 'vital image,' an immaterial aspect of humans, animals and objects. Albert (1985:146) calls it the 'fundamental vital principal'; it also designates all forms of visual or audio reproduction (e.g. drawings, recorded voice). Lizot (Ibid.: 283) refers to it as, 'reflection, emanation, immaterial constituent of living things…' The *pei no uhutɨpɨ* of a person or part of the body can be taken by supernatural entities, causing illness and death if not recaptured and reinserted. It is also the *no uhutɨpɨ* of *hekuras*, 'shaman's helper spirits,' 'spirits of the forest,' that descend onto the shaman when he transforms into them under the effect of hallucinogens.

Pei noreshi: A person's animal alter ego living in remote parts of the forest so as to preclude mutual encounters.[49] This animal shares with the person its physical fate. If the one is ill or injured so is the other; if the animal dies, so does the person. *Noreshi* in Ocamo also refers to images: photographs, drawings, figurines, are all *noreshi*.

Pei puhi: Strictly meaning 'the face'; I was told it was '*pensamiento*,' one's thoughts. The word *puhi* enters into all Yanomamɨ concepts that refer to intellectual or emotional activity, it can then be thought of as 'consciousness' (cf. Lizot, Ibid.:343; Albert, 1985:141).

Pei no porepɨ: According to Lizot (Ibid.:277) and to the usage I encountered in Ocamo, *pore* is an 'immaterial principle produced by the liberation of the *pei mɨ amo* upon death.' Albert (1985:143-45) finds it is the origin of non-conscious activity like dreaming, shamanic trance, involuntary movements, alterations of consciousness due to illness, etc. Following Albert we can call it a 'spectral form,' a kind of 'dormant ghost' within.

Pei mɨshia: Strictly it means 'breath,' but in shamanic contexts it is associated with life (Lizot, Ibid.:231), and in this way people can speak of the *pei mɨshia* as what has been taken from a person and needs to be recovered by the shaman. Albert (Ibid:146) describes the *mɨshia* as being related to the *no porepɨ* form since they are simultaneous signs of death: you die when the *no porepɨ* leaves the biological body, a moment accompanied by the last expiration.

[49] The exception to this rule is the harpy eagle that may live close to its human counterpart (Lizot, 1985).

Using the distinction made by Albert (Ibid.:164) and based on my observations let us distinguish a biological body, *pei sikɨ*, from an 'ontological' one which refers to the vital immaterial aspects: *pei mɨ amo*, *pei no uhutɨpɨ* and *pei noreshi*. All illness, beyond temporary and minor discomforts or pains, is an alteration of the integrity of the ontological constituents of the person. The dissociation of any of these forms by abduction or injury to one of these elements by material or immaterial objects such as darts, burning or predation, are the most common recognised causes of illness and death. Correspondingly alterations of consciousness are indexes of dissociation of ontological integrity, associated with the proximity of death. More speculatively, breathing is a similar index. Serious breathing alterations are equally signs of near death. The later stages of many respiratory diseases, very common in children, are marked by strong breathing alterations, causing great alarm.[50]

The last element to establish the linkages between the ontological and the biological bodies would be the blood, *pei ɨyë*. Albert (Ibid.:348-351) has discussed blood as 'the fundamental biological substance' associated with the *pei no uhutɨpɨ*. It is the principle agent of physiological activity. In illness the dissociation of the ontological body corresponds with the 'corruption of the [body's] flesh envelop that is essentially that of the blood that impregnates it.' (350)[51]

In short, all alterations of the ontological body have a biological manifestation. Blood, consciousness and breath are bio-psychological indexes of ontological health/integrity.

III. 1. 2. Aetiology

Let us now explore the causes of illness. I will only present what is necessary for further understanding.[52] Most illness can be explained by:

[50] Often it is suckling children who, at stages of extreme breathing difficulty, stop breast feeding. The impossibility of breast feeding is most despairing for mothers who, with that signal, fear the worst for their children. If feeding is a prime maker of kinship (see below), the negation of breast milk due to breathing difficulty is a kind of negation of humanity, a denial of kinship.
[51] We shall see in Chapter VII how Ocamo Yanomamɨ speak of intravenous physiological solutions as 'making you strong' and 'to avoid the blood running out' which is congruent with Albert's observations linking blood and biological vitality.
[52] On this see Albert (1985), Lizot (1998:32-33) and Alès & Chiappino (1981-2).

a) The abduction by supernatural entities of an aspect of the person. People most commonly refer to the *pei mɨ amo* or *pei no uhutɨpɨ*. The more common agents behind these aggressions are a) *yai*, to which people refer to as 'demons,' evil spirits; b) *pore*: ghosts of the dead; c) *hekura*: spirits of the forest (animals, plants and some natural elements). *Hekuras* are associated with large rocks and mountains, these being their dwellings. They are also the shaman's helper spirits that can be directed by them to attack the *pei mɨ amo* of people or cause devastating winds affecting entire communities. *Hekuras* have specific abilities and tools that enable a shaman to perform particular tasks in curing, defending the community or attacking enemies (e.g. arrows, machetes).

b) Harm to the *noreshi*. The animal alter-ego of a person may be wounded or killed (e.g. hunted by Yanomamɨ who live in unknown territories). The *noreshi* of small children is associated with a particular lizard. Occasionally this *noreshi*, that lives near them, goes missing and must be found again by the women lest the child die (Lizot, 1985:175).

c) *Shawara*: Also referred to as *nɨ wari*, are another class of supernatural beings. The shamans see them as burning light and refer to them as tiny demons that eat your blood/flesh. They are responsible for a series of illnesses and epidemics in general (Lizot, Unp.:391). Infecto-contagious diseases such as diarrhoea, flu, whooping cough, pneumonia, malaria, measles are all classed as *shawara*.

d) Use of *hërɨ* and manipulation of people's objects or footstep. *Hërɨ* refers to a range of magical substances derived mainly from wild or cultivated plants but also from insects or animal hair (Ibid.:60). They have a range of beneficial and negative effects: illness or death (with a variety of symptoms),[53] sterility, love magic, etc. *Hërɨ* can also be used on children as preventive of certain affections or to make them 'grow fast.' Prepared either as a drinkable concoction and/or rubbed over the body, they are also used as 'plant medicine' to reduce symptoms

[53] Albert (1985:249) mentions: breathing difficulty, fevers, muscular pains, head aches, etc. In Ocamo the most common reference to being *hërɨpɨ* (struck by *hërɨ*) was a strong head ache that would not pass with medicine and required the intervention of a shaman.

of illness. *Hëri* used for harm is normally blown with small blow pipes by enemy sorcerers hiding in the forest. One can also be struck with *hëri* whilst on visit in another community. Illness and death can also be caused by taking a personal item (like the tobacco wad) or earth from a footprint and later adding *hëri*. It is also whilst visiting another community that one can be subject of this type of sorcery. According to Albert (1985:251) *hëri* burns the *pei no uhutipi*, the blood drying up with the heat. During shamanic curing it is the *hekura* that will counter the *hëri's* action by themselves burning it. (cf. Lizot, Unp. b.:35).

e) Breaking of taboos: the breaking of certain alimentary taboos, or non-observance of the *unokai* murderers' (and female first menses, see Lizot, 1996b) ritual is detrimental to health. In this category we can also include the state of *toteshi* associated in Ocamo with an ongoing diarrhoea caused by the breaking of the parents' sexual interdiction before a child has weaned or is walking (cf. Lizot, Unp.:430). A child's ongoing respiratory difficulty can also be explained resorting to the non-observance of the sexual interdiction after drinking the ashes of a dead person in a *reahu* funerary feast.

Even accidents like snake or other poisonous bites can be interpreted as having an intentional agent, a *hekura* commanded by an enemy shaman, behind them (Lizot, 1985:115).

Albert (Ibid.:164-87) distinguishes two main phases of morbidity. The first is spoken in terms of localised symptoms in the body (*pei siki*) without apparent cause. If the symptoms don't improve and the person's state degenerates, an explanation involving the ontological body (*pei mi amo*) is sought. Characteristic of this phase, Albert explains, is the progressive and generalised alteration of consciousness, normal perception and corporeal sensation (Ibid.:168). The process of illness and dying is a matter of inverting the normal healthy situation whereby consciousness (*pei puhi*) is 'in control' and the unconscious 'spectral form' (*pei no porepi*) is 'dormant.' As the ontological body suffers dissociation or injury, the dormant *pei no porepi* takes over as the person becomes a ghost (*pore*) which is the final outcome if death occurs: the *pei mi amo* liberates a ghost (*pore*). We shall see, in Chapter VI, Ocamo expressions resonating with this description.

III. 1. 3. Illness and socio-geographical space

To complete our baseline we must tie the above aetiologies with the Yanomamɨ classification of social-political space described by Albert (1985).[54] A major distinction lies between human and non-human aggression on the ontological body. Attacks by supernatural beings like the *yai*, *pore* or *shawara* ‘demons of disease’ are non-human aggressions and expressions of maximum social alterity beyond the spheres of human social alterity we shall now summarise.

The inner most sphere of sociality is that of co-residents (*yahi t^{h}erimi*), those who live in the same village (Y. *shapono*). This is an ideally independent endogamous social-political unit, ‘a type of ideal sociological self, cemented by a network of dense intermarriages and by a system of generalised economic reciprocity (quotidian exchanges of food and services) between affines.’ (Ibid.:202). This is the ‘centre’ of the socio-political space to which no illness-causing human aggressions are attributed.

The next sphere is the ‘*ensemble multicommunitaire*,’ a group of proximate communities of ‘friends’ whose political alliance is fostered by the necessary intermarriage resulting from the impossibility of maintaining the ideal, endogamous group. These communities, linked by affinal ties, engage in continuous visits and exchanges of goods. They are also co-participants of the cycles of funerary *reahu* feasts where ritualised exchange of goods and ceremonial dialogues surround the ritual complex of preparing, distributing and consuming the ashes of the dead, maintaining a ‘balanced reciprocity.’ To this social sphere Albert links what he calls ‘alliance sorcery’ which he divides in three types: a) love magic; b) ‘common sorcery’ that causes ‘somatic or psychological troubles…associated with conflict involving economic, matrimonial or ceremonial exchange’ (Ibid.:240); and c) equally motivated ‘footstep-taking sorcery.’ All these actions involve a wide range of *hërɨ* substances. The common context for this type of sorcery is feasting or other occasions that involve visiting *shaponos* within the ensemble. This type of sorcery

causes illness requiring shamanic intervention for its cure and should not be lethal. A higher lethalness is attributed to footstep-taking, associated with enemies that, through the articulation of an ally of ego in a visiting context, obtain the stepped-upon earth or personal object to be manipulated.

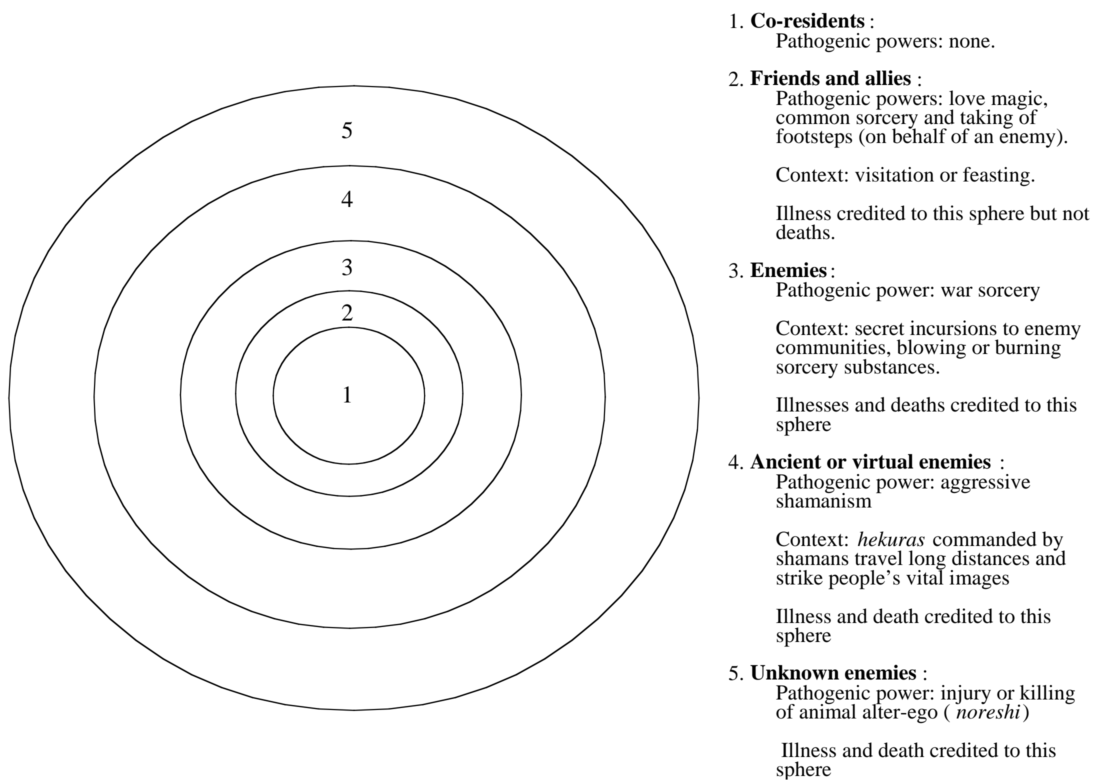
The next sphere is that of enemies (*napë tʰë pë*), more distant communities with whom 'negative reciprocity' on economic and matrimonial levels holds (Ibid.:218). These can also be targets of war raids and are credited with 'war sorcery.' Enemy sorcerers secretly approach the *shapono* and, with a blowpipe, blow darts with *hëri̵* on an inadvertent person in the vicinity of his/her community or simply blow *hëri̵* dust on top of the victim's head, hoping to cause their death. Another modality is to mix *hëri̵* with something to be consumed by the victim (e.g. plantain soup/juice). A third modality is that of burning a specific *hëri̵*, releasing a pathogenic smoke that causes an epidemic in hope of multiple deaths. This modality is related to *shawara* on which I will expand below.

Next is the sphere of 'ancient or virtual enemies' constituted by diffusely-known communities at such a remove that no real material or matrimonial exchange occurs, only mutual exchanges of symbolic aggression (Ibid.:219). To this sphere corresponds the modality of 'aggressive shamanism' whereby enemy shamans command their *hekura* spirits to attack people's 'vital images.' The main targets are children occasionally resulting in death.

The last sphere is that of 'unknown enemies' whose approximate location and existence is known by rumour (Ibid.:220) and with whom only symbolic aggressive exchanges are sustained. To this even more diffuse category of people is attributed the injury or killing of animal alter-egos. Based on Albert's (Ibid.:336-8) own summary, figure III.1 illustrates the directionality of social alterity and lethalness attributed to each sphere.

[54] This work has been done among the Yanomam in Brazil; I am taking it as valid for the Yanomamɨ. Alès (1990:75-76) provides a description of the Parima Yanomamɨ in Venezuela which very much coincides with Albert's analysis.

Figure III.1: Yanomamɨ socio-political space.



If we add non-human agents beyond these spheres, a socio-political and cosmological space, centred on the *shapono* (co-residents), expands. Increasing geographical and social distance go in tandem. In the outward direction, as real material exchanges decrease, symbolic ones increase as does the lethalness of the pathogenic power associated with each sphere. This ideal pattern will constitute our baseline throughout the thesis. Let us call it the 'Yanomamɨ conventional space.'[55]

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Having provided this base material, useful for all the thesis, I will now proceed to give an account of the origin of *shawara* before discussing its role in the interpretative trajectory of *criollos*.

III. 2. *Origin of shawara (epidemic diseases)*

> 'Long ago when Õmawë and his brother lived in this region there were no epidemics. It was when they turned into two malevolent beings that sickness and epidemics appeared; they created them. No, during the childhood and adult life of the twins there was no sickness. There were no diseases caused by spirits, only those caused by people who were familiar with certain magic plants which they burned to make one another ill. That was all there was. Õmawë and Yoawë engendered the spirit Õmêyêri and the rainbow; that was the origin of epidemics that appeared everywhere. That was when the epidemics came.' (Lizot in Wilbert & Simoneau, 1990:423).

What is twice stated in this narrative is that epidemics (in Lizot's (1989:253) Yanomamɨ text version epidemics are referred to as *no warɨ kë kɨ* or *shawara kë kɨ*) are not of Yanomamɨ origin. They are the creation of *yai* demons, extreme expressions of social alterity, beyond the spheres of Yanomamɨ (human) sociality. In Ocamo the *yai* are always spoken about as aggressive to human beings and considered powerful and lethal when they abduct peoples' vital aspects. People also say the rainbow or the red-coloured twilight skies are omens of epidemic diseases, *shawara*.

In the Yanomamɨ text, the 'magic plant' mentioned is a very powerful type of *hërɨ* called *oko shikɨ*, literally 'crab guts,' prepared by women and supposed to attack all the men of a community. The preparation is burnt and its smelly smoke is blown by the wind towards the enemy group. The verb used in the Yanomamɨ text is *he ya-* : 'to burn an malefic substance in the proximity of the residence of enemies to cause their death' (Lizot, Unp.: 88). Both substance and method correspond to one of the three types of 'war sorcery' Albert (1985:295) distinguishes, attributed to the sphere of enemies. This type of sorcery is precisely meant to cause collective epidemic-like disease or death *via* pathogenic smoke called *shawara wakëshi* or *wakeshi a wayu* (Ibid.:296). The myth seems to be saying that the closest indigenous referent to the *shawara* demons of disease created by the *yai* is this type of sorcery that a) is caused by enemies b) has collective effect and c) uses odorous smoke as its vector.

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[55] We must underline that communities within each of these socio-political categories vary depending on the historical evolution of political, economic and marital exchanges as well as geographical movements and processes of internal fission.

Another myth, however, suggests a similar yet alternative origin to *shawara* diseases. Omawë's son-in-law is skinning a bird whose feathers fly away; as he chases them, the bird (feathers) say 'skin, skin, skin'; the son-in-law returns in fear to Omawë who recognises this as 'the voice of an evil creature,' a *yai* demon. Then Omawë and his brother travel far downstream to a place where the Orinoco disappears under the ground. 'From then on, that was where they lived. At that moment the twins turned into supernatural beings [*yai*] who sent the spirits of sickness and epidemics' (Lizot in Wilbert & Simoneau, 1990:418-419). 'Down-river where the Orinoco goes underground' cannot but be a reference to the land of *criollos* for these come from down-river. That epidemic diseases came with *criollos* is what many people in Ocamo suggested when I enquired about the origin of *shawara*. Given the predatory nature of *shawara*, it seems the narratives cannot but locate their origin in equally anti-sociable[56] *yai* demons or at the limits of the known lived world: red lights on the horizon or 'where the Orinoco plunges into the earth' are spatial equivalents of the antisociable.

In the Upper Orinoco, people say epidemic diseases, *shawara*, came with *criollos*, when people came closer to the big river, the Orinoco. *Shawara* and *nɨ warɨ* are today synonyms referring most of the time to infecto-contagious diseases.[57] This correspondence does not stop *shawara* from being considered a class of predatory beings, as this *shapori* explains:

> '…a mɨmou frare! hei mot^{h}oka shĩĩpɨ kurenaha inaha no warɨ kë pë t^{h}ë mɨmou. Yahikɨ hamɨ, pei t^{h}ë pë yahikɨ hamɨ pë no warɨ iyaɨ…inaha t^{h}ë pë kuaaɨ no warɨ

[56] I use 'sociable' to distinguish it from 'social,' the former carrying the normal positive connotations of 'being social' (Strathern, 1999:18-19). Social encompasses 'sociable' in that it refers to all relations with beings with agency regardless of its positive or negative nature and whether they attempt to 'connect' persons or, on the contrary, to separate them.

[57] As Lizot (Unp.b.: 30) mentions, certain diseases of slow evolution can be considered the effect of *shawara*. An example comes from Ocamo. The death of the founding *shapori* in March 2001 was spoken in terms of *nɨ warɨ*. The doctors strongly suspected he had prostate cancer which was slowly spreading and correspondingly the man's health was progressively deteriorating. The Yanomamɨ, however, considered this the result of a counter attack from a Yekuana shaman many years before. A powerful poisonous invisible bomb was cast upon the Ocamo *shapori*. His brother, another *shapori*, spoke of this in terms of *nɨ warɨ* slowly eating the flesh of the founder. The Yanomamɨ term for shaman (and also his helper spirits) most used in Ocamo is *shapori*. Given the multiple forms of shamanism in Amazonia and elsewhere and that we have already provided some description of how *shaporis* work, I will henceforth use the Yanomamɨ term *shapori*.

t^hë pënɨ…Mosha kurenaha, mosha, mosha pë rë kurenaha…pei yahikɨ hamɨ t^hë pë iyataru totihio!…'

'…it looks yellow! Like sun light, that is what *no warɨ* look like. On [a persons] flesh, on the flesh is where the *no warɨ* eat…that is what the *no warɨ* do [that is their way]…Like *mosha* [generic term for maggots that live in fruit and meat, they are repugnant to the Yanomamɨ (Lizot, Unp.: 246)], like *mosha*…really slowly they eat the person's flesh!…'

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Having established the origins of *shawara* epidemic diseases, I will now use Albert's (1988) charting of the interpretative trajectory of *criollos*, epidemics and manufactured objects among the Brazilian Yanomam to demonstrate the process through which *shawara* became associated with the *criollos*. This framework will also illustrate the two poles of relationships between *criollos* and Yanomamɨ. The first, exemplified by the conflictive relations with early extractivists and scientists, epitomises the negative pole of relations with outsiders. The second, exemplified by the early Salesian missionaries, epitomises the positive pole of relations with *criollos*. I will argue that what determines the nature of these relations is the degree to which outsiders behave according to the Yanomamɨ 'morality of being human.'

III. 3. *Shawara, napë, manufactured objects*[58]

According to Albert (1988:94-96), in a period of indirect contact, the Yanomam did not conceive of the existence of Whites, only of themselves and surrounding Amerindians from whom they got pieces of metal used to make cutting tools. Epidemics between 1850 and 1920 are attributed to enemy 'war sorcery,' as the myth above would indicate. Whites are known by rumour of the existence of white bald spectres on the edges of terrestrial disc.[59] During a period of initial contacts (first

[58] I use Albert's framework having corroborated its congruence with the material I collected in Ocamo.
[59] The Yanomamɨ traditional cosmos has five discs or layers. The Yanomamɨ live on the third (from top to bottom) layer; above this is the sky where the dead souls go (*hetu mɨsi*) and above this is another extremely hot one (*tuku mɨsi* or *oshetiwë mɨsi*) inhabited by the sun-spirit and other beings. Below is the plane of the *amahiri* (*hetu mɨsi waro pata*), immortal beings on which the *shawara* demons are cast

decades of the 20th century), exchanges between White extractivists, expeditionaries and government officials increased. Epidemics propagated, always following Yanomam visits to White encampments in search for manufactured objects. Initially the Whites' appearance and inability to speak Yanomam confirmed rumours of pale, bald ghosts on the frontiers of the known world. However, Albert continues, their lack of toes (shoes), their capacity to change their skin at will (clothes), their hairy and white appearance, and their possession of extraordinary objects suggested to the Yanomam that Whites could be evil spirits found at the limits of Yanomam land.

At this stage, epidemics, objects and Whites become linked. Whites' metal tools are credited with pathogenic power. The fumes expelled by boxes of machetes and other items penetrated Yanomam bodies and made them ill. Whites should be evil spirits whose pathogenic objects were manufactured products, the foul fumes of which spread epidemics. This interpretation is based on Yanomamɨ's association of strong odours with pathogenic power, as explained above (Ibid.:96-98).

Contact and exchange with Whites intensified, as did possibilities of temporary work for them. Migration patterns were re-oriented towards the communities with regular exchanges with Whites. Albert argues that, whereas the association of Whites with evil spirits was transformed, their association with epidemics was reinforced in light of the number of severe epidemics that struck the region between the 20's and 60's. Conflict between Yanomam and visiting Whites became more frequent. From the latter's perspective, Indians were not easily put to their service, pestered them with demands for objects, and wouldn't provide women. The Yanomam, on their part, disdained Whites' avarice. The theory of Whites-objects-epidemics was re-oriented, associated with economic and matrimonial troubles between communities, with epidemics now suspected to be Whites' vengeance in an adapted version of 'war sorcery.' Combustion became the main source of lethal fumes. Whites' association with forms of Yanomam sorcery was at the same time their incorporation into the realm of humanity, but into the sphere of enemies (*napë*). (Ibid.:98-102)

Consider the following account of an Ocamo man.

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by *shaporis* once expelled from patient's bodies. The lowest plane is one of rottenness inhabited by grotesque giant worms (Lizot, Unp.b.:23-26).

> '[on the habit the *punapɨwei t^heri* had of stealing]…but now there are no *punapɨwei t^heri*, all that *shapono* disappeared, they are finished. This is what my grandfather says: 'those were the Colombians, those were the Colombians because the *punapɨwei t^heri* took their gear, torches, nylon and machetes, they took all of it.' Well I don't know but my grandfather says that those Colombians had a poison [Y. *hëri*, Sp. *veneno*] and they would also burn gasoline, they set fire and burnt that poison [like 'war sorcery'] and with the smoke they all got ill, they died…they all died…'

They burnt sheets, plastic and tires.[60]

III. 4. *Extractivists: criollos as enemies*

Consider the following tale told by a Yanomamɨ to Lizot. The events described date between 1940-45. A group of latex extractors had camped by the river near a community. The Yanomamɨ spotted them and after initial observation from the forest, approached them, lured by their manufactured items and dogs.

> 'We bartered fruits and manioc and, squatting down a safe distance away from the big kettles full of heavily bubbling latex, we would throw pieces of wood and balls of earth against their sides, which rang out with a terrifying noise: tin, tin…From their insides rose a worrisome smoke: It gave birth to the *Shawara* demons who make their way into human bodies where they inflict pain, provoke disease and shortly death if the shamans are powerless to cast them out. Several of our children died; we knew it was because of the kettles and the Whites (Lizot, 1985:3-4).

Later the Yanomamɨ devise a trick to steal one of the dogs, pretending to exchange it for one of their sons who would work for the foreigners. On the night after the exchange the child, as planned, escapes his masters and returns to the community. Fearing retaliation the Yanomamɨ keep their distance for some time. They then plan a more serious attempt at stealing the Whites' goods having judged them selfish in not

[60] Cocco (1972:73), based on Helena Valero, dates the presence of some *criollos* somewhere between Ocamo and Mavaca sometime between 1930 and 1950.

offering them. This episode ends with a Yanomamɨ being injured by gunshot when the Whites request their goods back once the Yanomamɨ have been caught red-handed. Some time later, a Yanomamɨ runs into the Whites while hunting and shoots an arrow through one's throat in retaliation for the previous injury and the death of the *shawara* spread by them (Ibid.:4-5).

These incidents not only speak of smoke as a vector of predatory disease, but also tell us of the nature of initial encounters between extractivists, scientists and Yanomamɨ. Most of these encounters recount theft, deception and/or fear-loaded, tense relations of exchange and quite frequently, abduction and killing (Cocco, 1972:59-73). But let us pause on Lizot's passage because certain underlying moral circumstances, that to this day pervade relations between Yanomamɨs and *criollos*, doctors included, are made clear.

First, there is little or no verbal communication between the extractivists and the Yanomamɨ; these sit at a distance and observe. Doctors today generally have only the faintest knowledge of the Yanomamɨ language and often rely on interpreters to communicate with patients, specially in upriver trips. Occasionally patients leave the rural clinic in anger because they cannot make themselves understood. It is also frequent to see patients nodding in agreement when detailed instructions are given to them in Spanish even when they are not understanding. The nodding gives the doctor the impression the patient has understood everything when in reality the person takes the medicine, goes home and leaves it unused. Yanomamɨ youngsters, '*huya*,'[61] often visit the doctors in their residence without talking to them. Sometimes alone but more often in a small group of friends, they sit down and converse among themselves about what the doctor is doing, frequently privately making fun of him/her.

Second, the mutual judgement of amorality. The Yanomamɨ consider the extractivists stingy; the latter clearly disapproved of having their objects stolen. The point is that, for the Yanomamɨ, the negation of exchange is the moral equivalent of theft for the *criollos* which is why it is equally disturbing. To share what you have is a

[61] The word distinguishes adolescents from children (Y. *ihiru*) and elders (Y. *pata*). Lizot (Unp.:128) says it refers to 'person of the male sex capable of procreation' which fits perfectly with the usage I

prime moral dictum for Yanomamɨ, stinginess a terrible amoral quality. It is the one condition considered when a dead person's soul is on its way to the sky where souls live happily. The stingy must take another path towards a huge blaze, the *shopari wakë* (cf. Lizot, 1985:184). I also agree with Alès (2000) in highlighting the ethical value the Yanomamɨ place on avoiding or addressing their relatives' suffering. It is ethically proper to ameliorate your relatives' suffering be it pain, hunger, sadness or hardship.

> 'Many actions of a person, in the give and take of everyday life, are thought of in terms of how 'not to suffer.' (135) [Later] 'In circumstances both banal and serious, then, close kinspeople and friends must mutually avoid making one another suffer…This is why one has to give happiness to, and be generous with, one's peers…Consequently it is difficult to refuse to satisfy someone who is lacking tobacco, food, or an implement – or company, or a wife…All these actions are marks of attention, affection and amity; they are constructive of everyday life, sociality and conviviality.' (136)

Non-sharing is anti-sociable, signifying a desire not to enter into convivial relations.[62]

For extractivists and doctors alike, it is the entrenchment of private property as an essential right that is a condition to 'live in society.' Under these premises theft is an equal negation of the desire for conviviality. We shall see in Chapter VI how today's relations with doctors pose the same underlying moral issue in the management of the rural clinic's resources (boat, gasoline, motor) as well as the doctors food and other personal items. Specially during initial periods of stay, doctors and students are criticised by the Yanomamɨ for being stingy (Y. *shi imi*, Sp. *mesquino*). Yanomamɨ stress that doctors need to be concerned (Sp. *preocupar*) for people's suffering (Y. *no pre-* Sp. *sufrir*). These words are among the first to enter doctors' Upper Orinoco

encountered in Ocamo. *Huya* are an important category of people for they are the one who most engage with resident *criollos* like doctors.

[62] Here I follow Overing & Passes's (2000) lead. What I mean by convivial is expressed by the Spanish term '*convivencia*' which, in the simplest of ways, means to live well together with other people in a cordial and harmonious environment, that way of living which makes you feel good to be where you are.

vocabulary. Doctors on their part complain about the frequent minor thefts they are subject to, calling *huya* petty thieves (Sp. *malandros*).

Third, the use of deception. In Lizot's passage the Yanomamɨ organise a cunning deception in view of the extractivists' stinginess. Particularly during the first months of stay in Ocamo, some 'interface' Yanomamɨ would occasionally devise tricks, taking advantage of the newcomers.[63] For example, the doctor could be urgently called upon to visit upriver to see an extremely ill patient only to realise, on arrival, there was none: the motorist or another companion had dealings to resolve. Doctors take time to learn the tricks of Ocamo's old foxes.

The final parallel I want to draw between these early encounters and current relations with doctors is the context of visiting in which they occur. Albert points out that the pattern of the early Whites' incursions made them particularly prone to be guilty of sorcery. Many instances of 'alliance sorcery' using *hërɨ* occur in the context of visits. One must always be suspicious of visitors, even from friendly communities. These circumstances resemble those of the ever-changing doctors who seldom stay in Ocamo for more than one year, and the students who rotate every 10 weeks. Under this scheme there is little time for trust to build. The doctors are not going to be suspected of illegal relations with women or sorcery but their real intentions, conviction to help and abilities, are not taken for granted. Yanomamɨ political discourse on doctors and students emphasises their impermanence and associates it with a lack of real concern for the Yanomamɨ (Chapter VIII).

In short, poor communication, mutual assessment of immorality in the exchange of goods, and deception are frequent aspects of the relations with today's *criollos* which, in the case of doctors/students, are all aggravated by their impermanence.

The myth of the origin of plantains is most illuminating in this respect for it provides a reflection on the type of relations typical of strangers or outsiders and, in

[63] By 'interface' I am referring to the sector of Yanomamɨ communities that normally relate more to *criollos* (doctors, missionaries, etc.) than others. In Ocamo this refers mostly to *huya* (male youngsters) but it also includes modern political representatives.

this sense, is almost a metaphor for relationships with *criollos*.[64] Several versions of this myth can be found in the literature; I will only highlight what is relevant to this discussion more closely following a version reported by Cocco (1972: 464-67) told by the then Iyëwei t^{h}eri captain and which was also told to me by one of his sons.

III. 4. 1. The morality of being human

The myth speaks of a Yanomamɨ called Pore, which is the 'ghost of the dead.' The first interesting point is that Pore lives far away, alone with his family with no other Yanomamɨ. Pore is the only person who knows how to cultivate plantains; at that time Yanomamɨ ate only wild fruit, game and earth or rotten wood. One day, when far from their *shapono,* a small group of Yanomamɨ run into unknown footsteps which they follow to Pore's house. Initially hesitating, uncertain about the possible hostility of the unknown resident, they finally enter the *shapono*. My friend elaborates particularly on this hesitation: 'will the stranger react as an enemy? Are we enough to defend ourselves? He might be friendly'…indicating the real concern infused by the possibility of entering the *shapono* of a complete stranger unannounced. Pore's son tells his father to offer the Yanomamɨ banana soup: 'don't you see that they are very hungry.' Pore refuses to give the plantains about which the Yanomamɨ knew nothing, even though he had plenty hanging in his house and a garden full of ripe fruit: ' 'No' said Porehimi in an ugly voice.' Here the myth teller comments to Cocco: 'Porehimi was giving an example to those Yanomamɨ living today who are stingy' (Ibid.:464). The Yanomamɨ are finally given some plantains to taste and then return to their own *shapono* and tell others of their encounter with the stingy Pore. Later they return to Pore who again refuses the plantains but accedes to show them his garden; this was a trick for the visitors to learn the trail to the garden and later come and steal from it. In the garden Pore initially refuses to provide seedlings for the Yanomamɨ to grow their own plants but, feeling sorry, agrees to give them a few of only a couple of species. The Yanomamɨ then leave once more, but soon two Yanomamɨ return and secretly steal from Pore the species he denied them. Sometime later, Pore visits the Yanomamɨ to see how their plantation is going and realises they have stolen from him. He enters

[64] This myth was brought to my attention by my friend and colleague Javier Carrera who has long experience working with the Yanomamɨ. Javier not only pointed me in the direction of this myth but also its reflection of relations with *criollos*.

the *shapono* and scolds the Yanomamɨ calling them thieves, 'with his ugly voice.' He never visited again; he left his own *shapono* and garden to live even further away.

Given the centrality of plantains in Yanomamɨ diet, the myth plays out the negation of a fundamental cultural item. But the myth relates this to two aspects of Pore's behaviour: his isolation and his inability to speak well. The interrelated triad of meaning is stinginess, isolation and poor communication. Such behaviour is proper of Pore, *a ghost*, *not a human being*. As we have seen, these are some of the salient aspects of relations between *criollos* and Yanomamɨ. Doctors in particular only stay for short periods with the Yanomamɨ, returning to live far away in their cities.

Distance, lack of communication and stinginess are all pointing to the same negation of social exchange hinting at the congruence between morality and humanity. In this sense outsiders, epitomised in myth by the Pore, the ghost, and today by *criollos*, are less human/moral.[65]

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In this section we have established some continuities between the behaviour of early extractivists and today's doctors. Outsiders (Yanomamɨ or *criollo*) are, before anything else, possible enemies, people from whom deception and distrust are expected and reciprocated. The pattern of 'visiting strangers,' adopted by doctors and students works to reinforce these meanings. The moral implications of non-co-residence, inability for proper communication and exchange continue to be obstacles for doctor-Yanomamɨ convivial relations and are important factors in doctor-patient rapport (both topics dealt in Chapter VI).

[65] Notably, in terms of the constitution of the person, *criollos*, I was told, are 'made up' of the same components outlined above, that is, they are equally equipped as Yanomamɨ are for human/moral action. Equally, 'humanity' differs from 'personhood' in the same way that the 'sociable' does from 'social.' Personhood implies agency and, to follow Vivieros de Castro (1998), a 'point of view' on the world. There are human and non-human persons; a *hekura* 'spirit of the forest' or '*shapori's* helper spirit' is a non-human person. Humanity is epitomised by close kin who live together in a way totally inverse to that exemplified by Pore, the 'stranger ghost.' In this way, humanity/morality a is matter of degree that varies in a continuum defined by personhood that includes *yai* demons, close kin, enemies, *criollos*, *pores*, *shawara*, etc.

Now we shall explore the opposite pole of relations with *criollos*, exemplified by the early Salesians in Ocamo. In contrast with the extractivists, Father Cocco and several nuns remained for a long period in Ocamo, were extremely generous with food, labour opportunities and manufactured goods and, in general, behaved much more like kin to the Yanomamɨ: speaking the language and using kinship terms. This discussion exemplifies how behaving like a proper human being developed a quasi-kinship relation with Yanomamɨ. It is the same 'morality of being human,' of not behaving like Pore the ghost, that made all the difference between the extractivist 'enemy' and the missionary 'co-resident.'

III. 5. ***Missionaries: criollos as friends***

Albert (Ibid.:102-4) describes how, during the late 50's and early 60's the first permanent missionary posts were established among the Yanomam. In view of *their continual assistance and permanent co-residence*, their status was redefined and included in the socio-political sphere of co-residents who are not suspect of sorcery aggression.

My informants in Ocamo agree. Father Cocco and Bonvecchio arrived in Ocamo in 1957. The arrival of Cocco began a hitherto unseen flux of manufactured objects in and along the Ocamo. From 1960 to 1972 he reports the following (Ibid.:378):

Table III.1: Flow of goods from the Ocamo mission (1960-72).

Machetes: 3850	Batteries: 14000
Axes: 620	Loin cloths: 7350 mts
Pots: 2850	Fabric for clothes: 6500 mts
Fishing nylon: 260 kg	Glass beads: 280 kgs
Fishing hooks: 759000	Cups: 2616
Torches: 750	Plastic plates: 1020

As Ferguson (1995), Chagnon (1997), Albert (1988) and Cocco (Ibid.:377) himself have shown, this massive influx of objects had, and continues to have, an important impact on Yanomamɨ socio-politics. Migration and visiting patterns became

reoriented as villages sought to locate themselves favourably in articulation with the mission villages. 'Mission villages' like Ocamo could also tilt the balance of women exchanges in their favour, being able to extract more wives from goods-poor villages. Today, most upriver marriages involve Ocamo women marrying upriver men; Ocamo men marrying upriver women may also substitute a canoe or shotgun, scarce and highly valued in upriver communities, for the usual brideservice obligations. In having more ready access to shotguns and outboard motors, mission villages were, and are, at a military advantage if needed.[66]

But what interests me is how the people of Ocamo comment on their relations with missionaries. On the one hand, they stress permanence, sharing and care; on the other, they elicit two fundamental issues of historical importance: a) a trade-off between the benefits of having *criollos* with them and its downsides and b) the 'edenic' abundance of the early missionaries as a standard of 'good *criollo* behaviour.'

III. 5. 1. The trade-off

The Iyëwei made a historical trade-off when settling with the missionaries: an exchange of Western goods, education, some healthcare and the 'word of God,' for the collateral effects of suffering the *shawara* that missionaries and other *criollos* produced with the combustion of Western goods and the use of motors and electric generators.

The following is an account recreating the type of conversations held during the period of initial co-residence:

> 'Before we did not know the *criollos*, the *napë*, when we were free we never got ill or anything and now we know the napë and they bring *shawara*, what are we going to do? We are already dying out [Sp. *acabando*], because of diarrhoea, hepatitis, measles and we are bit-by-bit going to wear out, [Sp. *gastando*]. So lets escape, lets speak well with the missionaries, lets tell them we will be back in 2 or 3 months, lets speak well so they don't get worried. This is how they

[66] Consider that in 2001, among the 10 communities in greater Ocamo there were 36 shotguns. Among the five communities in middle Ocamo, between 2 and 4 hours upriver, there were 6 shotguns. Among

> talked, this is what my mother used to tell me…[they make a meeting with Cocco where they say] ‘Father, please, we cannot live here all the time because of the *shawara,* you came and brought the *shawara* with the motor – because when you start the motor, smoke comes out, when you drive it, smoke comes out, you see – with that smoke we get *shawara*, we are going to go upriver where we used to live for some 3 months and then we will be back…’

The *Iyëwei t^heri's* option was to stay next to Cocco and flee upriver to ancient gardens when epidemics hit them. At some point, when the mission had provided an electric generator for ‘their’ Yanomamɨ it was seen as a source of *shawara*.

> ‘…when they started the motors, you know when you start the motor smoke comes out, then they would say / first they would ask: ‘are these not *shawara*?’, ‘[a missionary answer to Yanomamɨ anxiety] no, this is smoke, smoke of gasoline’…another would say: ‘are they not poisonous?’ ‘no!’ He would say, the same happened with the electric generator, that one was different, with the smoke of the generator we got ill, they would say, but not with the smoke of the motor…they thought they got ill with that [generator] when they started it / there were two generators for the community, so when they turned it on: ‘no don’t get close to where the smoke is, that is *shawara*’…then in a few days they would get ill, since there was so much *shawara* around here then our parents would tell us: ‘no, no, no, that is *shawara*, get in the house’…then the *shaporis* would say ‘these *napë* here are burning garbage, the ones that burn cans, those are *shawara*, that is making us ill and with the smoke of the generator’ but they didn’t call it ‘generator’ they called it ‘*mɨ shipirima*’…‘smells like shit’…children didn’t get close to it nor any other, when they started it, at that moment people got into their houses, when the smoke ended they came out.’

There must have been a number of theories, where one smoke (generator) was more pathogenic than another (motors). What was clear is that the Iyëwei were suffering from *criollo*-introduced *shawara*. To this day, a number of people consider the burning of garbage by the missionaries and the doctors as *shawara*-producing. In any case, the missionaries would have been considered co-resident friends but living with them had its price: *shawara*.

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the first two communities on the River of Honey, approximately 6 hours upriver, there were no shotguns. I knew of no raids along the Ocamo during my fieldwork.

JA: Why are the Yanomamɨ not angry with the *napë*, if the *napë* brought *shawara* with the motor?

‘hapa pë hushuoma. Yanomamɨ pë hushuoma hapa: ‘weti t^hë ha shawara pë shiro përaihe? pëma pë wãri ta she!’ pë kuma. Hei tëhë inaha pë kuimi. ‘Ho, inaha poo’ weti t^hë ha? inaha pë pë kuu ‘ellos lo trae cosas, ropa, pantalon si cuando nosotros no queremos a los napë de donde conseguimos’ inaha pë puhi kuu hei tëhë.’

‘A long time ago they were angry, the Yanomamɨ were angry a long time ago: ‘why are they always bringing *shawara*, lets kill them!’ they would say. Today they don’t say this. ‘Ok, it doesn’t matter’ Why? Because they say: ‘they bring stuff, clothes, trousers, if we don’t treat the *napë* well where will we get this?’ this is how they think nowadays.’

As other Amerindian groups were willing to enter into exploitative debt-bondage relations with White bosses (Hugh-Jones, 1992; Gow, 2001) to access Western goods, the Ocamo Yanomamɨ were willing to live with *criollos* enduring the consequences of *shawara*.

It must be clear by now that the interpretation of *criollos* is first and foremost a relational one. It is a change in the nature of relationships that leads the Yanomamɨ to re-interpret potential ghosts as human enemies and then as friends. This relational nature of social categories is what gives the ‘Yanomamɨ conventional space’ and its transformed version the ‘*napë* transformational axis’ (see Chapter IV) all their performative (Sahlins, 1985) and dynamic character.

III. 5. 2. Cocco’s quasi-kinship and making kin

The arrival and establishment of Cocco in Ocamo set a standard for what one could call ‘ideal *criollo* relationships.’ He arrived after a prolonged period of intermittent exchanges with extractivists that had been characterised by tension, misunderstandings, deception, and violence. On the other hand, his seemingly limitless generosity in providing food and goods in exchange for work has not been

matched either by the succeeding missionaries, or an institution like the health system.[67] Only the advent of party politics in the mid 90's and the National Guard's social development plan in 2000-1 have produced comparable – yet punctual – flows of goods.

The Cocco period is remembered as years of abundance. Cocco, as the source of this bounty, provided an image of a local *criollo* mediating between the Yanomamɨ and an inexhaustible source of Western goods and food. In different periods he kept pigs, sheep, chickens, but also promoted the creation of rice plantations and exchanged grated manioc with neighbouring Yekuana. In light of this, all resident *criollos* that have succeeded Cocco are seen as comparatively stingy and hence less moral. This seems particularly prominent in the case of today's missionaries.

> '…the Yanomamɨ from here, the Iyëwei t^{h}eri, how do they say now? Now these missionaries that came after: 'stingy, very selfish,' this is how they say. First lived Cocco, he was very generous, he really was generous. Now they still say this, they remember…that's what the people say, what the elders say.'

I want to underline the emphasis people put in their accounts on missionaries' provision of food and their permanence.

> '…after they began making grated manioc [Sp. *mañoco*], manoic cakes [Sp. *casabe*] and the Father would buy, buy, the people worked here, we were short of nothing whilst the people had *mañoco*, *casabe*, sardines we had / the priest had a garden of rice…he planted rice noooo way!…the people worked…they would go to the mission and then the Father said: 'well this rice is for you, don't ask for food, this rice is yours'… nooo! A lot of rice!…'

And

> '…and then lived [in Ocamo] Father Fernandez, not a year but rather 3 or 4 months…then came Father Aguilar…I was around ten I was already realising

[67] After 1975 missionaries homogenised and changed their policies from a 'civilising' project to one where they would be 'accompanying a Yanomamɨ historical project,' a change experienced in other

> [Y. *puhi moyawë*][68] little by little knowing, seeing how the missionaries would come and then leave. Father Cocco no, *he never left*, not at all…Sor Felicita helped the Yanomamɨ a lot…*with her food we grew*, she would give food, she helped a lot, that's why we loved Sor Felicita a lot and *she lasted many years working*.'

Cocco behaved as a father to all the *Iyëwei tʰeri*. This appropriate social behaviour must have not only humanised the missionaries but also expressed *their desire to be kin*, albeit of a strange kind. The above expressions resonate with what Gow (2001:7) explains of the Piro of the Peruvian Amazon. Kinship is forged by the memory of being fed and cared for by your elders. Vilaça (2002:352) succinctly expresses what many now agree is the basis of kinship in Amazonia:

> '[on the Piro] proximity and living together are so decisive in determining kinship that genealogical kin who live far away may be excluded from this kin circle…[now in general] It should be noted that this is not a purely formal or terminological assimilation, but a true process of consubsantialization, generated by proximity, intimate living, commensality, mutual care…To become kin, it is necessary to desire to be kin and to act as such: for example, by living together, respecting alimentary taboos…calling people by kin terms, and so on.'[69]

So in not behaving like kin, today's resident *criollos* are intentionally negating a kind of kinship. Notably, the two nuns of Ocamo refer to the Yanomamɨ with kin terms that evoke affection like *naka* (daughter/younger female), *moka* (son/younger male), *ihiru* (infant). On the contrary, doctors rarely do this, tending to call people by name or very frequently simply *wãrõ* (male) or *suwë* (female).

To exemplify the relevance of behaving like kin I present the following extracts of a telling conversation with a friend of some 45 years of age who was taken as a child to Caracas and Maracay by a pilot that arrived in Ocamo. He says he stayed there for about one year:

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parts of missionised Amazonia (see Jackson, 1995; Hugh-Jones, 1997 for examples in the Colombian Vaupés).

[68] This term is frequently used to express the acquisition of knowledge/understanding as children grow.

[69] On this subject see also Gow (1991; 2001), McCallum (2001), Viveiros de Castro (2001).

> '…I was still young, then, when he took me, I didn't remember my father nor my mother anymore…when we got there [Maracay] I only cried for two days and then I forgot everything…'

The expression 'not remembering,' the act of not being aware about your parents, or any close relative for that matter, is unthinkable. Only the dead must be forgotten – and at great ritual expense. The light tone with which I was told this account was rhetorically exclaiming 'can you imaging such immoral behaviour?!'

> '…and his wife [pilot's] treated me well as if I were her son, then I would call her 'mother' and to the man I said 'father,' and then to an old man…'grandfather'…'

Once in the city, living in a new family, the use of kin terms is a way of telling me he was becoming *napë*, forgetting his parents he was becoming kin to others. Once a friend came to me slightly concerned about his daughter who had become very close to one of the dentists that had spent a few days in Ocamo: 'she says she wants to go to Caracas with her, she calls her mother.' In effect, once the dentist left, I was asked by a young companion of this girl not mention her name, for I had done so already and this had set the girl off crying.

> '…then my father and mother here [Ocamo] were thinking about me: 'where has he gone, is he lost or did the *napë* steal him [they asked Cocco to communicate with the pilot telling him they were dying with malaria to prompt the child's return]…the man [pilot] said 'you have to go to Ocamo but you will not stay, you stay only for a week and then I will pick you up'…then, when I arrived, I said: 'but who are these? I don't have a clue who they are.' I didn't understand the Yanomamɨ language…and then my father, when he recognised me, he took me and I would say: 'no, no, no, *shami*! *Shami*! dirty! dirty! I didn't say '*shami*' I said '*sucio*' don't touch me…then Cocco would say 'no, this is your father and your mother' and I would say 'Really?' 'You are Yanomamɨ' Cocco would say, 'no, what do you mean Yanomamɨ, I don't know who the Yanomamɨ are'…'

Spatial and cognitive distance from Yanomamɨ parents and mutuality with *criollos* had made this boy *napë*. Hence he evokes his alterity precisely with the markers of non-humanity: not speaking the language – emphasising it was Spanish that he spoke – not remembering he was Yanomamɨ and deploying a typical *criollo* stereotype: 'dirty Indians.'

This episode that reiterates the transformative power of continuous social exchange merits a short discussion. First, kinship is about making people similar, intentionally behaving morally as kin. Our discussion shows the same conditions make Cocco, a *criollo*, quasi-kin. Meaning that the 'construction of kinship' (to use Vivieros de Castro's (2001) expression – see Chapter V) and what we can call the 'domestication of outsiders' involve the same efforts and practices.[70]

Second, consider the following parallel. Gow (2001:35) recounts a Piro myth of mortality. A man was 'tired of living with his kinspeople' – a reference to death – and 'went to live under the earth' – land of the dead. A man in the underworld asked him whether he wanted to live their 'he said he did,' after which he sheds his worldly clothes and is given animal skins and begins to live 'just as in his world' but in the underworld. At one point he gets 'homesick' and goes back to fetch his kin but now the world looks strangely red, he doesn't recognise the way to his house. Wearing animal skin – he is a peccary now, the form the dead take on earth – his wife rejects him but his son accompanies back to the underworld.

This is a classic example of Amerindian perspectivism (Viveiros de Castro, 1998) at work: changing your body you become another type of being, acquiring their perspective on the world. But the human (Indian) perspective is the way all species with soul see themselves, hence the man in the underworld provides animal skins to enable a this-worldly visitor to live there just like ordinary Piro. When he returns in

[70] I use 'domestication' with a double sense. First Overing's (1999:85) usage: 'domesticated' life as a harmonious living with others managed by the mastery of the capacity for sustaining an ambience always threatened by perils of not doing so. In this way a 'domesticated outsider' is one who is pressed into the 'morality of being human' or adopts this way of life among the Yanomamɨ by self conviction – a self-domestication. The other side to my usage will become clearer in Chapters V and VI, when we will see how doctors, in a position of 'potential affines' (Vivieros de Castro, 1993), are de-fused and powerless outsiders very much controlled by Yanomamɨ. In this sense their domestication reminds us of the place of captured enemies or pets in many Amazonian societies (see Fausto, 2000; Vivieros de Castro, 1992).

animal form, he sees the world from a peccary perspective, hence the red sky; he looses his way; his wife rejects him. In this sense bodies encode relationships and are the sites of a perspective on the world.

This comparison illuminates how changing clothes/skins is a time-compressed version of 'behaving like kin,' living together, speaking the language, using kin terms, just what the Ocamo boy does to 'forget' his parents and become *napë*. When he returns he doesn't recognise the Yanomamɨ nor his parents, just like 'the man who went under the earth' doesn't make his way home. Just like the Ocamo boy calls the Yanomamɨ 'dirty' from a *criollo* perspective, 'the man who went under the earth' is rejected by his wife who, from a human perspective, sees an animal not a human being. The only difference is that 'the boy who went to the city' is not a myth.

So, if making kin is about producing similarity by behaving like kin, the body is the site where the relations involved in this production are made visible: so long as bodies are the same, people are kin because they make each other. This entails that 'body' must be seen as a habitus, as Vivieros de Castro (1998:478) suggests, 'an assemblage of affects or ways of being' including, for example, eating habits and language but, by implication, also that gamut of moral behaviours we have called the 'morality of being human.' (cf. McCallum, 2001:66-7) Let us call this intentional production of bodies and perspectives *via* 'the morality of being human,' 'making kin.'[71]

Next; if the perspective-altering changing of bodies – typical of the realm of the extraordinary, myth and shamanism – is of a kind with 'behaving like kin' – typical of the quotidian – it is because everyday life involves a constant interplay of producing evidence of one's effects on others. This gives life a performative aspect, the reflection in modes of action of the relational character of both the 'Yanomamɨ conventional space' and 'making kin.' To respond to a Yanomamɨ interlocutor in Yanomamɨ; to ameliorate another's suffering; to feed a child are in a performative continuum with coming back from a year in the city and calling one's parents 'dirty Indians,' or mistaking a spirit in the forest for a Yanomamɨ (see Chapter VI).

[71] To follow Vilaça's paper cited above, aptly entitled 'Making kin out of Others in Amazonia.'

This is important to note for we shall see, in subsequent chapters (VI – VIII), how these modes of action, testing one's effect on others, are as common among Yanomamɨ as they are with doctors in both medical and non-medical contexts. The same applies for other *criollos*, like state representatives in meetings or protests.

Early missionaries' behaviour fulfilled the condition for the production of trust, affect and memory. In Ocamo when I asked about the past, people spoke almost exclusively about Cocco and the early missionaries despite the passage of a number of other agents of national society.[72] Now Cocco's kinship was of a strange kind. Missionaries were clearly not from Ocamo, they didn't marry any Yanomamɨ, yet they behaved as kin *to all* the Yanomamɨ. I will return to this discussion in Chapter V.

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Before concluding I will briefly present the way in which *shawara* is spoken about today as *napë* in origin and character.

III. 6. *Shawara today: ontologically napë*

Nowadays *shawara* is generally thought of as a *napë* introduction associated with all forms of *napë* combustion and smoke-producing transport.

> 'ya kuo mãõ tëhë…pata pë hõrã pënomi…Pëɨ mai, inaha pëtawë pë hõrã kuoma. Hei tëhë kɨ yai shawara ikari a warou. Shawara pruka a ha waronɨ yamakɨ kai shapono waisipɨaɨ, hapa tëhë, shawara kuo mãõ tëhë peeemee! he parohoa yahi a hõrã kuoma…weti tʰë ha shawara a warokema? Ayacuhco hamɨ basura pë yapraɨhe y carro mami pë kai yapraɨhe y motor bomba pë kai [?] wakë shĩĩ pë kai haɨ, carro wakë shĩĩ pë kai haɨ, avion pë kai hayuyou…ɨhɨ mihi tʰë pënɨ shawara a prërëmaɨhe...'

[72] For example, accounts of malaria personnel and their activities (resident in the Upper Orinoco since late 50s to the early 80s) or of the activities of the onchocerciasis programme (resident since late 70's to early 80's) were never spontaneous. I had to ask specifically about them. The detail of these accounts was limited to anecdotal events. Memory was blurry, specific names forgotten. None of these presences merited the emotional recounting of the missionaries' permanence. Notably, neither the malaria nor the onchocerciasis programmes were ever based in Ocamo, here they were always visitors. In short, Ocamo people's memory was filtered by the 'morality of being human.'

> ‘When I was not yet born…it is said the elders did not get ill…They wouldn’t get ill, it was just like that. Nowadays *shawara* really comes strong. Since a lot of *shawara* has come we are becoming less, a long time ago, when there was no *shawara peeemeee*! they say there were many, many houses…why did *shawara* come to us? Because they [*napë*] burn garbage in Puerto Ayacucho, they also burn the tires of cars, also the motorised pumps [?] smoke also comes out, the smoke of cars, aeroplanes also pass by…it is because of them [cars, aeroplanes, etc.] that *shawara* fall on us one after the other…’

It seems likely that beliefs in a generalised spread of *shawara* and its indestructible nature are based in knowledge of the existence of huge numbers of *criollos* who habitually use smoke-producing technology in tandem with knowledge and experience of the epidemics that have afflicted all Yanomamɨ.

But *shawara’s criollo* nature goes beyond its source. At least in some cases, *shawara* speaks Spanish and echoes the sounds of its origin: factories. The following narration also refers to the odours of *shawara* but in a shamanic context where *shaporis* are able to identify aggressors by their characteristic smell.

> JA: How does the smoke / how does the smoke make you ill, do you know or does the *shapori* know, how is that?
>
> ‘no, no, we don’t know, the *shaporis* know.’
>
> JA: And how do they know?
>
> ‘they smell, they take it oaaa! They smell, [they say] it smells of paper, of [plastic] pot…’
>
> JA: So is it like dirt inside you?
>
> ‘No, no…then the plastic pots and that stuff, its as if a *napë* were talking not the pots / OK so that [garbage] was burned, the *shapori* say: ‘this is garbage, there it is [the speaker is imagining a shamanic session where the *shapori* sees the causes of illness] the *shawara* is speaking *napë*’…from where they are fabricated it sounds, those machines…those machines have to make noise where

> the *shawara* is [this is how they are identified] then the *shapori* says: 'that's what they are burning that is why we are always with *shawara* here, here you can listen to it' all the machines go 'kan, kri, kran'…the *shawara* its speaks Spanish '*gnaganganga*' it complains/moans [because its being attacked by the *shapori*] so then the *shapori*, his helper spirit says: 'look father[73] this *shawara* is from the *napë*, we have to make it flee, we have to make wind so that it takes it somewhere else then this *shawara* we have to break it…we have to send it down there [to the lower cosmic disc where the *amahiri* live]…'

The resemblance with Davi Kopenawa's discourse is striking. Davi a renowned shaman/spokesperson of the Yanomam, combines elements of shamanic knowledge and his knowledge of the White world which incorporates elements of environmental discourse as a strategy to defend his people. For Davi the spread of *shawara* is maximum due to the combustion of minerals that have been taken from the earth into factories, just as gold miners extract the gold inside the earth and burn it releasing sickening fumes. *Shawara* in its maximum extension not only affects the Yanomam but all the people in the world: Whites call it 'pollution.' (Albert, 2000:252)[74]

Concluding remarks

Let me summarise some of this chapter's conclusions in relation with the rest of the thesis. First, *shawara* is a key concept that historically links the Yanomamɨ with *criollos*. Following Wagner (1981), this process involved innovation by the extension of the known. This process had two simultaneous expressions. It saw the interpretation of *criollos* on the basis of the (known) conventional Yanomamɨ space as a proximal movement of decreasing alterity – a Yanomamɨ-fication. It was accompanied by an inverse movement of the native category of *shawara*, from an indigenous epidemic-causing 'war sorcery,' to a *criollo* conglomerate of infecto-contagious diseases, a distal movement of increasing alterity – a *criollo*-fication.

[73] *Shaporis'* helper sprits refer to him as 'father'; the *shapori* correspondingly calls them 'sons.'
[74] Albert (2000:253) continues to relate how *shawara* demons take on White characteristics for the Yanomam: they slash peoples throats with machetes, keep their victims in boxes or cans, fry them in furnaces, use their skin for making nets, etc.

Second, the passage of *criollos* through the Yanomamɨ conventional space is guided by the 'morality of being human.' The more you behave like kin, the more human/moral (co-resident) you are, departing from conditions, behaving like Pore, the ghost, the less human/moral (enemy). As ideal types, extractivists elicit the 'enemy' side of relations with *criollos*: distrust, deception, theft, violence. Early missionaries embody the 'friendly' side: provision, care, protection, instruction. Today's relations with doctors exhibit elements of both. We can see their yearly progress through Ocamo as a compressed passage from somewhere near the enemy pole to somewhere near the friend pole. Never reaching the extremes in any case, they begin as strangers and end as strange quasi-kin, yet still faint versions of kinship *a la* Cocco. Initial months are full of distrust and disregard; departure draws tears and leaves behind memories, clothes, radios, children's names. We have shown how co-residence, sharing, speaking the language, using kin terms all promote the creation of trust and affect. This is the process of '(self) domesticating outsiders' which we can now see makes the constant rotation of doctors under the rural year scheme incompatible with the circumstances that can foster convivial relations with *criollos*. Chapter VI develops how this incompatibility is played out in daily relations. Third, the 'construction of kinship' and the 'domestication of outsiders' involve similar intentions and practices. They are processes of producing similarity through moral relationships.

In the following chapter I depart from Albert's (1988) analysis because a crucial effect of the proximal movement of *criollos* through the Yanomamɨ conventional space was the redefinition of the terms on which these social categories existed. In other words, the proximal movement of *criollos* was also the redefinition of the meanings of '*napë*' and 'Yanomamɨ.' On the other hand, as the missionaries were becoming quasi-kin, by implication, because of the mutuality of making kin, Ocamo Yanomamɨ were simultaneously 'becoming *napë*.' These are the subjects of the next chapter.

Chapter IV: Becoming *napë* and the '*napë* transformational axis'

The last chapter discussed the innovational trajectories of *criollos* and *shawara* according to the conventional relations that constitute Yanomamɨ socio-political space. Following Wagner's (1981) theoretical framework, the conventional, when innovated, becomes in some degree particularised; inevitably the innovation must be recognisable as something known and in this way it is conventionalised. This is a constant dialectic between convention and the innovation. This means that, in 'using' the conventional Yanomamɨ space to interpret *criollos*, it is modified producing a new set of conventional relationships.

The relationally-constituted notions of 'Yanomamɨ' and '*napë*' are transformed as inter-ethnic exchange intensifies. This is much more than a semantic expansion. I will show that a new context of interpretation of relations has emerged. This '*napë* transformational axis' co-exists with what Albert (1985) has described, but its guiding variable *is not 'enmity' but a 'historical transformation into napë.'* This 'axis' must be understood as a context: a set of concepts and practices that constitutes a network of *conventional* relations contextually uniting or separating different categories of Yanomamɨ and *criollos*.

This network-context is fundamental to our analysis. Just as Yanomamɨ shamanism – as most other versions – cannot be reduced to curing but is rather the management of socio-political relations with different degrees of alterity, we must see relations within the health system as one aspect of Yanomamɨs' more encompassing management of relations with other alters: *criollos*.

The first part of this chapter is devoted to the analysis of 'becoming *napë*' as a historical transformation that frames Ocamo people's understanding of themselves in relations with *criollos* and other Yanomamɨ. This historical process involves a body/habitus transformation and the acquisition of *criollo* knowledge to become 'civilised,' meaning that their being is dual, they are Yanomamɨ/*napë*. Engagement with the world of *criollos* is essential to the sustenance of a 'civilised' life in Ocamo. All interface Yanomamɨ – to different degrees – manage relations with this 'outside

world' through their mediation that involves a mixture of two processes: translation of the *criollo* world and control of *criollos* and their resources. In this mediative role, interface Yanomamɨ on the '*napë* transformational axis' fulfil the 'foreign affairs' political role of *shaporis* in the Yanomamɨ conventional space.[75] The second part of the chapter is devoted to the analysis of the result of the historical 'becoming *napë*': current relations on the '*napë* transformational axis.'

IV. 1. *Becoming 'civilizado'; becoming napë*

Ocamo peoples' narratives of the missionary and recent past speak of transformations of relations with *criollos*. One set of ideas refers to changes in habitus corroborating Vilaça's (1999) analysis, based on a perspectivist notion of the body, of inter-ethnic contact as 'metamorphosis.' Another set differs and speaks of the acquisition of *criollo* knowledge.[76] Both these modalities of recounting the past establish a link between 'how we used to be' and how the people upriver still are. I will treat both of these in turn.

IV. 1. 1. Becoming *napë*: a change of body/habitus

The following is representative of Ocamo narratives of encounter with missionaries:

> '…he would help [Cocco], he also gave things, loin-cloths, because before there were no loin-cloths only, *wãõ*, penis sheaths, only that then / before the Yanomamɨ were afraid, they were afraid, they didn't know the *napë*…here Father Cocco lived with the Iyëwei t^{h}eri…before they didn't have their clothes, before they wandered naked, in the first time, [they were] naked…the missionaries helped the Yanomamɨ, they gave clothes, they made them become

[75] My argument here finds important echoes in Gow's (2001) and McCallum's (2001) analyses of relations with Whites and 'the outside' as sources and sites of necessities for the sustenance of Piro and Cashinahua current lifestyles. In suggesting a transformative correspondence between *shapori* and influential interface Yanomamɨ – mainly modern leaders and politicians – I am echoing several authors who, in emphasising indigenous perspectives and continuities speak of a series of transformative substitutions. See Introduction.

[76] Gow (2001) is a fine combination of both these ingredients of Piro people's view of historical engagements with Whites. See also Rival (2002:161-3) for similar discussion of the place of the body and its new habits (e.g. diets, specific hygiene practices, a sedentary lifestyle) in 'becoming civilised' – always in relationship to another – among the Ecuadorian Huaorani.

like the *napë* with shoes, there was also the school and the church…so they got to know the missionaries well, they used trousers, T-shirts, all…'

Most such narratives stress a passage from being afraid of the *napë* to getting to know them, a passage accompanied by the changing of body habits. Getting to 'know the *napë* well' implies to become like them: dressing, eating and living like them.

Extracts from an interview with a man from Karohi point in a similar direction:

> '…napë pë no kiri t^{h}amahe, pë tokuama…Hapa no patapɨ, kamiyë no patapɨ rë kui pë pë hehu a hamɨ pë përihou tëhë, pë hapa napëonomi…hei tëhë pëmakɨ prewë pëmakɨ napëprou, zinc kë kɨ yahi hamɨ pëmakɨ titihou, napë nii pëmakɨ ha tërënɨ pëmakɨ niya waruwaruprarou…'

> '…the *napë* would make them [the ancients] fearful and they would flee…A long time ago the ancients / when the ancients lived in the mountains, they did not live like *napë*…nowadays lots of us are becoming *napë*, we are living in houses with zinc [roofs], when we obtain *napë* food we eat it…'[77]

A common marker of historical change is the passage from living far away in the forest to living near the *napë* along the Orinoco. This man also mentions *napë* habits such as living in houses with metal roofs and eating *napë* food (typically rice, pasta, sardines). All this refers to a transformation from living 'as the ancients did,' to living as we do today. And as Gow (2001:7-8) finds for the Piro, this transformative process has had its consequences (notably *shawara*) but it is one of which Ocamo people consider an achievement, their pride is in being Yanomamɨ and *civilizado*.

Vilaça suggests that, in the process of inter-ethnic contact, 'indigenous sociology is above all a 'physiology,' so that in place of 'acculturation' or 'friction,' what we have is transubstantiation, metamorphosis.' Further on:

[77] This interview was part of a short documentary (Wallace, 2001), devoted to the preparations for the Yanomamɨ Mavaca conference of November 2001. I have translated the last verb '*waruwaruprarou*' in a very simple form as 'eat,' but it must be noted that the root *waruwarumo-* refers specifically to eating from the palm of your hands (Lizot, Unp.:463). I am unaware of the reason for this choice of words.

> 'Thus, when the Wari' say that they are turning into Whites, this is a way to say that today they eat rice and pasta, that they wear shorts and wash with soap…Clothing is a constituent part of a set of habits that form the body' (1999:255).

Which is precisely how Yanomamɨ would put it. But I want to add how the form 'because before the ancients didn't have x' or 'didn't know x' is common to both historical narratives of transformation into *napë* and myths involving the acquisition of cultural items such as plantains, fire, etc. Occasionally, as in the first case above, the speaker refers to the pre-missionary period as 'the first time' or 'the first ones,' the equivalent position of being the pre-transformation 'ancients' in mythical narratives.

Following Gow's (2001) lead, let us examine the context in which I was told the myth of Pore (Chapter III) as well as the context where the Ocamo captain told it to Cocco. I was interviewing a friend (aprox. 40 years old) who had been telling me about Father Cocco and his generosity, his goods, food, assistance and education. Next I changed subject and asked him for a myth, a tale of the *no patapɨ*, 'the ancients,' about the origin of the Yanomamɨ. He recited the myth of Pore even though he – son of a great *shapori* – knew well the Yanomamɨ origin myth. I suspect the sequence of our conversation led him to tell this myth. We were speaking about the times of Cocco, a highly transformative period when the Ocamo people see themselves as beginning to become *civilizado*. It is plausible that my informant's choice was telling me that, just as the acquisition of plantain was an essential aspect of 'being Yanomamɨ' since mythical times, the acquisition through Cocco of a *criollo* habitus, is essential to how Yanomamɨ feel about themselves today.

In short, these contexts of myth telling to *criollos* and the commonality of narrative forms indicate that Yanomamɨ in Ocamo can speak of their historical relations with *criollos* as time-compressed events of habitus transformations, as repetitions or instances of occurrences in mythical times. Table IV.1 summarises these analogies.

Table IV.1: Analogies between mythical and historical transformations.

	Mythical context (becoming Yanomamɨ)	Historical context (becoming *napë*)
Pre transformation	Ancients (lacking culture)	Yanomamɨ
Post transformation	Yanomamɨ, animals, natural features, etc.	'Civilised' Yanomamɨ
Acquisition	Yanomamɨ cultural items (fire, plantains, etc.)	*Criollo* cultural items (e.g. clothes, tools)

Further supporting the idea of transformation or metamorphosis is the usage of the particle *–pro-* in the term '*napëprou*' which is the common way of saying 'being *civilizado.*' According to Lizot -*pro*- 'connotes the idea of transformation and, when suffixed to a noun [like *napë*], [it] verbalises it, indicating a change of nature, of state, of form, etc.' (1996:83). Moreover -*pro*- indicates the final phase of a process which is still happening, the perfective -*prariyo*- is used when the process is complete. So '*napëprou*' is in fact 'becoming *napë.*' Mythological transformations, as metamorphosis, are also linguistically marked by the *pro/prariyo* form.

To be '*napëprou*' is to imagine yourself in an ongoing state of transformation into *napë*. This sense of *napë* as limit – a point you approach but never reach – is consistent with Yanomamɨ representatives' political discourse which portrays today's Yanomamɨ 'as walking the *napë's* path' (i.e. progress). We can see how different this sense of collective transformation into *napë* is from doctors' implicit discourse of the static naturalised Indian whose adoption of *criollo* ways is 'contaminating' (Chapter II). What Ocamo people see as a trajectory into a better future many *criollos* see as a degeneration; a 'loss of culture.'

But we must return to the issue of *shawara* for it too points towards a transformation of habitus. I asked whether *shawara* would disappear if we removed all the motors, combustion and *criollos* from the Upper Orinoco.

> 'Ma pë kai mraimi ya se formo pë kurprou waikirayoma shawara ɨhɨ kë. No quita kuami, mihi shawara / shoati mihi kama pë shawara kuprou waikirayoma.'

'No, it will not disappear, it has already been formed, it has already been formed, you see. It doesn't go, nothing! That *shawara* / those have already become *shawara* for ever.'[78]

Others mentioned that there was no point in retreating back to the deeper forest away from *criollos* because *shawara* is everywhere now and it will never disappear. *Criollo*-produced *shawara* has infested all the forest and is another habitus transformation produced by contact affecting, afflicting Yanomamɨ bodies.

A final instance of body transformations came to me from a trained nurse. In a technically sophisticated language (its accuracy is not the point here) it expresses an internal change of the Yanomamɨ body, a consequence of changed nutritional habits:

'…a long time ago, our culture lived / they lived in the headwaters, when the Yanomamɨ didn't know medicines, they didn't know head-aches, there was almost no sickness, [Sp. *enfermedad*, always referring to *shawara*] because they didn't know how to eat what the *napë* make, and that stuff / our blood is now too mixed, with the vitamins of *napë* food and the vitamins of the food we eat in the headwaters. That vitamin doesn't have enough resistance, it has no potency…nowadays…a small child already has hepatitis, they get ill early because they have very low vitamin levels, they are already accustomed.'[79]

This theory would certainly appear plausible for many Yanomamɨ. That *criollos* are weak is evidenced in their feebleness in the forest, always quick to complain about their suffering. So in becoming *napë*, through acquiring their eating habits, the statement suggests Yanomamɨ have become weaker, more vulnerable to disease.

Another friend spoke of 'already being accustomed to living with sickness.' To be 'accustomed' implies the irreversibility of a process. You cannot go back and undo

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[78] 'Those' might be referring to the mythical origins of *shawara* where the demiurges transformed into *yai* demons and this spread *shawara* throughout (see section III.2. pp. 79).

[79] This indigenous analysis is echoed by the Kayapó who say that eating Brazilian food and drinking alcohol or having sex with them makes you 'weak' (Turner, 1991:304). Elder Huaorani say the bodies of young Huaorani are 'bland' and 'soft' due to their new diet of manioc, rice, oats and sugar (Rival, 2002:162). This is an interesting contrast with the Piro who consider themselves 'of mixed blood' but due to marrying other Indians rather than eating White's food, even when the eating of 'real food' – game, plantains, manioc – is a diacritic feature that marks them off as history-kinship fostered communities of kin.

yourself into an original state, just as animals cannot de-transform themselves into ancient Yanomamɨ. Whichever way you see it, either the forest is *shawara*-infested or your body is feeble or 'accustomed' to certain habits. Orinoco Yanomamɨ are *napë* now, they are *civilizado*, they accept the costs and try to reap the benefits. Irreversibility leads us back to the notion of *napë* as limit, as a direction of historical transformation-progression that drives current representatives' discourse: the *only* way to improve is to continue the *napëprou* trajectory, meaning not to live in cities, marry *criollos*, or drop shamanism, but to be dual Yanomamɨ/*napë*, to have healthcare, education and manufactured goods and greater control over these *criollo* resources (see Chapter VIII).[80]

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We have so far explored the notion of 'becoming *napë*' as a change of body/habitus. Following Vilaça's lead we showed this to be a metamorphosis of such relevance that it can be rendered in mythical terms. This alternative – which co-exists alongside more matter-of-fact ways of speaking about past relations with *criollos* (cf. Hugh-Jones, 1988: 140) – prefigures change as a repetition and what is repeated is a transformation, an other-becoming (cf. Gow, 2001). But listening to the Yanomamɨ a second component of *napëprou* becomes apparent: the acquisition of *criollo* knowledge.

IV. 1. 2. Becoming *napë*: acquiring *napë* knowledge

Like many other Amerindians the Yanomamɨ are not interested in accumulating Western goods but rather in controlling their distribution. Depending on the case, motivations for this are a combination of the two sides of each contact situation: relation with national society and relation with other 'deeper' indigenous communities. Motivation always has a mixed element of economic and political levelling with Whites and of procuring a favourable position in internal economic and political relations. In this context education, in particular the acquisition of the *criollo*

[80] See Gallois (2000), Turner (1991), Hugh-Jones (1997), Rival (2002) for similar analyses that show the indigenous interest (Waiãpi, Kayapó, Barasana, Huaorani respectively) in controlling the resources they need from the outside.

language, Spanish, became a crucial means to communicate with the resident missionaries and facilitate access and distribution of Western goods.

Today many Yanomamɨ speak Spanish, have travelled beyond the Upper Orinoco, and have progressively got involved in regional (and a few national) politics. The flow of Western goods coming from missionaries has also declined. Given all this, education, not just speaking Spanish but a broader conception of *criollo* knowledge (Spanish, maths, politics, travel), epitomised in the ability to read and write, is now fundamental for the Yanomamɨ to be able to take the place the missionaries and themselves secure Western goods found beyond the Upper Orinoco.[81]

> 'I always say, 'before when he taught us [Cocco], when he was teaching us, before he would give gifts…he would bring all sorts of things, pots, loin cloths, nylon, hooks, he helped, he cooked wheat…he gave food, grated manioc…so they still think [elders]: 'why don't they do like those missionaries? [today's]' then I say: 'no, he first taught us, he helped us because we didn't know the language of the *napë*, since we were really Yanomamɨ, really *waikasi*, he would help us. Now there is no help, now we know how to speak, we know how to study and now we have to think how we are going to find money with work…it isn't as it used to be.'

This view, I think, is representative of politically 'lay' people. For those Yanomamɨ involved in (indigenous or *criollo*) politics, wide-scope *criollo* knowledge is fundamental for the defense of their rights (healthcare, education and political participation, land) and to liase with *criollo* politicians (Mayor, Governor, other officials) in the process of obtaining votes for themselves or other party members and requesting the allocation of goods (electric generators, boats, motors, etc.) for one's community. Spanish competency and a 6th grade education is compulsory for work as a nurse in the health system. Any community wanting to have more control over their health situation – particularly relevant in the Mavaca 2001 conference (Chapter VIII)

[81] Hugh-Jones (1997) suggests a similar passage among the Barasana who, during earlier phases of contact with Whites were not interested in education but trade. The later development of concern for education is a reflection of the balancing of power relations that allows for the Indians to have more control over their relations with national society. Even when I am suggesting the Ocamo concern for education was present from early stages with the missionaries, the passage from focusing on goods themselves to their control, together with controlling disease, for example, is similar.

– experiences the need for *criollo* knowledge as a condition in the production of nurses.

I want to argue that *criollo* knowledge has become complementary to shamanism, on the one hand, and ecological knowledge, on the other. Whilst shamanism is key for the management of socio-political relations on the 'traditional' axis, education is key for the management of relations on the '*napë* transformational axis' with *criollos*, necessary for the sustenance of the *napë* lifestyle of Yanomamɨ along the Orinoco. Shamanism is a technique of mediation with the spirit world (*hekuras*, *yai*, *shawara* demons, etc.) and the invisible image/aspect of everything (*pei no uhutɨpɨ*), connecting ordinary Yanomamɨ with this complementary world *via* the *shapori*. Wide-scope education is an equivalent technique of mediation with the *napë* world, connecting ordinary Yanomamɨ with another complementary world *via* the educated or 'interface' Yanomamɨ. If *shaporis* have the ability to take the Other's point of view, the perspective of spirits, as requisite to engage with them in co-ordination, negotiation, dialogue, aggression, etc, then 'interface' Yanomamɨ have the same ability to assume the position of '*napë*' in order to manage relations with them, rendering their world comprehensible to those Yanomamɨ who have less experience of *criollos* (translation) and attempting to put *criollo* resources at the service of the community (control).

IV. 2. *Reading/writing and seeing*

If sight is the privileged capacity of the *shapori*, who sees what no-one else can, then reading/writing are the 'eyes' of those who mediate with the *criollos.* The recent spread of party politics in the Upper Orinoco (mid 90's) and the even more recent development programme *Plan Casiquiare* (from 2000) must have reiterated the importance of being able to read and write for the Yanomamɨ. It was through writing that many Yanomamɨ expressed their needs to the military agents in a memorable visit of the President to La Esmeralda (2000). Months later an unprecedented number of outboard motors and boats were officially delivered to a number of Yanomamɨ communities. Foreseeing that the President would once again produce the goods in the near future, in the months previous to a second visit (April 2001), I was approached

by a number of Yanomamɨ to help them write ‘community projects,’ lists of material needs accompanied by ‘*criollo* acceptable’ motivations.

For some at least, reading/writing and paper documents are associated with *criollos*’ abilities to produce trade goods. I once asked a young friend from Maweti (3 hours upriver) about the ‘mosquito net project’ that had provided people in greater Ocamo with insecticide-impregnated nets as a malaria control measure. On this he commented:

> ‘… aaaa mosquitero hei pë rë kui…hei papel pë hamɨ ɨhɨ rë kë, pë noreshi taɨhe este mosquitero hɨtɨtɨwë pë noreshi taɨhe doctora [name] iha…ɨhɨ tëhë, mosquitero hɨtɨtɨwë! pë t^hapraɨ plastico hamɨ, ɨhɨ tëhë pë shimaɨ, pë warou Ocamo ha, ɨhɨ tëhë mosquitero pë shetekaɨ…Lechoza, Yohoopë…miha Ocamo ya warokei tëhë…shoati ya t^hë t^haprai nareo, hɨtɨtɨwë mosquitero, hɨtɨtɨwë franera, hɨtɨtɨwë pantalon, hɨtɨtɨwë ya t^hë pë noreshi t^hama…’

> ‘…aaah! Those mosquito nets…the ones on the paper, they draw them [write on paper], they all write for the doctor…then she made many nets in plastic bags, then she sent them, they arrived in Ocamo, then they gave them to the communities…Lechoza, Yohoopë…when I arrive over there in Ocamo…I always draw too, all the nets, all the T-shirts, all the trousers, I wrote for everything…’[82]

This resonates with Gow’s (2001:195) description of the role of writing in the White-Piro relations during the rubber period in the late 19th century. ‘Sangama [a prophetic Piro who claimed to know how to read and write] makes it clear that the power of the White bosses over Piro people rests on their knowledge of writing, and the way in which that knowledge gave them control over the fluvial trade.’

But the power of paper documents in the Upper Orinoco is also one of enabling or disabling other processes like participation in regional/national elections, where national identity cards are required. In short, reading/writing and the ability to produce paper documents is the knowledge Yanomamɨ need to aspire to control the

[82] Hundreds of mosquito nets were sent to Ocamo by plane in large plastic packaging. Here they were stored and then distributed. This *huya’s* account is referring to these events.

flow of goods (writing projects), the improvement of healthcare (producing health personnel), and to defend themselves from conniving outsiders (cf. Hugh-Jones 1997; Gow 1993).

A matter I will develop more extensively in Chapter VI is the manner in which Yanomamɨ in Ocamo make analogies between *shaporis* and doctors. If, in certain curing circumstances, doctors are '*napë shaporis*,' it is because of their special *criollo* knowledge epitomised in reading/writing. This is but an instance of how the *criollo* technology of reading/writing is equivalent to the shamanic technology of 'seeing.' Akin to this analogy an Ocamo friend translated for me the notion of a *hekura* descending on the *shapori* as 'arrives where the Yanomamɨ are and gives his capacity [to the *shapori*].' The other context in which he frequently used the term 'capacity' was speaking of people like himself, young, educated Yanomamɨ. Both *shapori* and educated Yanomamɨ are '*capacitados*.'[83]

IV. 3. *Translation and shamanism*

Let me now draw on the Mavaca Yanomamɨ conference of 2001 as a site where the mediating/translating role of interface Yanomamɨ (mission-educated and politicians) was most evident. Their mediation/translation subsumes what we have been discussing regarding becoming *napë* as body transformation and acquisition of knowledge. At the same time it makes explicit the equivalence between *criollo* and shamanic knowledge; writing and seeing.

In his first intervention in the conference, standing on a platform in front of a mixed audience of community representatives with different degrees of exchange with the missions and health system, one of the nurses of the Upper Orinoco dedicated most of his speech to explain to those upriver Yanomamɨ what the event was about:

[83] The usage of this term in particular might have been incorporated from the common way in which many training courses are described in Spanish as '*Cursos de capacitación*' or 'capacitating courses.' In general the verb '*capacitar*' has the educational connotation of 'enabling,' providing a knowledge or skill to perform a certain task (e.g. nursing).

> Congreso…hei t^{h}ë rë kui t^{h}ë mimou shomi, hawë epena pëma paapë ɨhɨ t^{h}ë mai …t^{h}ë mɨmou shomi yaro ɨhɨ hei t^{h}ë pata ma rë onimarë yaurë, secretario hei pë kai kua ɨhɨ rë kë, t^{h}ë mɨmou shomi, t^{h}ë napë yaro! no patapɨ pënɨ t^{h}ë taimihe!…'
>
> 'This congress looks different, it is not like taking *yopo*…because it looks different, there are big hanging letters [a large banner behind the platform that wrote 'National Yanomamɨ Conference, Shakit^{h}a 2001'], there are also secretaries, you see, it looks different because it is *napë*, the ancients don't know about this!…'

The speaker was dressed wearing trousers, T-shirt, belt, shoes, in front of a mixed audience where those from upriver where only sporting shorts, loincloths or ragged *criollo* attires, others wore traditional adornments. Being a nurse he also had a stethoscope hanging round his neck and a notebook in his hand. The 'dress code' and 'accessories' refer to the two aspects of being *napë* we have just outlined. Clothes point to a *napë* body, the stethoscope and notebook point to *napë* knowledge. Without having yet spoken, this man is being *napë*.

He highlights how the conference looks different from taking *yopo*, trying to link this form of political congregation, the Conference, with a Yanomamɨ event often used to discuss important matters, a *yopo* session. But in saying it is not a *yopo* session he is translating quite the opposite, he is making the Conference resonate with the *yopo* session in such a way that upriver people can see this as a '*napë* form of taking *yopo*.' This resonance is only possible by a Yanomamɨ/*napë* who is able to 'see' like a *napë* and 'see' like a Yanomamɨ, rendering difference as analogy.

Next he makes reference to the writing on the banner and the 'secretaries'; a few Yanomamɨ that were writing down the proceedings. These are the only two remarks about what is different and both are related to writing: the banner; the secretaries. What is underlined is that writing is at least one of the sites of the speaker's privileged knowledge. Finally the difference is explained: it's a *napë* procedure, something with which the ancients are not familiar. Locating difference in the *napëness* of the event simply reiterates in words what has already been said in form.

I am not arguing that the Yanomamɨ perceive 'interface' Yanomamɨ as *shaporis*. What I am saying is that the possibility of their mediation is grounded on the same ontological premises as shamanism: true knowledge comes from becoming an Other and taking that Other's point of view. Mediation between worlds is possible for those people who have a foot in both (Viveiros de Castro, ms.). Like *shaporis* are Yanomamɨ/*hekuras*, people from places like Ocamo are Yanomamɨ/*napë*. This is the aesthetic form by which mediation is indigenously recognised and validated.

Carneiro da Cunha (1998:12-13) reminds us of how, particularly in context of encroaching colonial situations, 'shamans, travellers in space and time' are prime translators rendering the unknown resonate with known through correspondence. What I am suggesting is to flip this argument of shamanism as translation on its head, and see translation (mediation) as unavoidably shamanic in form.

Before ending this section I want to refer to the words of Davi Kopenawa in Albert (2000:248) under a section appropriately named 'See, know.' In the context of the destructive gold miners affecting the Yanomam, Davi links their predatory nature to their ignorance.[84] Ignorant of what the *shaporis* see when they take hallucinogens, ignorant of the 'vital image' of the forest.

> 'In this way, he [Davi] underlines the irreducible antagonism between two forms of knowledge, that of the 'foreign, enemies,' [gold miners] that has its roots in writing, and that of Yanomami, based on vision – shamanic knowledge[.]'

In saying that true knowledge is shamanic he is also saying that there is a *criollo* counterpart acquired through writing on paper in schools which only refers to 'the realm of manufactured objects and machines from which the Yanomamɨ are excluded' (Ibid.:249).[85] This plays out the complementarity between the *criollo* knowledge/world and the shamanic knowledge/world.

[84] Gallois (2000:227) describes how Waiãpi also link Whites destructive nature – also referring to gold miners – to their ignorance.

[85] The equivalence is found elsewhere: '…the Indians I know in the Putumayo foothills sometimes say [*yagé*] is a special gift from God to the Indians and for Indians only. '*Yagé*' is our school,' '*yagé* is our study,' they may say, and *yagé* is conceived as something akin to the origin of knowledge and their society' (Taussig, 1987:140).

Congruent with the rendering of the missionary encounter as a collective transformation of mythical dimensions is the mediation of interface Yanomamɨ between *criollo* and Yanomamɨ worlds in shamanic-like form. The one is a historical collective metamorphosis that makes the dual Yanomamɨ/*napë* being of Orinoco Yanomamɨ, the other is the enacting of this dual nature through mediation. The same ontological premises are maintained in both cases and could exemplify those 'things that go unsaid' that Taylor (1996:203) suggests form a circle of reinforcing premises that uphold a lived world as a coherent experience of notions so obvious as to fall outside discursive elaboration. If myth and shamanism are in constant interplay updating and validating each other, on the '*napë* transformational axis,' it is a sense of 'becoming *napë*' and mediation (translation and control) that entertain this dialectic.

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Thus far we have presented the historical 'becoming *napë*' of Ocamo Yanomamɨ as a transformation in body and knowledge which allows for a dual Yanomamɨ/*napë* being, referred to as being '*civilizado*.' We will now develop the synchronic aspect of this becoming. This aspect of *napëprou* exists because of the internal 'gradient of contact' among Yanomamɨ: long-time differential exchange with missionaries and the health system. It constitutes a network that finds Ocamo Yanomamɨ in a middle ground between a Yanomamɨ pole and a *criollo* pole, a positioning that is key for constructing and sustaining their dual identity.

IV. 4. *The 'napë transformational axis' played out on a river*

The usage of terms 'Yanomamɨ' and '*napë*' reveal the co-existence of two planes or socio-political axes. In the first plane, '*napë*' has connotations of alterity in terms of enmity. Its simplest meaning is 'enemy.' A series of derivative terms are all associated with it: *napëmaɨ*: 'to hate, to detest or have aversion for someone'; *napëmou*: 'to menace, to show hostility' (Lizot, Unp.:257-258). The semantic field of '*napë*' has another side which refers to *criollos*. *Napëaɨ*: 'to begin to know the *criollos*, or do like them' (Ibid.), *napëmou*: 'to behave like *criollos*; to speak Spanish'; *napëprou*: 'to become *criollo*.' In both cases, '*napë*' is a strictly relational concept, it

refers to how one person or group stands in relation to another. The semantic field of '*napë*' encompasses the historical shift in relations with *criollos*, from 'enemies' to '*criollo* body/knowledge.' The fact that *criollos* are still called '*napë*' reminds us that the innovation is an extension and not obliteration of convention: there is something enemy-like in *criollos*. I will now focus on the second set of connotations, exploring the '*napë* transformational axis.'

To gauge this gradient, recall the material and experiential difference between upriver, mid-river and Ocamo Yanomamɨ I outlined in Chapter I. Exchange relations between upriver and Orinoco Yanomamɨ send manufactured products upriver (metal tools, clothes, mosquito nets) and indigenous ones down (*yopo*, tobacco, plantains). *Reahu* funerary feasting and other visits are plentiful along the Ocamo and presumably have become more frequent with the growth in the number of motors. Alongside these, there are some altogether novel relations. Ocamo Yanomamɨ accompany doctors upriver as helpers, interpreters and nurses. Ocamo politicians venture upriver to rally support for themselves or their party. Some influential Yanomamɨ hire upriver people to clear the forest for making their gardens or simply to clear the bush around their houses. People in Ocamo occasionally harbour relatives' children from upriver while they study in the school. Occasionally upriver Yanomamɨ need treatment in the rural clinic, whilst being harboured by relatives others make fun of their sense of loss and ignorance of the *criollo* life style of Ocamo.

All these relationships play out in the '*napë* transformational' context and involve two positions, '*napë*' as *criollo* habitus and knowledge, and 'Yanomamɨ.' On the '*napë* transformational axis,' people in Ocamo consider themselves 'Yanomamɨ' and the category '*napë*' refers to resident missionaries, doctors, anthropologists and all non-indigenous people that live beyond the Upper Orinoco. With reference to only themselves – Yanomamɨ that is – the neighbouring Yekuana are also '*napë*.' Historically, however, before the encounter with *criollos* and their transformation, the Yekuana were also 'Yanomamɨ' – based on their body/habitus. When the contextual reference is non-indigenous people, all Indians are 'Yanomamɨ.' Only in a mythical context can *criollos* be considered 'Yanomamɨ,' for they too are the result of transformations of ancient Yanomamɨ. Beyond this there is no context in which

criollos can be seen as 'Yanomamɨ,' and in this sense they are *napë yai*, 'real *napë*.'[86] The term *yai* (Sp. *propio*) has connotations of 'real, essential, true.'[87]

Being 'Yanomamɨ' is something Ocamo people share with people upriver but there is recognition that these are also 'real Yanomamɨ' just as in comparison to the Yekuana, *criollos* are *napë yai*. '*Waikasi*' is the term that conveys this sense of 'real, true, Yanomamɨ,' it connotes the state of 'being like the ancients' of being 'uncivilised' associated with upriver Yanomamɨ. This usage is derived from the *criollo* term that used to be used to designate the Yanomamɨ with connotations of 'fear-inspiring savage.' However, '*waika*' is a Yanomamɨ term for designating others, forming a geographical and sociological oppositional pair with '*shamat*^{h}*ari*.' For any given group the *waika* are northern Yanomamɨ and the *shamat*^{h}*ari* are to the south (Lizot, 1994:227).

Consider again my friend telling me how he explains to the elders why the missionaries are not generous anymore:

> '…then I say: 'no, he [Cocco] first taught us, he helped us because we didn't know the language of the *napë*, since we were *propio* Yanomamɨ, *propio waikasi*, he would help us…Cocco taught us, we are already *civilizado* and we can do as we wish…'

So before becoming *civilizado*, Ocamo people were *waikasi* just as the upriver Yanomamɨ. Now 'being like ancients' is correlated with a lack of *napë* habitus and

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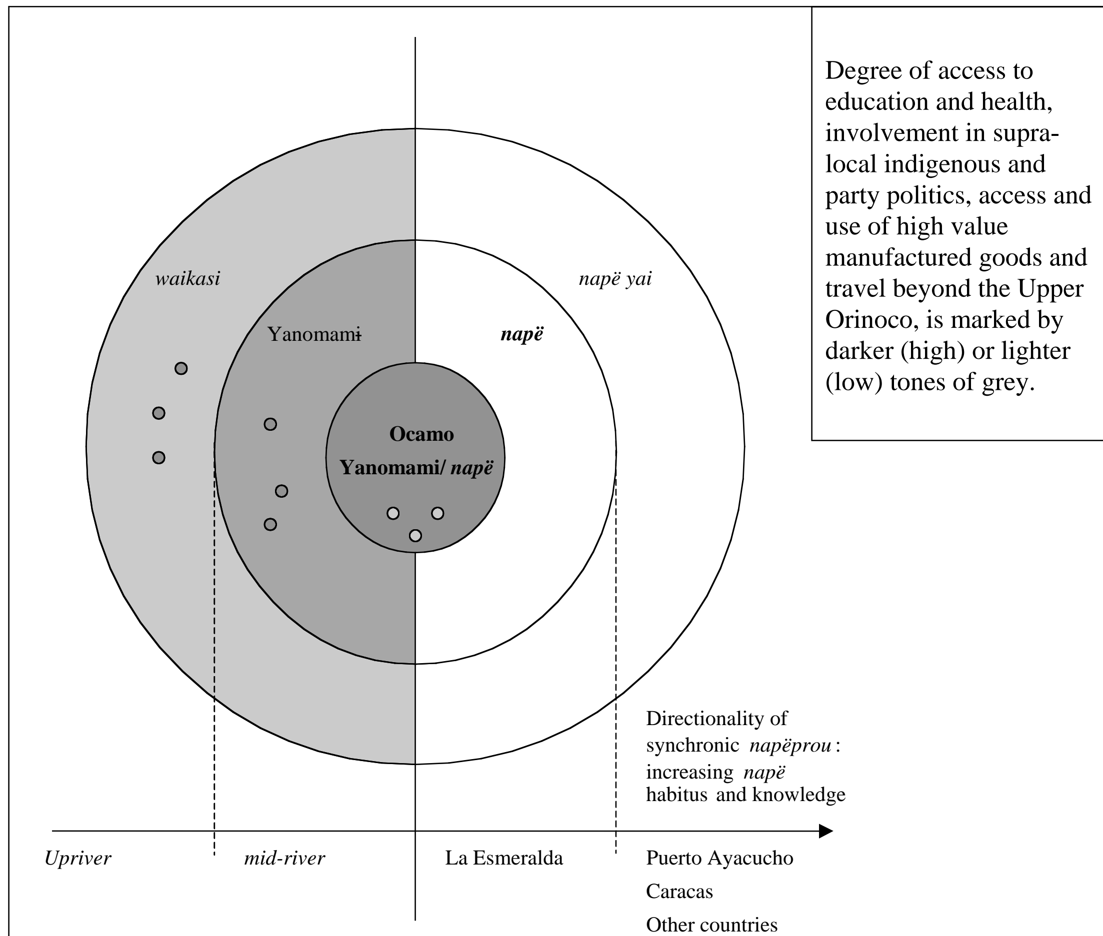
[86] The myth in question deals with the differentiation of human groups. As cannibal waters rise threatening to kill the ancients, some creep up mount *Mãiyõ* to save themselves. As the water rushes by them, it carries with them many Yanomamɨ. When the water resides after the sacrifice of an old woman who is thrown into the water, these washed away Yanomamɨ will become Whites, other Indians, other Yanomamɨ groups, etc. This is what many in Ocamo and upriver told me to be the origin of *criollos*. This summary is from Lizot (1975:35).

[87] '*yayë*,' in Albert's analysis of the Yanomam (Ramos & Albert, 1977:82) is a most important distinction between 'real' cognatic kin (consanguines and actual affines) and 'mere' kin, 'those whose linking truncal sibling set in the common genealogical space is more remote than the second ascending generation and therefore forgotten.' These 'mere' kin are reclassified as potential affines. His later analysis (1985:221-235; 221 ff. 30) retains the essence of this argument. Lizot (1977:59) writing on the Yanomamɨ, argues the term '*yaiyë*' alongside '*mashi*,' 'same class, type, side of something' designates siblings and parallel cousins. Its usage defines a bilateral kindred who recognise a common male ancestor. Lizot (1971b:26) refers to the verb *yai-* to differentiate half-siblings. It also refers to be living together with your *mashi* relatives (Ibid. & Unp.:479). In any case it is important to note its role as marker of greater sameness and proximity in the context of kinship.

knowledge. Those in between, 'mid-river' people are midway between *waikasi* (upriver) and Yanomamɨ/*napë* (Ocamo). Figure IV.1 summarises some of the aspects of the '*napë* transformational axis' we have thus far encountered from the vantage point of Ocamo.

Figure IV.1: *Napë* transformational axis: Ocamo perspective.[88]



Retaining the Ocamo vantage point, let us summarise a series of markers of being 'real Yanomamɨ.' People upriver don't know how to eat *criollo* food. They will eat pasta and rice but not mixed with sauces or unknown vegetables. One Ocamo friend

[88] The 'spots' within each sphere are meant to convey some heterogeneity. There are isolated cases of people living in upriver communities who will have had more exposure to *criollo* institutions and hence they stand out in their communities. These individuals become key mediators when doctors or other *criollos* visit. Equally some elders and others in Ocamo are less knowledgeable in *criollo* affairs than the average and may be seen as 'traditionalists.' Although I will not treat this in the thesis, it is important to note that women travel much less beyond the Upper Orinoco than men. In Ocamo it was also common for them to leave school before men (around 4th grade) to marry. In general women have less dealings with *criollos*, a sphere of politics mostly reserved for men. McCallum (2001) develops these differences and examines male-female complementarity to great effect.

said they ate with only a bit of salt, not like them, that learned with the missionaries. People in Ocamo may occasionally say they don't want to go upriver because they always end up giving desired items away. A final common marker is to live '*pa' dentro*' 'deep in' the forest or *hashiri hamɨ*[89] not close to large rivers (cf. Gow, 1993).

Just as there are markers of 'real Yanomamɨ' there are associations attached to 'real *napë*.' Let us refer to the outer sphere of the *napë yai*, for it is an expression of the 'power of the outside' essential for social reproduction, a theme that has been described throughout Amazonia.[90] My argument coincides with McCallum (2001) and Gow (2001) in that this sphere is the source of that which makes possible a 'Yanomamɨ/*napë*' life. It is this dependency on the outside that makes the management of relations with this sphere of *napë yai* on the '*napë* transformational axis' an equivalent to the shamanic management of relations in Albert's outer human spheres (3,4 and 5 in Chapter III figure III.1). This outer sphere combines extreme creative and destructive power. The outside can work to your benefit or your demise and has important connotations of danger. In this regard it is an instance of the widespread Amazonian ambiguity of the outside – in its sociological and cosmological expressions (see Overing, 1983-4; Viveiros de Castro, 1993; 2002). Hence, it is this general scheme of 'management of the powerful yet dangerous outside' that frames relations with doctors as we shall discuss at length in Chapters VI, VII and VIII.

Napë yai find ultimate expression in powerful *criollos* that lie beyond the Upper Orinoco that can importantly influence Yanomamɨ lives. People like the President, some charity organisations, ministers, the Governor, higher officials of institutions they know locally, such as the Regional Health Director. These personalities,

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[89] The term according to Lizot (Unp.:52) strictly means 'on the firm ground, to travel by land' as opposed to on the river.

[90] See Overing (1983-4) for general argument on the need for proper mixing of difference for the production of social life; Viveiros de Castro (1992) for a general proposition of 'the enemy' as 'the centre of a society without centre' in his Araweté and Tupinamba analysis; Turner (1991:295) for the Kayapó process of transforming nature (outside) into the socialised village (inside); McCallum (2001) for the Cashinahua complementarity of male agency that exchanges with the dangerous outside to obtain its products and female agency that then transforms these products into 'real people'; Fausto (2000) for the Pakaranã dependence on dreams about Others beyond kinship for the bestowal of enemy songs essential for ritual reproduction.

normally treated as '*pata prowehewë*' or '*pata yai*,'[91] 'big/important/influential men' or 'real bosses,' can mobilise important quantities of manufactured products, produce nurse or microscopist courses, procure massive amounts of gasoline or food to support meetings, mobilise helicopters in attention to epidemics, influence territorial demarcation, etc. They stand for powerful sources enabling 'becoming *napë*.' But this is one of many expressions of *criollos*' power/danger. Let me summarise some examples.

First, *criollos* are associated with the extraordinary knowledge and ability to produce awe-inspiring technological items ranging from motors, watches, sound systems and remote control.[92] Second, the hospital in Puerto Ayacucho combines positive power to cure with a dangerous potential to injure or kill. People recognise the hospital as a site of higher technology and knowledge than the rural clinic. In an Ocamo *huya's* terms:

> '…we Yanomamɨ think that you [Hospital Director] will save us in the larger hospital with the technological machines [Sp. *aparatos*] here. In the Upper Orinoco there are rural clinics but there are no *aparatos* to save the Yanomamɨ and there is not sufficient important medicine, but here, here in the centre, in Ayacucho is the big hospital, and the specialist doctors that know more about all the diseases.'

On the other hand, for some the hospital is a dangerous place full of unknown *criollos* with intentions and concerns one cannot previously know. People are conscious that some trips to the hospital end in death.

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[91] *Pata* means 'big.' It can also be used in designating any person older than oneself. Along these lines it is used to refer to the elders as important people with moral authority. In political terms it can refer to a community headman. In Ocamo it referred to a group of elders that had considerable weight in community decisions, those whom Yanomamɨ modern politicians had to convince to get support. P*ata prowehewë* was also used in Ocamo with reference to *criollos*. Within the health system the Head of District was referred to as *pata prowehewe*, a term transferred to the Regional Director when he was present which carried the connotations of 'the boss.' In a purely indigenous context it also means 'big/important man of age,' with the same political connotations as *pata*.

[92] Medical students provide people in Ocamo with constant technological updating for they are particularly prone to sport new gear special for the jungle. Examples during my stay included a GPS and a satellite telephone.

Third, even when local *criollos* produce *shawara*, often it is said to be coming from far away nameable 'lands of *criollos*.'

> '…that *shawara* I don't know where it comes from' I think / other *shaporis* say: 'look that *shawara* you see…it comes from where the *napë* live the other / Brazil, that *shawara* is from Brazil'...the other one [a *shapori*] says: '*shawara* from around here comes, but it only lasts a bit, but the really strong *shawara* comes from…another country.'

Fourth, a special place in the Ocamo imagination, meriting more attention than I give at present, is occupied by the figure of the *malandro*, typically residing in Puerto Ayacucho. '*Malandro*,' refers to urban criminals ranging from petty thieves to murderers. I was struck by the tales Yanomamɨ had of their experiences in Puerto Ayacucho. It seemed that no-one had escaped an encounter with a *malandro*. The danger of the city is epitomised by this figure: a violent, reckless kind of *napë* wandering to see who they can attack. Men speak of being robbed, attacked and chased by the city *malandros*. Others tell of seeing encounters between *malandros* and the police: shoot-outs, knife stabbings, beatings, etc. '*Malandro*' has also been incorporated into Ocamo Spanish designating *huya* who trick or steal from the doctors, or 'bother' women i.e. 'illegal relations.' We may recall from Chapter II that '*malandro*' is also a term that typifies Orinoco Yanomamɨ among rotating students and doctors.

Summing up, *criollos* have become archetypal outsiders subsuming a synthesis of meanings that speak of a mix of creative and destructive powers. Just as, in Amazonia, an enemy is frequently a trading partner, a name giver, a fertiliser, the *napë yai*, epitomise the ambiguous nature of *criollos*: possessors and creators of manufactured goods; creators and disseminators of disease; sometimes dangerously violent *malandros*; other times helping the Yanomamɨ (missionaries, doctors). From this pool of *napë yai* come all the local/resident *criollos* (missionaries, doctors, military personnel), who are known to be less powerful and less 'virulent' only once some familiarity is established. Resident *criollos* are 'domesticated' versions of the real thing.

Having discussed the synthesis of dangerous yet necessary power of *napë yai* let us make a brief aside to present one of the consequences of this ambiguous image of *criollos* and then continue to the end of the analysis of the '*napë* transformational axis.' One of the components of managing relations with *criollos* is protection from their intrinsic deceiving and potentially harming nature (control). People (*criollos* and Yanomamɨ) in the Upper Orinoco gave me the impression that this component had, since the intensification of party politics in the mid 90's and the concomitant increase in inter-institutional rivalry, become more prominent. Relations with local *criollos* seemed to be in a period of heightened tension. All this can be resumed as a period of 'awakening.'

IV. 5. *Awakening*

One politician and supporter of the Mayor spoke of this new stage in Yanomamɨ political life as an 'eye opener,' a liberation from the protective umbrella of the missionaries.

> '…now the Yanomamɨ are awakening a bit because of politics, you see, because politics allowed the Yanomamɨ to awaken, I say this because before they didn't know how to make meetings, they didn't know how to criticise, they didn't know how to tell the good one [person/project?] from the bad one, they didn't know! They would just live like that without thinking about something else, in another world. Now we know the people, we know the ideology of the person, of the doctors, of the Salesian mission and of you the anthropologists…this is why today the Yanomamɨ are awakening to defend [ourselves] prior to 1996 the Yanomamɨ were very immature…'

This is part of a wider feeling of 'awakening' common to many Yanomamɨ representatives. Awakening implies that the Yanomamɨ, as a people, have been historically deceived by innumerable *criollos*, but that now they had the knowledge and experience to realise who is who and identify the real intentions of any *criollo*. It is undeniable that many *criollos* have taken advantage of the Yanomamɨ in the past. However, this awakening includes recasting other kinds of relations in new light. For instance, commenting on how nowadays no-one will do unpaid work for the doctors,

the Ocamo microscopist would say 'working for free is a thing of the past' or '*napës* don't work for free.' When working for free is seen as unfair and abusive, doctors are recast as another instance of *criollos* having taken advantage of Yanomamɨs' previous ignorance. The importance of this self-appraisal cannot be understated; it contributes to the intense control new *criollos*, like doctors or myself, experience.

We are now in a position to synthesise some of the analogies we have been discussing between shamanism and interface Yanomamɨ within the corresponding Yanomamɨ conventional and *napë* transformational contexts.

Table IV.2: Correspondence between shamanism and Yanomamɨ – *criollo* relations.

	Shamanism	Yanomamɨ – *criollo* politics
Role	Mediation: control of resources of the invisible world for benefit and defense of the community	Mediation: translation and control of *criollos* and their resources for the benefit and defense of the community
Capacity	Knowledge of the *hekuras* who enable the *shapori* to 'see'	*Criollo* knowledge epitomised in reading/writing
Condition	Dual Yanomamɨ/*hekura*	Dual Yanomamɨ/*napë*
Oriented to	Outer spheres of 'Yanomamɨ conventional space'	*Napë yai* (resident or outside *criollos*)

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Now let us return to our main analysis. One more aspect of the '*napë* transformational axis' remains to be analysed; the question of what makes a Yanomamɨ '*napë*' from different Yanomamɨ perspectives (e.g. mid-river and upriver).

IV. 6. *Napë and Yanomamɨ positions in the context of exchange*

From mid and upriver perspectives, Ocamo Yanomamɨ in certain contexts are considered *napë*. One feature stands out as defining degrees of *napëness* throughout the river: possession or provision of manufactured goods. In Maweti (mid-river) I asked whether the people in Ocamo were *napë* or Yanomamɨ.

> ‘Ocamo t^{h}eri pë rë kui? mision ha pë rë kurë?…Ma, pë napëmi….Esmeralda ha t^{h}ë shiro napë, Ayacucho ha t^{h}ë napë…hasta Ocamo t^{h}ë napëmi. T^{h}ë napë ha kunoha heyeha payeri pruka t^{h}ë hipeɨhe.’
>
> ‘The people of Ocamo? those who live at the mission?…No, they are not *napë*…In La Esmeralda its *napë* [it’s a *napë’s* place], in Ayacucho its *napë*, up to Ocamo it is not *napë*. If they were *napë* they would bring lots of [material] help here.’

This statement depicts the spatial gradient of *napëness* nicely. This man, who frequently visits Ocamo and sees himself on more or less equal ‘*napë* footing’ to them, gives us the mark of ‘real *napë*’: beyond possession, provision of goods. An influential man in Ocamo referring to a leader who always talks about ‘being like the *napë*,’ expanded:

> ‘…‘if you want to be *napë*, that’s OK, but then what are you going to give me if you become *napë*? Nothing!’, that’s what the Yanomamɨ say… ‘OK you want to be *napë* but where are you going to make/produce [Sp. *fabricar*] fishing nylon, hooks, machetes’ that’s how they say.’

Here, ‘*napë*’ beyond provision, is production. In short, the gradient of *napëness* goes from possession, to provision, to production of manufactured objects, and in this context of exchange anybody who has objects to give stands in a ‘*napë*’ position to one who receives or is lacking such items, who will be in a ‘Yanomamɨ’ position. The poles of possible positions are the *napë yai* (producers) and *waikasi* (always receivers). All those in between (Ocamo and mid-river people) are, in their condition of middlemen, Yanomamɨ/*napë*. From a down-river perspective they are ‘Yanomamɨ’ (receivers), from an upriver perspective they are ‘*napë*’ (providers). It is probably this exchange context that most commonly links down and upriver Yanomamɨ.

Table IV.3: Summary of analysis.

	Waikasi	Yanomamɨ	*Napë*	*Napë yai*
Space	Upriver or 'deep in' the forest	Ocamo	La Esmeralda and beyond	Ayacucho, other cities and countries
Napë Body/knowledge	• Less clothes and objects. Little or no high value items (motor, shotguns, radio) • No Spanish speakers. No schooling • Don't know how to eat *criollo* food • Strong bodies: don't get tired or hungry	• Regular use and access to clothes and objects. Some high value items (motor, shotguns, radio) • Spanish speakers and schooling • Eat some *criollo* food regularly • Strong bodies: don't get tired or hungry	• More *criollo* lifestyle: houses, food, clothes • Better Spanish speakers and schooling	• Complete *criollo* lifestyle: houses, food, clothes, cars, TV, etc. • Creative knowledge of technology. • 'Weak,' non-resistant, quickly tired and hungry
Exchange of manufactured objects	Only possession	Possession and provision	Provision	Production
Relation to *criollos* (Yanomamɨ for last two columns)	• Easily tricked • Mediated by Ocamo Yanomamɨ	• Awakened, not easily tricked • Unmediated	• Conniving, suspect of hidden agenda	• Conniving, suspect of hidden agenda • Disseminators of *shawara*.
Example	Pashopeka	Ocamo	Yekuana and *criollos* in La Esmeralda, other indigenous people in Amazonas	*Criollos* like doctors and missionaries and all those who live beyond the Upper Orinoco

IV. 7. *'Napë transformational axis' elsewhere*

What I have described thus far as the '*napë* transformational axis' with its historical and synchronic dimensions has counterparts in other historical and geographical parts of Amazonia. Having derived much of my analysis from Gow (1993; 1994) I will use his work for comparative purpose.

Gow (1993) writes from the perspective of the Piro on the Bajo Urubamba in Peru extending his analysis to other groups of North West Amazonia, all engaged in the debt-credit relations with successive White *patrones* that sprung during the rubber period. He places '*gringos*' and 'wild Indians' at opposite end of a continuum filled in by Amazonians like the Piro. Piro consider themselves *gente civilizada*, 'civilised people' which distinguishes them in body/habitus and knowledge terms from 'wild Indians' like the Yaminahua. The latter differ in body/habitus for they don't use clothes or salt and live deep in the forest. These are markers of a moral negation of exchange which Piro see as a fundamental to their being because it is through marriage exchanges with different peoples that they have a kinship-history which has yielded them as people of 'mixed blood.' It is also through exchanges with the local

patrones that they access 'fine things' i.e. manufactured products. Piro also differ in knowledge from the Yaminahua. After long periods of enslavement by rubber bosses Piro people have acquired knowledge of Spanish, reading/writing and the handling of money, so now they are not easily cheated by their *patrones*. Wild Indians, lacking this knowledge are easily exploited. At the other pole lie the *gringos* who live 'outside,' and hold the unobtainable knowledge that transforms raw materials into manufactured products in factories. These too, in not intermarrying with the local people, are negating exchange, and as the Yaminahua, are excluded from being real people. The *gringo* pole epitomises knowledge, the 'Wild Indian' pole brute body force. Piro are in the middle half knowledgeable and hard workers.

Let me summarise the parallels with the '*napë* transformational' axis:

- Both Piro and Ocamo people consider themselves 'civilised,' a state historically reached with not little effort. Enslavement by the rubber bosses or suffering *shawara* diseases in the Yanomamɨ case.
- The condition of 'civilised' is defined with reference to opposed 'pure' states: 'Wild Indian' and '*gringo*' for the Piro, *waikasi* and *napë yai*, for the Ocamo Yanomamɨ. The Piro and Ocamo Yanomamɨ combine both poles.
- Body/habitus and Whites' knowledge are the terms commonly used to differentiate people along the network.
- The network defines three spaces, roughly: deep forest (Indian pole), village (mixed), and outside (White pole).

In a similar analysis of Northwest Amazonia, Gow (1994:99), presents the terms of 'White,' '*mestizo*,' and 'Indian' as categories used in this large area 'to locate people in particular positions in the hierarchy of socio-economic power in the region and to contest such placements.' This usage adds another parallel.

- In the regional commercial network, from an internal point of view, 'Indians' are pure debtors, '*mestizos*' are debtor/creditors, and Whites are pure creditors. This resonates with the distinction I discussed between production (*napë yai*), provision (*napë*) possession and provision (Ocamo Yanomamɨ) and receivers of manufactured products (*waikasi*).

But there are also important differences. The Piro prototype of 'Wild Indian' is not another Piro but people from another ethnic group (Yaminahua). This point is illuminating of a further particularity of the Yanomamɨ situation. Just as 'humanity' is a relational condition on a continuum with maximum expression found in kin, the '*napë* transformational axis,' being an innovation upon the Yanomamɨ conventional space, is a context that makes important internal differentiation among the Yanomamɨ. Next, the Piro conception of 'being civilised' is founded on their history-kinship process of intermarriage with other Indians. Ocamo people have not intermarried with other Indians and strongly disapprove of the possibility of marrying *criollos*.[93] Neither do upriver Yanomamɨ negate exchange with Ocamo people, on the contrary, it is prolific. This difference is in part explained by the comparatively long-term integration of the Piro into a regional network of economic capitalistic relations, which is why this Yanomamɨ current context is so interesting: it can shed light on processes in other areas of Amazonia on which there is only archival references or filtered collective memory. The co-existence of the 'Yanomamɨ conventional space' and the '*napë* transformational axis' was perhaps a transitory phase precursor to the panorama ethnographically available for the Western Amazonia of Gow's analysis. Third, the inter-ethnic situation in the Upper Orinoco has been characterised by the comparative absence of exploitative enslavement or debt-credit relations found in Northwest Amazonia. Brutal circumstances precluded the possibility of strategic accommodation more available to the Upper Orinoco Yanomamɨ.

Concluding remarks

This chapter has explored the historical and synchronic aspects of a single process of 'becoming *napë*.' As a historical progression it is both a body/habitus transformation and the acquisition of *criollo* knowledge. As a synchronic context of relations within a network of Yanomamɨ with differential exchange with *criollos*, a '*napë* transformational axis' is defined, placing the past at the upriver segment of the

[93]Along the Padamo river is Toki, a mixed Yanomamɨ / Yekuana village where intermarriage occurs normally between a Yekuana man and a Yanomamɨ woman. In Ocamo, I knew of only one case of a temporary marriage to a *criollo* in La Esmeralda. This seemed to be strategic because the man was a shop owner, but the arrangement broke down. There are a couple of non-Yanomamɨ Indian women in

network – people yet to be transformed – and a guiding condition of '*napë*' (body/habitus and knowledge) at the other end. A graded social-political space appears which echoes Albert's (1985) 'conventional space' in the congruence between the outer spheres of enemies (actual, virtual/ancient, unknown) and outer sphere of the *napë yai* that subsumes the maximum expression of creative and destructive *criollo* powers that need to be harnessed by mediating Yanomamɨ. Congruent with the idea of 'becoming *napë*' as a (historical/mythical) collective transformation is the aesthetics of (synchronic/shamanic) political mediation between *criollos* and Yanomamɨ. The dual Yanomamɨ/*napë* being of Orinoco Yanomamɨ is the ontological condition for a mediation that articulates the *napë yai* with those in the category of 'Yanomamɨ' or *waikasi* 'real Yanomamɨ.'

I have purposely left open ended some aspects of the discussions of this and the last chapter. Chapter V will bring together our discussion under a single theoretical framework that will at once also be the analytical stepping stone from the rest of the thesis.

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the Mavaca area. When I asked about the reasons for disapproval I only got vague answers to the effect that it just shouldn't happen, one man suggested 'will the *criollo* give his sister in exchange?'

Chapter V: Theoretical discussion

This chapter is devoted to putting our previous discussion into conversation with Amazonian theory whilst providing a theoretical framework to complement its interpretation and ground the analysis in subsequent chapters.

Having contrasted the '*napë* transformational axis' with Gow's analysis we have found similarities yet also important differences. What underlies these similarities? A first clue comes from Gow's (1993) own following of Taussig's (1987) lead. The diverse colonisers of the region deployed a fertile imagery of 'Wild Indians' echoed in the written history of the area. His task is to explore how such 'imported' imagery is pervasively used by contemporary Indians themselves as constitutive of their self-definition. The Ocamo use of the term 'civilised' to designate a condition of Yanomamɨ/*napë* which is derived from *criollo* images of Indians as 'irrational' and 'savage' as opposed to the 'civilised' *criollos* entrenched in Amazonas, is exemplary. The term '*waikasi*' in its pejorative Ocamo usage is derived from the *criollo* use of the term '*waika*.' The term '*malandro*,' as discussed in Chapter IV, could be added to this list.

But whereas much of the idiom deployed on the '*napë* transformational axis' is 'imported,' its dynamic in everyday circumstances is a constant interplay between indigenous forms of action, idioms and discourses and *criollo* ones, as our discussion of the correspondence between shamanism and *criollo*-oriented politics suggests.

Albert (2000:241), in the context of inter-ethnic political discourse, hints at this interplay: 'the self-representation of inter-ethnic actors builds itself at the crossroads of the image they have of the other and of their own image reflected in the other.' I wish to go beyond the sphere of inter-ethnic discourse and see how such reverberation not just of images but motivations and actions occurs in daily exchanges between *criollo* doctors and Yanomamɨ as well as in meetings – more typical sites of political discourse.

We must however provide ourselves with a theory to analyse, within a single framework, this network of relations that contains *criollos*, Yanomamɨ/*napë* and '*waikasi*.'

V. 1. *The givens and human agency*

Historical analysis illuminates what changes but also what remains constant. One gets the impression that had this historical encounter in the Upper Orinoco been different, many aspects of today's relations with doctors would still hold. Let me propose an argument based on what is constant in the historical outline presented. We have in the term '*napë*' a register of change in stability. The semantic field of '*napë*' passed from exclusive reference to enmity to included *criollo* behaviour and attributes. Yet its relational nature persists, one cannot be *napë* on one's own, one is *napë* to someone else. *Napë* also retains its direction towards the outside: the prototypical enemy lives far away beyond the sphere of friendly communities, kinship and daily interaction. The prototypical *criollo* lives beyond the Upper Orinoco. If *shaporis* and interface Yanomamɨ are managing relations with 'the outside' alike, and for the same reasons a constant is found in Yanomamɨ's relation to exteriority, and if historical relations with national society have not yet changed this, it is because this relation is prior to and beyond human agency. To follow Wagner (1981) and Vivieros de Castro (2001:19) this relation is (non-intentionally) constructed as given or innate, the outsider will always be a dangerous but necessary Other.

Human agency can either domesticate outsiders or to keep them at a distance. Domestication involves a movement from alterity to identity. Individual people can traverse such a path, like the early missionaries or doctors in their first months, but the nature of the outside remains unaffected by individual passages, neither does the passage ever completely remove the trace of its origin; ambiguous creative/destructive power.

Also constant are the forms of 'domestication.' Coming close to a community or failing to do so, has always been predicated on 'the morality of being human': living with kin, sharing food, speaking the language, use of kin terms, marrying affines (participation in funerary ceremonies, defending your kin, etc. see below). These

cultural conventions define the moral path to be laboriously carved in the domestication of outsiders. The Yanomamɨ moral conditions of humanity must then, as the relation with exteriority, be beyond human agency, another given experienced as *the nature of being human*. By observing a historical process we have reached two conclusions that Viveiros de Castro (1998) has done by other means a) 'culture' is the *given* nature of being human and b) the space between complete (given) difference and close identity is the site of human agency.

In Viveiros de Castro's (2001:25) words with reference to kinship and an Amazonian 'theory of general relationaliy':

> 'Since affinity is the fundamental state of the relational field, then something must be done, a certain amount of energy must be spent to create pockets of consanguineal valence there. Consanguinity must purposefully be carved out of affinity, made to emerge from the affinal background as an 'inventional' (i.e. intentional) from universally given difference.' (2001: 26)

He then equates this 'carving' to the 'construction of kinship' or more extensively a 'theory of generalised relationality' which is equivalent to the 'domestication of outsiders' *via* the 'morality of being human.'[94] Let us retain this proposition for further discussion.

I mean 'culture' in the anthropological sense, subsuming all that we can call 'cultural and social conventions': rules, language, morality, socio-cosmological order. All the constitutive relations of 'society' are given and hence need not be made. What needs making are kin, be they Yanomamɨ (see section III. 5. 2.) or Yanomamɨ/*napë*.

But we must take a step back into Wagner's (1981) theorising because in the givenness of the conventional lies a most crucial distinction between Yanomamɨ and *criollo* doctors that will enable our understanding of their relations – a proposition extendable to many White-Amerindian relations.

[94] At this stage an important clarification. Just as 'the sociable' is encompassed by 'the social' which then also includes 'the anti-sociable,' 'the (given) conventional' encompasses 'the moral.' Albert's socio-political spheres express conventional relations even when relations with enemies are predatory and not moral (i.e. there are not relations to be held among co-residents or allies, only enemies).

For *criollos*, and Euro-Americans in general, 'culture,' that gamut of conventions different groups of people share between themselves in whatever context (a professional associations, a country, a family), is not given but made. We deliberately 'collectivise' by making conventions: we make rules, schemes, organisations, corporations, bureaucracies, standards, etc. because our given is the world of 'natural incident' (Wagner's wording) and the particular. In this case 'individuals' are innate and it is society and culture that needs to made by considerable collectivising (connecting) efforts. Rules, morality and all sorts of conventions are produced to make social life between particular individuals, possible. Here the form of the (differentiated) given which needs to be collectivised through the intentional multiplication of conventions is nature, of which humans are a part.

People like Wagner's Daribi, Yanomamɨ, or many Amerindians, on the contrary, are not 'collectivising' traditions but 'differentiating' ones. Once the collective is given, what one strives to do is to particularise from a background of similarity, here people focus on 'knocking convention out of balance' (Wagner, 1981:88), they strive to differentiate themselves off from others like poets aspire to originality. Here the form of the (collective) given is culture – equated with humanity and the possession of a soul – and intentional action strives to differentiate. Not surprisingly Viveiros de Castro in his analysis of Amerindian kinship comments how 'here the 'game' of rules is part of the rules of the game.' (2002:133).

Both Amerindians and Westerners engage in collectivising and differentiating action, however, all action operates within a meta-premise of what is given and what is available to human action and, in this, Amerindians' choice is a complete inversion of Westerners.' A Western poet deliberately developing her own style is an example of differentiating action in a collectivising tradition. Her style, however, will be considered her innate creativity. Ritual, where 'the moral' is explicitly done or evoked, is an example of collectivising action in a differentiating tradition. The ritual specialist, however, is often but a vessel for the powers of the cosmos and in this sense embodies the collective, and is not an author as a poet. For example, in curing, it is a Yanomamɨ *shapori's* helper spirits who in fact do the cure, in becoming them, he 'connects' ordinary Yanomamɨ with a collective of 'vital images.'

The importance of these givens cannot be overstated. Let me summarise some of its implications that will serve our analysis in coming chapters.

V. 2. *Making society and making kin*

The inverse distribution of what is given and what is the realm of human activity between Yanomamɨ and *criollos* impinges profoundly on this relationship. Ever since the establishment of Cocco in Ocamo, Yanomamɨ were interested in making Yanomamɨ/*napë* kin, this is *napëprou*, ‘becoming *napë*.’ Missionaries on the contrary were interested in ‘civilising’ which was for the most a project of making society, not kin because for them, this was what was missing and needed to be made. This is probably the most encompassing mutual interest and misunderstanding. Missionaries and other early state agents produce fixed ‘leaders’ and ‘communities’ as a necessary form of engagement. Regardless of the status of the ‘captain’ of Ocamo previous to Cocco’s arrival, he was surely made powerful through this privileged relation. ‘Ocamo’ as a fixed community was defined by this encounter even when there exist to this day a number of lines of fracture and supra-local connections that come to the fore in different contexts. ‘Captain’ and ‘communities’ are the most simple and visible forms of introducing organisation. The establishment of the school and the Sunday church introduce a number of routines and rules. The economic co-operative SUYAO is an organisation with rules which, in time, has aimed at supra-local political representation – a higher level of organisation. This is a well known aspect of missionary activity and other forms of incorporation into the state: states attempt to reproduce their own forms among indigenous peoples in order to relate to them. And in essence this is tends to be about ‘making society.’[95]

What is less evident is how a service like the health system is about the same thing. Chapter VI will explore how doctors’ efforts to make order, rules, organisation, responsibility, etc. is at odds with the innate conventional social order of Yanomamɨ which on the ‘*napë* transformational axis,’ places *criollo* doctors in a specific position carrying forth a synthesis of positive and negative meaning. As a result doctors and

[95] For an analysis of Amazonian leadership towards nation-states see Brown (1993).

Yanomamɨ are constantly resisting each other, and such resistance comes as motivation for both. As Wagner (1981:51) writes:

> 'a people who deliberately differentiate [Yanomamɨ] as the form of their action will invariably counterinvent a *motivating* collectivity [a social order of which *criollos* are a part] as 'innate,' and a people who deliberately collectivize [doctors] will counterinvent a *motivating* differentiation in this way [disorganised Yanomamɨ].'

In short, doctors enter the Yanomamɨ world as part of an innate conventionalised order (culture); Yanomamɨ enter doctor's world as innate particularity (nature). They mutually want to do something about each other.

V. 3. *'Becoming napë' and 'domesticating outsiders'*

If Yanomamɨ consider the conventional as innate and are constantly trying to differentiate against it then *napëprou* is the prime form of differentiation Ocamo Yanomamɨ have available to them against a background of Yanomamɨ similarity. Several anthropologists have noted that the Amerindian lived world points more to a constant 'becoming' than a stable 'being':

> 'For the Araweté, the person is inherently in transition; human destiny is a process of 'other becoming.'' (Viveiros de Castro, 1992:1)

For the Araweté this is about becoming Ma̲ï gods, who stand in the ambiguous position of being post-mortem destiny but also cannibal enemies. For the 16th century Tupinamba, 'becoming' was a matter of 'enemy becoming' (Ibid.). Gow's analysis of Piro historical relations with Whites argues that Piro's lived world is a 'system of transformations,' where myth and lived world echo each other's intrinsic transformational nature:

> 'The shifts…in styles of clothing, shamanry or ritual life over the twentieth century are genuine changes, and must be understood as so by the analyst. They are understood to be so by the Piro people. But they do not raise, for Piro

> people, the problem of continuity and change, for Piro people know that they are transformations of transformations. For example, 'ancient people's clothing' and 'white people's clothing' are certainly different, but they are transformational versions of the same transformation that all clothing effects.' Gow (2001:309).

Ocamo Yanomamɨ can non-problematically see their 'civilised' being as an instance of mythical transformation. When differentiation is the name of the game, transformation is what 'happens' in time.[96]

Next, we have spoken in Chapter III about 'domesticating *criollos*' that ends up in quasi-kinship *a la* Cocco and in Chapter IV about 'becoming *napë*.' What relationship is there between these two transformations? Well, one important convergence is that they are both about differentiation, but crucially the first 'happens' in the context of the 'Yanomamɨ conventional space' in accordance to the 'morality of being human,' the second 'happens' in the '*napë* transformational' context.[97]

Napëprou is a body/habitus transformation and acquisition of knowledge which is intentionally made or 'worked upon' an innate condition of Yanomamɨ, hence the dual condition of Yanomamɨ/*napë* is referred to as 'becoming *napë*,' being Yanomamɨ is an unmarked, taken-for-granted state. Being Yanomamɨ as an innate/human/moral condition collectivises Ocamo 'civilised' Yanomamɨ with their upriver compatriots and collectively differentiates all Yanomamɨ from *criollos*. The *napë* 'side' of 'civilised' Yanomamɨ is 'artificial' and is the site of continuous differentiation against mid and upriver Yanomamɨ, it also collectivises 'civilised' Yanomamɨ with *criollos*, each in their contexts.

'Domesticating *criollos*,' is more a matter of the conventional 'theory of generalised relationality.' It is about artificially removing innate alterity by behaving like kin and becoming more human/moral – a 'becoming Yanomamɨ.' Insofar as a *criollo* acquires a Yanomamɨ/*napë* duality, it is his/her artificial Yanomamɨness (speaking the

[96] As an aside, it is worth mentioning that beyond all the political-economic power reconfigurations among the Yanomamɨ that manufactured objects and *criollo* knowledge have fostered, we must recognise that 'becoming *napë*' is part of what makes life exciting and this, in itself, is a motor for becoming.

language, for example) that can collectivise *criollos* with Yanomamɨ – this is particularly relevant in treating gravely-ill patients (see Chapter VI). Their innate *napë* 'side,' however, the unmarked taken-for-granted status, in most contexts differentiates them from all Yanomamɨ.

These two trajectories generate a performative spectrum along the river network into the city where people are contextually differentiating and collectivising themselves in exchange relations, medical upriver visits, meetings, etc.

What effectuates both 'becoming *napë*' and 'domesticating *criollos*' is 'obviation.' The concept of 'obviation' is part of Wagner's (1978; 1981; 1986) complex theory of symbolism. My usage is inspired by his own explanation (1978:31-32) of the two senses of the word 'obviate': making prominent certain associations of a symbol – making them immediately apparent – at the expense of others which are by implication 'overlooked.' Obviation is moreover, 'the process by which the realm of human responsibility must forever be created out of the innate, and the realm of the innate must be constituted out of that of the artificial.' (Ibid.:31).

In reference to 'domesticating *criollos*,' to obviate is to artificially/intentionally stress sameness through everyday co-residence, speaking the language, use of kin terms, etc. and certain ritualised contexts 'overlooking' innate danger and Otherness of *criollos*. In reference to 'becoming *napë*' obviation takes place when Yanomamɨ stress *napëness* overlooking the innate Yanomamɨ condition in upriver contexts, or when they stress Yanomamɨness overlooking the '*napë* side' in relations with *criollos*. 'Civilised' Yanomamɨ can also stress Yanomamɨ sameness among their upriver counterparts or *criollo* sameness among *criollos*. Given that '*napë*' is associated with the provision of objects, the context of exchange is probably the one that most readily evokes obviation and differentiating action.

This context evidences a certain indigenous mode of action which I will develop in more depth in Chapter VI but which, in crude terms, aims at compelling other people into action. In this way someone wanting to receive an object will press another into

[97] All the following discussion will be matched by substantial exemplification in Chapters VI-VIII.

giving, presenting themselves as being in need, which amounts to seeing yourself from a *napë* point of view. This happens throughout the length of the river network.

I asked an elder in Pashopeka which were the differences between *napë* and Yanomamɨ:

> 'Kamiyë ei ya wã haɨ shiwarihiwë mrai…yamakɨ ã rii haɨ sharirio…Kamiyë ei waikasi kë ya rii ma rë kui. Rukëmotima t^{h}ë pë ha yamakɨ ha rukënɨ yamakɨ au shɨrɨkɨprarou ma rë mai.'

> 'I do not speak mixed-up/twisted…we speak straight…Me, I am *waikasi*, that's who I am. We don't wear clothes and stand in a straight line looking white [wearing white clothes], don't you see!'

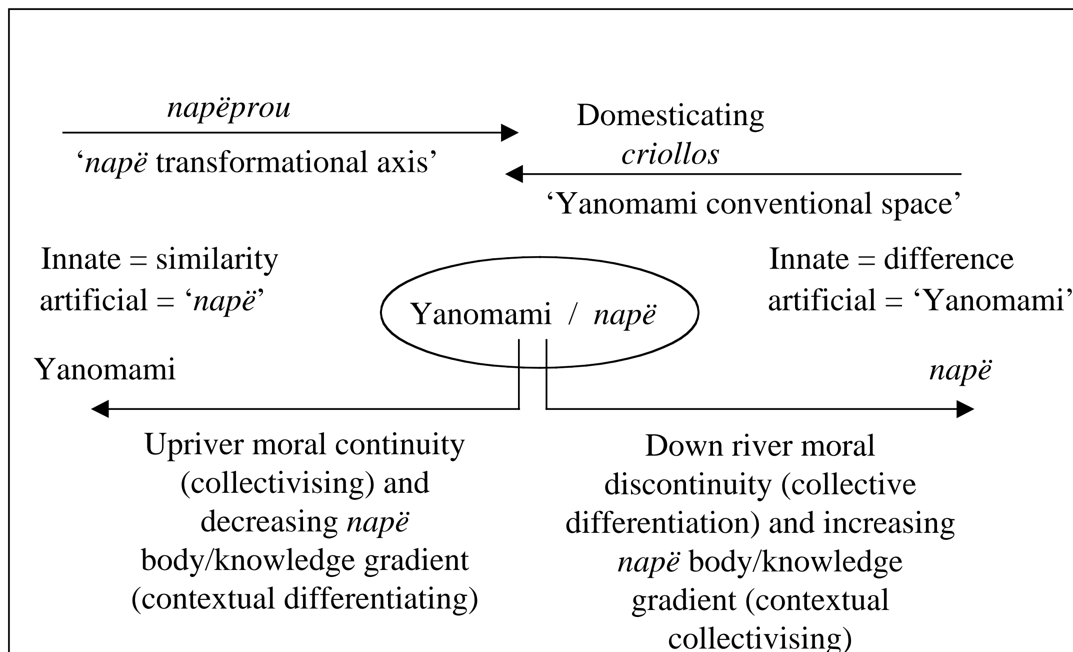
This reminds us of the weight of correct speech as a maker of being Yanomamɨ (human). But what is also revealing is the self-reference of being *waikasi*. If we recall Lizot (1994:227), this is a term used to designate others and should have no self-reference function. I think this man being interviewed by myself (*napë yai*) in the company of Ocamo people (*napë*), is seeing himself from the Ocamo perspective with this usage i.e. not using clothes. Consider the translation offered by my Ocamo assistant.

> 'I am a *propio* Yanomamɨ, we are not using T-shirts, we are not standing all together in white T-shirts.'

This is the same ability Ocamo Yanomamɨ display when they attempt to make visiting *criollos* or officials feel guilty presenting themselves as '*pobrecitos*,' 'poor, helpless things' who 'know nothing,' that is, to see yourself as the *criollos* see you: disadvantaged Indians needing help. Both cases then are instances of presenting yourself from the *napë* point of view. Intentional obviation gives the '*napë* transformational axis' its performative character where people may 'perform Yanomamɨ' and 'perform *napë*' depending on the context. I mean performance not as false theatricality – which is how *criollos* see this – but as action which aims at producing an effect over another, say, extract a coveted object from a doctor or make

a Yanomamɨ patient 'collaborate' in her curing.[98]This notion of performance is key for our analysis of doctor-Yanomamɨ relations in medical and non-medical contexts.

Figure V.1: Summary of relations between *napëprou* and 'domesticating *criollos*.'



V. 4. *Criollos and potential affinity*

Ocamo Yanomamɨ are 'becoming *napë*' and simultaneously relating to upriver 'uncivilised' Yanomamɨ in all forms of exchange because *napëprou* is not a 'loss of culture,' that is, it is not dehumanising. The innate condition 'Yanomamɨ' threads a moral continuity from Ocamo upriver enabling the co-existence of the 'Yanomamɨ conventional space' and the '*napë* transformational axis.'

'Domesticating *criollos*' ends in quasi-kinship (in the best of cases) because the key step to real kinship is never taken: marriage exchange. Kept at the fringes of real kinship *criollos* are never fully human/moral which fundamentally separates them from the Yanomamɨ. I follow Gow's (2001) lead to propose that *criollos*, in general, assume the role of 'potential affines' as described by Viveiros de Castro (1993; 2002).

[98] All this proposition is derived from Vivieros de Castro (1998;2001), Wagner (1981) and Strathern (1990).

In Chapter III we discussed Cocco's bizarre kinship with the Yanomamɨ as non-realised affinity resulting from a process of domestication: co-residence, provision, speaking the language, use of kin terms. In Chapter IV we stressed the dependency on the outside for social reproduction that, in the context of the '*napë* transformational axis,' takes the form of necessity of the powerful outside sphere of the *napë yai* for the sustenance of a Yanomamɨ/*napë* or 'civilised' way of life in Ocamo. Combining these two aspects of the inter-ethnic situation we reach the equation between 'dangerous but necessary Others' and affinity in Amazonian anthropology (see Overing, 1983-4; Rivière, 1984; 1993; Viveiros de Castro, 2002). Affinity has always an ambiguous value. It both relates (channelling economic, political, marital and ritual exchange) and separates (at the root of community friction and fission). In Albert's (1985:221-35) analysis, in-marrying outsiders from allied communities, subsumed under the extensive category of classificatory or 'potential affines' become real affines and in this situation of effective affinity they are subsumed alongside consanguines as 'real kin.'[99] This obviation of alterity is common to other Guianese Amerindians in their effort to equate a cognatic kindred with co-residence (Rivière, 1984:69-71). It is precisely this process of successive obviation of alterity from the extreme outside to close identity which places 'domestication of *criollos*' and the 'construction of kinship' on a continuum.

Vivieros de Castro (1993;2002) has synthesised a generally applicable notion of 'potential affinity' that best fits the kind of relation between Yanomamɨ and *criollos*. A 'potential affine' is one where a) there is no effectuation of real affinity for what one exchanges with these partners are other things like rituals, dead, names, souls, heads, etc. b) it is 'collective and generic' and involves exchange with the exterior of the sociable. Potential affinity 'qualifies relations between generic categories: compatriots and enemies, living and dead, humans and animals, humans and spirits…[it] is a politico-ritual phenomenon, exterior and superior to the plane encompassed by kinship.' (2002:159)

[99] Alès (1990:82) finds that close classificatory affines are included in terms of solidarity and affection with close consanguines. In general, she says, 'co-residence brings close more distant kin, as separation distances close kin.' Both Albert and Alès coincide in the congruence with the Piaroa case as described by Overing (1975).

Notably, the normal term of address between *criollos* (e.g. long time malaria personnel) and Yanomamɨ in Upper Orinoco is '*shori*,' 'brother-in-law.' Gow (2001:305-306) suggests a continuity of the position of potential affine as a historical shifting of the position of 'possessor of objects' between different waves of outsiders that could better fill this role for the Piro. The continuity stretches from indigenous trade networks through debt bondage relations with White bosses, to missionaries, to hacienda owners, to current White *patrones* (cf. Hugh-Jones, 1992). The semantic shift of the Piro word *kajitu*/*kajine* from the context of trade to its current meaning of 'Whites' is suggestive of the adequacy of this usage of 'potential affinity.'

My argument is the same but the ethnography yields a variation. The use of the term '*napë*' for *criollos* indicates that here the indigenous reference is enmity and *shawara*, as a *criollo* form of predatory aggression, emphasises their simultaneous status as 'enemies' and 'providers of objects.' Hence the equivalence between Albert's enemy spheres who predate Yanomamɨ and the outer sphere of *napë yai*. The shift is then from one type of enemy to another. Moreover, if the Piro reacted to different waves of better providers of objects, in the Upper Orinoco what we have is the multiplication of simultaneous alternatives. The advent of clientelistic party politics and the military's indigenous development programme present themselves as alternative sources of goods which, since the Salesian adoption of a less paternalistic policy, were in decline.

But what about 'domesticated' resident *criollos* (missionaries, doctors)? These weaker versions of *napë yai* correspond with Vivieros de Castro's '*included thirds*,' ritualised relations with individual representatives of the category of potential affines that fulfil a mediating role between the opposed us/them groups, between the local and the exterior: foreigners, enemies, etc. (2002:162). Vivieros de Castro draws many examples from the ritually elaborated expressions of affinity amidst warfare relations between killer and killed. This is the case among the Tupinamba, Araweté, Wari' and Jivaro. But this special relation is also representative of formal friendships (Descola, 1997 for the Achuar), long distance trading partners (Overing, 1983-4 for the Piaroa), or certain godparent relations between Indians and White *patrones* (Hugh-Jones, 1992; Gow, 2001).

In this mediating role, we also find Yanomam classificatory affines. Albert (1985: 524-568) has shown that it is people drawn from this category (non-realised potential affinity) that fulfil two important mediative roles during *reahu* funerary ceremonies. On the one hand, potential affines in performing the funerary services obviate the distinction between consanguine and affinal kin – internal to co-residents – and the distinction between co-residents and non-co-resident 'guests' – internal to the group of allied communities. Such an obviation symbolically dissolves difference in favour of the 'ideal local group' (with no affines) and the 'ideal community of allies' (with no outsiders). When we consider the wider system of symbolic exchanges, potential affines are assimilated to the socio-political category of 'allies' and mediate between 'kin/co-residents' (mourners) and 'non-kin/enemies' (predators). In other words, the deliberate obviation of alterity is necessary to produce the image of the 'ideal' local group against that of the enemy – the 'ideal' locus of predatory alterity. In time, in accordance to the ritual reciprocity among allies, potential affines contribute to the sustenance of 'an armature of symbolic transactions constituted by cycles of deaths, mourning and funerary services.' (Ibid.:548)[100]

Included thirds mediate between different levels of alterity and the local group by way of obviating their own alterity, enabling a social reproduction (symbolic or real) that depends on an innately dangerous yet powerful outside. In the case of *criollos* in Ocamo, it was the early missionaries epitomised by Cocco that fulfilled the mediating role enabling 'civilisation.' Nowadays added to missionaries are institutional *criollos* like doctors partially fulfilling this role. 'Politically lay' Yanomamɨ try to make resident *criollos* either community or personal '*thirds*,' with reference to the clinic resources and every cure of a doctor is an instance of the necessity of *criollos*, made possible by this localised 'ally' version of the generic *criollo*. But this role is increasingly being taken over by 'civilised' Yanomamɨ. Representatives' and politicians' attempts to control *criollo* resources, are manifestations of this mediation *vis a vis* their communities. All Ocamo people in their relations with upriver communities fulfil the mediation between *criollos* and *waikasi*. In Chapter VI we shall

[100] It must be noted that the Yanomam funerary process includes the exposition of the corpse in the forest for its decomposition, after which the bones taken back to the village and cremated. This is not part of the normal 'funerary services' among Ocamo Yanomamɨ, who proceed directly to cremate the corpse. Exposition in the forest in racks, high above the ground, is done when there are multiple deaths in the case of epidemics.

see how health meetings in Ocamo, where doctors and community leaders play the key roles, are a matter of obviating the outsider meaning of doctors, expelling difference beyond the community to 'live well' or 'work well' with the doctors. Meetings are in this sense analogous in the '*napë* transformational' context, of *reahu* feasting in the 'Yanomamɨ conventional space.'

But there is an important difference. *Criollos* don't intermarry with Yanomamɨ and hence have no real obligations to any specific group. This is the character of their potentiality: generality. They are metonymic extensions of the *napë yai*, and cannot avoid their innate condition of potential affines being 'providers of objects and (curing) solutions.' 'Civilised' Yanomamɨ, on the contrary, are always real kin to specific people. It is hard to balance between *institutional obligations to all*, the kind of potential affinity *criollos* represent, and obligations of real kinship *to some*. Nurses, motorists, or politicians, all working for constituencies that go beyond their personal perspective of kinship obligations or even 'allied communities,' are constantly criticised for misusing clinic resources, not tending everybody properly, distributing political posts only among their group, etc. Similar criticisms of preferential treatment surround the management of the co-operative (cf. McCallum 2001:117-19). Doctors also note Yanomamɨ personnel's differential interest in helping when in communities with or without relatives.

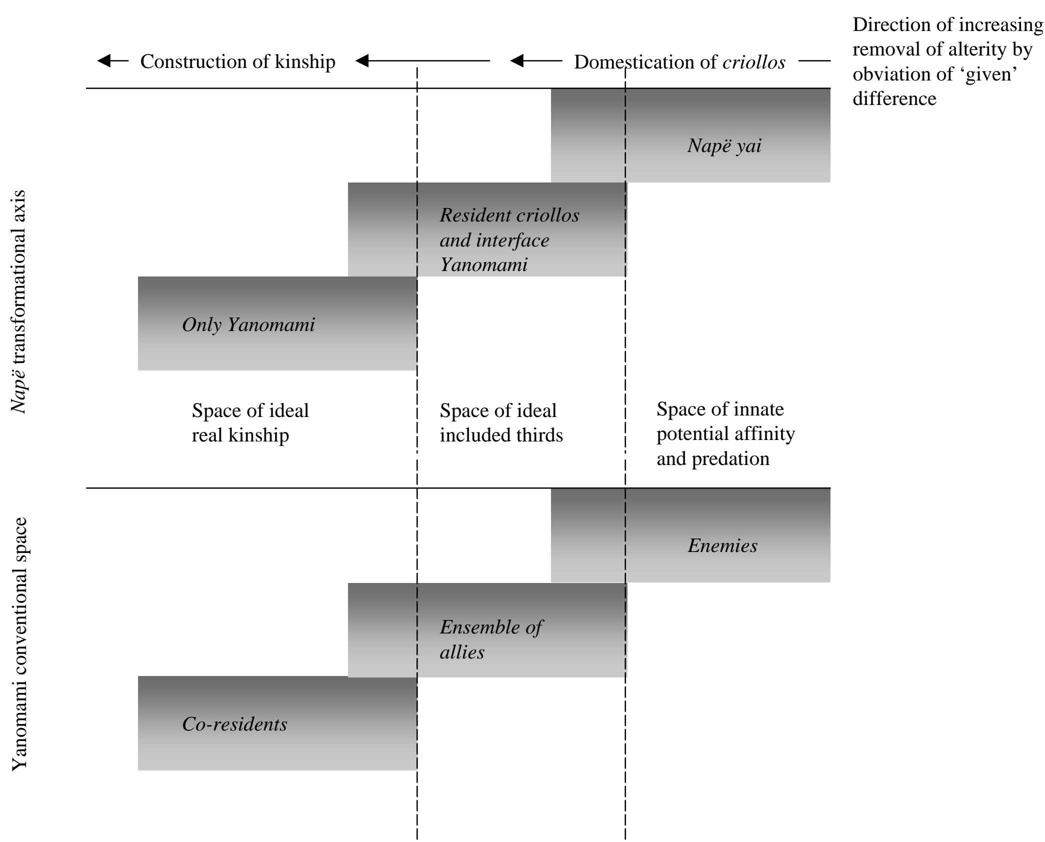
Recapitulating the transformative substitutions between '*napë* transformational' and 'Yanomamɨ conventional' contexts. *Napë yai* are 'potential affines,' both 'producers of objects' –in a more general sense 'solutions' (healthcare, education) – and producers of predatory *shawara*. Their place is that of the three categories of enemies who engage in reciprocal symbolic predation on the 'Yanomamɨ conventional space.'

'Included thirds' are resident *criollos* with whom, through a degree of domestication (obviation of alterity), sociable yet ambiguous and tense relations are sustained. Not managing many resources they are less capable of help or damage. Alongside them are interface Yanomamɨ who translate the *criollo* world and attempt to control *criollos* (resident and outside) and their resources. Both these groups are generally 'allies' of the community, yet in relations fraught with tension roughly corresponding with the category of 'friends and allies.'

Finally, a community like Ocamo, even when fraught with internal factionalism becomes a united 'Yanomamɨ' group in opposition to *criollos*. The same solidarity can subsume all the Yanomamɨ of the Upper Orinoco in one collective position against *criollos* (see Chapters VI, VIII). In this sense the correspondence is with the innermost sphere of co-residents.

The '*napë* transformational axis' then yields a relational field that resonates with Albert's tertiary distinction that Vivieros de Castro (2002:152) generalises for Amazonia.

Figure V.2: Congruence between '*napë* transformational axis' and 'Yanomamɨ conventional space.'



Having established correspondences between the 'Yanomamɨ conventional space' and the '*napë* transformational axis' I now focus on important differences. The first is

the nature of reciprocal relations between *criollos* and Yanomamɨ. The second involves a linear/hierarchical component of the '*napë* transformational axis.'

V. 5. *Reciprocity with the napë yai*

In Albert's scheme, relations with enemies are of reciprocal predation (warfare and mystical attack). How do the Yanomamɨ reciprocate, if at all, *napës*' generalised predatory *shawara*? To my knowledge at least, neither in private nor public discourse do the people in Ocamo suggest any form of reciprocity. Moreover, even when they acknowledge *criollos* as the source of *shawara*, demands for improving healthcare are not couched in terms of accountability (cf. Gallois, 1991; 2000 for the Waiãpi).[101]

We must recall the irreversibility of the generalised spread of *shawara* and the historical trade-off of 'accepting' *shawara* to access manufactured goods. Yanomamɨ cannot 'predate' directly on *criollos* because they would cut themselves off from the sources of goods and solutions. Instead, it is the demand for a unidirectional flow of solutions towards the Yanomamɨ that 'balances' a flow of disease in the same direction. The Yanomamɨ consume *criollos*' goods and solutions as *shawara* consumes the Yanomamɨ. But consumption of manufactured goods is not seen as retaliation but rather as a means of 'becoming *napë*' which, in its healthcare manifestation, is seeking greater control over the operational level of the system i.e. demanding more nurses, microscopists, expanding the network of services (see Chapter VIII). So one 'force' behind the 'voracious' demands all *criollos* experience could come from this 'only alternative' to continue making the historical trade-off worthwhile. This 'force' would be tied to 'becoming *napë*.' On the other hand, we can suggest another 'force' associated with the domestication of *criollos*.

In general *criollos* (voluntarily) curtail their possibility of closer kinship with the Yanomamɨ by not marrying. By implication they are excluded from participation in ritual verbal exchanges (*wayamou*, *himou*) as well as funerary feasting, *reahu*.

[101] Gallois (2000:222-3) speaks of the role of myth in the legitimising process of Waiãpi discourses towards institutional Whites in Brazil. In myth, the origin of several diseases is explained as the result of White's careless behaviour as they caught and henceforth spread diseases after being vomited on by *Janejar*, one of the cultural demiurges. *Janejar* then teaches Whites the use of medicines to cure

Excluded from matrimonial, ritual, and verbal exchange the only avenue available for *criollos* to become sociable is through the exchange of *criollo* goods and food.

In short, a worthwhile 'becoming *napë*' requires a degree of sociability with *criollos*, implying their 'domestication.' These processes are mutually implicated, and a delicate balance allows for both to continue: too much 'voracious consumption' and conflict with *criollos* (e.g. doctors) and the process breaks down; too little demand for solutions and *napëprou* ceases to make sense (e.g. too many ill people).

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I want to briefly pause on the exclusion of *criollos* from marriage exchange. Keeping *criollos* as domesticated potential affines strikes me as a strategic 'choice' of great effect in the management of resident *criollos*.

V. 6. *General and powerless criollo potential affines*

People in Ocamo strongly disapprove of the possibility of marriage with *criollos*. One unarticulated motivation could be the neutralising effect this choice has. *Criollos* remain accessible to all if lacking real kin ties, all Yanomamɨ have an 'equal stake' in them and their goods. Concomitantly no-one is obligated to defend resident *criollos* with the moral force that real kinship imputes. The complementary effect of being a *criollo* potential affine is to be a powerless one. With no-one to defend them, deceit, theft, threats against resident *criollos* inspire less concern on their perpetrators; the likelihood of retaliation is almost nil.

Two qualifications. In their generality resident *criollos* differ from some cases of 'included thirds' that refer to inter-personal relations (e.g. captive-killer, trading partners, formal friends). In their powerlessness they resemble the position of the Tupinamba captive in an enemy's group – a parody that ends in death (see Viveiros de Castro, 1992) – and differ from White *patrones* who have the upper hand in their economic ties with Indians. On the other hand, powerlessness is not a feature of

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themselves, making them 'owners' of this knowledge. As disseminators of disease and 'owners' of medicines Whites are in the obligation to make them extensive to the Waiãpi *via* decent healthcare.

interface Yanomamɨ in their role of mediation. On the contrary, translating and controlling *napës* is empowering; a key ingredient of modern leadership. In this sense resident *criollos* are their political capital. So we have two types of local potential affinity: resident *criollos* (generalised and powerless) and interface Yanomamɨ (generalised but with difficulty, and powerful).

These two qualities of resident *criollos*, generality and powerlessness, function as a political substitute to reciprocal predation of the outside. It is the right means for controlling *criollos* in the delicate politics of 'becoming *napë*,' the local solution to the Amerindian problem of balancing autonomy and dependency on the modern outside: Whites and their institutions.[102]

V. 7. *A linear component in concentric and diametric dualism*

The '*napë* transformational axis' differs from the 'Yanomamɨ conventional space' in another crucial way: the inequality inherent in Yanomamɨ-*napë* relations. Albert's socio-political space is socio-centric and isomorphic. Enmity and alliance are reciprocal relations between equals. This is not so in relations that sustain Yanomamɨ-*napë* positions. In the exchange context, Ocamo Yanomamɨ have the upper hand in controlling the flow of scarce and valued goods upriver. In more general terms the progressive-cumulative nature of 'becoming *napë*' – acquiring goods and knowledge – introduces a linear hierarchical element to the 'classic form' of concentric and diametric dualism of the Amerindian 'theory of general relationality' in Viveiros de Castro's (2001) analysis.

The interplay between concentric and diametric dualism combines the consanguine/affine division with an 'analogic' socio-spatial differentiation. At the local group level, consanguinity obviates affinity. As we enter the supra-local scene, affinity and consanguinity are balanced and, at a greater socio-spatial distance, affinity, reigns 'un-obviated.' The maximal distance finds cannibal predation underlying the whole range of relationality. Figure V.2 (pp. 143) helps to show that if

[102] For ethnographically detailed analysis see Turner (1991) on the Kayapó; Hugh-Jones (1992) on the Barasana; Gow (2001) on the Piro; McCallum (2001) on the Cashinahua; Albert (1988; 1993) on the

we substitute the pair consanguine/affine for Yanomamɨ/*napë*, the relational field from the Ocamo point of view outwards in the *criollo* direction is equivalent (affinity = '*napë*' and domestication is a matter of obviating innate *napëness*). However, if we look around to the upriver direction we have people defined by the increasing lack of *napë* body/knowledge. Here instead of removing '*napëness*' it is what needs to be added, difference ceases to be the innate condition and becomes the inventional site of human endeavour, hence 'becoming *napë*.' Because the direction and limit point in the '*napë* transformational' context is '*napë*,' a linear hierarchy runs through the field of concentric and diametric dualism dissolving its isomorphism. Partially echoing Turner (1991:297) on Kayapó relations with the Brazilian state,[103] the *napë* transformational context continues to be socio-centric but the social totality includes a wide variety of *criollos*. Ocamo 'civilised' Yanomamɨ are more a middle point in a linear network than a centre of a concentric space (hence the term 'axis' rather than 'space' for the '*napë* transformational' context).[104]

Concluding remarks

In this chapter we have provided a theoretical framework for the '*napë* transformational axis' both in its historical and synchronic dimensions. The analysis corroborates the usefulness of an Amazonian theory developed in 'traditional' contexts in the interpretation of 'modern' relations with members of national society. The congruence between Albert's socio-political spheres and the '*napë* transformational axis,' between 'construction of kinship' and the 'domestication of *criollos*' demonstrates the need to understand inter-ethnic relations as transformative substitutions (themselves obviations), besides analysis of cultural erosion from 'inter-ethnic friction.'

Yanomam. For a number of cases in the Northern Amazon see the contributions in Ramos & Albert (2000).

[103] Partial in that Turner stresses the continuity of the socio-centric ordering of the cosmos, however, his analysis concentrates only on the Kayapó-White interface and hence lacks the important network quality I am describing and that others like Gow (1993), Carneiro da Cunha (1998) and Hugh-Jones (1992) have discussed.

[104] Carneiro da Cunha (1998:10-11) describes this same transformation, from an egalitarian isomorphism to a network of domination, in the context of the early 20th century rubber debt-credit network in Western Brazil (river Juruá-Manaos-Belem-Europe).

The comparative analysis with other parts of historical Amazonia also sheds light on possible early stages of contact that later developed into complex economic-political networks. The co-existence of a concentric space with a network linear space; the simultaneity of egalitarian and unequal relations embedded in a body/knowledge gradient of contact; the sharp moral discontinuity between Indian and White may have been components of many 'fronts' of contact throughout Amazonia. The fragile negotiation of 'becoming *napë*' and 'domesticating outsiders' inherent in inter-ethnic politics, seeking a balance between indigenous autonomy and dependency on the outside is echoed throughout contemporary Amazonia.

We cannot understate the relevance of what is phenomenologically innate and what is open to human agency; what is collectivising and differentiating. First; the duality of 'civilised' Yanomamɨ is based on a innate/moral Yanomamɨ aspect and a 'worked upon' (body/knowledge) *napë* aspect. '*Napë*' and 'Yanomamɨ' become context-dependant performances creating a range of collectivising/differentiating possibilities throughout the network of relations in which the heath system is embedded. Second; Yanomamɨ 'becoming *napë*' is a matter of making kin (society and culture are innate) and *criollo* projects (missionaries, doctors, planners) of 'civilising' Yanomamɨ (all with different meanings) a matter of making society (individuals are innate). This is both the congruence and the misunderstanding of the 'contact situation' in the Upper Orinoco. We shall now proceed to analysing the everyday relations of doctors in Ocamo in both medical and non-medical contexts. This shall put flesh to this theoretical armature.

Chapter VI: Doctors and *criollo* potential affinity

In Chapter V we proposed to see *criollos* as 'potential affines' within the '*napë* transformational axis.' Here we shall see what this entails. The chapter is long and divided in four parts. First, we shall examine the qualities of doctors' potential affinity ('provider of objects,' generality, powerlessness) and the social dynamic of doctor-community relations that results. I shall argue that this dynamic resonates with Yanomamɨ cycles of village creation and fission underlying the conflict between doctors' efforts to make conventions and Yanomamɨ efforts to mark themselves off from those conventions. All this analysis revolves around non-medical contexts. Second, we shall explore the implication of doctors' potential affinity in medical contexts. Three common scenarios are discussed: everyday events in the clinic, the treatment of gravely-ill patients, and negotiations of patients and relatives as to the place and type of treatment. The third section explores the final quality of doctors' potential affinity, being pivots of relations among Yanomamɨ in individual and collective instances (meetings). Finally, I shall discuss how upriver medical trips become opportunities for 'civilised' Ocamo Yanomamɨ to differentiate against their upriver 'real Yanomamɨ' counterparts.

All this discussion illuminates, from different perspectives, the contribution of the health system to the 'becoming *napë*' trajectory of Ocamo people and how doctors are fully integrated into the articulation of a socio-political network that finds *criollos* at one pole and *waikasi* 'real Yanomamɨ' on the other.

VI. 1. *Doctors as napës: non-medical contexts*

VI. 1. 1. Doctors as 'providers of objects'

Doctors' primary function in greater Ocamo[105] is to provide medical assistance, however, as *criollos* they cannot avoid carrying forth meanings ascribed to them as a category of people. The most relevant of these 'extra' meanings is to be sources of desirable goods. There are three ways in which they become focus of Yanomamɨ

[105] In this chapter when I say 'Ocamo' I will refer to Barrio Nuevo and Barrio Viejo, 'greater Ocamo' referring to the conglomerate of communities.

attention. First, they manage the health system's operational equipment: motors, boats and gasoline. Second, they bring personal property necessary for living in Ocamo and periodically replenish their food supplies (every two/three months). Third, doctors offer a few job opportunities beyond the fixed salaried posts of microscopist and nurse for which long term training is needed.

Let me refer initially to the post of motorist. This salaried job is paid by the health authorities. Like any other job, it represents a valued income for the worker but it has important perks. The motorist's constant travels up and down-river make him an important news bearer and manipulator. Medical trips upriver are also opportunities for exchanging items either for himself or others in Ocamo. Virtually no medical trip upriver is devoid of exchange. Motorists, in a close relationship with the doctors, also have privileged access to clinic resources. They are also delegated the selection of extra crew for cooking, locating the river channel, etc, helpers who themselves are interested in visiting relatives, lovers, exchange, etc. Finally, each upriver trip is also a hunting trip for the Yanomamɨ crew. The motorist, in short, is in a pivotal and influential position within Ocamo and linking it upriver. We shall see below that changing of the motorist was an event seriously affecting the relations with the Ocamo doctor.[106]

Doctors in charge of the clinic resources become the focus of often relentless requests for gasoline, motor, and boat. Although officially the clinic doesn't give gasoline away (chronic shortage impedes the fulfilment of visiting schedules), either in cases of grave illness, or to those who can return fuel (leaders, salaried workers), gasoline is provided. In most cases, however, doctors have long discussions as to why they cannot dispose of the gasoline that is 'for everybody.' The same applies to the motor and boat. Some doctors establish a special friendship with a few Yanomamɨ who are favoured in these decisions. For example, during one period of my stay, the motorist regularly borrowed the clinic boat to hunt/fish.

Doctors and students invariably exchange clothes for arrows, ornaments or basket-work. *Criollo* food, mainly rice, pasta, sardines, sugar, salt and oil, is either given

[106] Recall that the job offer in Ocamo is very reduced in comparison to the 'demand' (see ff. 10, pp. 26).

away or exchanged for glass bead necklaces, baskets, smoked fish or garden produce. Doctors leaving on holiday (aprox. 10 days every 3 months) normally carry a number of requests including watches, radios, clothes, glass beads, and other special favours like framing course-completion diplomas.

Doctors are often advisors to Yanomamɨ, writing letters or 'projects,' they explain unknown Spanish words and become sources of Spanish names for unnamed children. An important sense in which doctors contribute to Ocamo people's *criollo* knowledge (complementing school education and political participation) is through daily interaction, where Yanomamɨ learn about *criollo* ways, *criollo* morality and how to manage *criollos* more effectively.

Through this provision of *criollo* goods, food and jobs, doctors are one of the alternative sources that facilitate Ocamo Yanomamɨ's dual Yanomamɨ/*napë* life, contributing to a *criollo* habitus in Ocamo and allowing Ocamo people to assume the *napë* position of provider of goods upriver. Daily interaction adds to the knowledge component of 'becoming *napë*.' In short, in both body/habitus and knowledge terms, doctors are forced into the ongoing *napëprou* project of Ocamo people and their concomitant differentiation *vis a vis* their upriver counterparts.

VI. 1. 2. Potential affinity: generality and powerlessness

Exchanges with the doctor are normally done in private to avoid publicity. But this subterfuge almost never works: all Yanomamɨ know who has got what from the doctors. In giving personal items, lending the motor or gasoline to specific people, doctors expose themselves to provide for all. My emergency need for the boat is as important as any-ones'. Without real kin-based obligations, everybody has the same 'right' to benefit from doctors' resources. Many doctors are compelled to give to those who come as a consequence of an initial exchange. Obviously at some point items are refused on whatever grounds. Similarly, people complain if all minor jobs (e.g. cutting grass) fall to the same persons.[107]

[107] Chagnon (1997:16) describes a similar circumstance for his initial period in the field: 'Their begging for food was not provoked by hunger, but by a desire to try something new and to attempt to establish a coercive relationship in which I would accede to a demand. If one received something, all others would immediately have to test the system to see if they, too, could coerce me.' Anthropologists, like doctors,

This is a hard act to balance. Whilst denial of food, a daily occurrence, is most of the time inconsequential because people are simply 'probing' to complete a meal, inevitably doctors will misjudge real necessity for this probing, in which case the moral recrimination of stinginess takes force. Misjudgement of necessity (Yanomamɨ may be faking) when it comes to requesting gasoline or the motor, for example, to fetch a *shapori* for a patient also triggers recriminations. A strict rule of not lending anything, whatever the circumstances, leads to prolonged tense relations. Equally, doctors who never share or exchange food or never have people in the house are less popular. In short, a doctor who closes her/himself off to exchange is considered anti-sociable and is less appreciated.

Having no kin to defend them, doctors are easy targets of thefts and trickery on the part of *huya* (youngsters) who know their misbehaviours cannot be retaliated. Doctors' clothes hung to dry were always at risk of disappearing; anything at stick-distance from the house windows could also be taken during the doctors' absence. On a couple of occasions the doctors' house was broken into and food stolen when on upriver visits. As we shall see below, doctors dispose of none of the Yanomamɨ conflict-aversion or resolution devices, this being the essence of their disempowerment.

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Does doctors' potential affinity result in any pattern in the long run? Let me discuss the passage of three doctors through Ocamo and then compare them to the relations between the two sides or factions of Ocamo to suggest that doctor-community (Ocamo) relations resemble the relations internal to Yanomamɨ communities.

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are generalised potential affines. However, as our discussion in Chapter V and below shows, there is much more than this 'coercive testing' in requesting goods.

VI. 1. 3. Doctor – Yanomamɨ relations as factional/affinal ones

At the beginning of 2000, two new doctors arrived in Ocamo. One of them, Carlos, took care of clinic resources whilst they both shared all other activities of primary care. Carlos recalls this first incident involving resources:

> 'Apparently they had got used to asking for gasoline from the student [in Ocamo before they arrived]… apparently he conceded in everything…he would give them the gasoline of the clinic, the gasoline for upriver visits, for the generator…[the new doctors had orders from the Head of District not to give anything to anyone. One day the wife of an influential man, Daniel, came for gasoline and Carlos denies the request]… the woman leaves to her house and Daniel comes back with a knife in his hand. I had already some appreciation for Daniel because we had been on two trips with him as motorist…I thought he was coming to say hello but he came walking fast, knife in hand, and raised it in threatening way…[Daniel] 'doctor why will you not give me gasoline…all the doctors here give gasoline, if you don't give gasoline I will cut your throat'…then what was I supposed to do? I hadn't been a month here, I don't know if its true or not but just in case I said 'ah! so that's how it is!, well take the keys then, take your gasoline! [Laughter].'

This was one of a series of problems Carlos encountered. Alejandro, the other doctor, with hindsight suggested that Ocamo's leaders were orchestrating a campaign to discredit Carlos. He was criticised for sending feverish children to bathe in the river as part of treatment, for giving the wrong medicines, etc. He was also involved in an agitated case of a dehydrated child with one of the communities (see below). After three months Carlos had become a kind of public enemy, during a meeting with the Regional Health Director in Ocamo, community leaders requested his removal. He himself was feeling miserable because Ocamo people made his life impossible for incomprehensible reasons. He left Ocamo in April to work in Parima where he had a smooth experience.

A combination of factors contributed to the departure of Carlos, yet I have little doubt that the upholding of a stiff control over resources disgruntled a few influential

Yanomamɨ who then made the most of medical issues to infuse distrust in the community. After Carlos left, Alejandro was left to run the clinic.

> 'And then my nightmare began, the Yanomamɨ didn't bother Carlos anymore, they began to screw me with the thefts…they would put water in the gasoline tanks…they put water in the electricity generator, I couldn't leave anything at all outside because it was stolen…you had to be everywhere, in the house, in the clinic…every time you went upriver I thought about what could be happening in Ocamo…'

Fed up, he decided to have a meeting with the leaders and health personnel, threatening to leave the community: it was clear they didn't want a doctor, 'I cannot live in a jail, I feel that you have me in a jail' he told them. That week Alejandro was informed that the community had held a meeting deciding they wanted him to stay, assuring him things would improve. He responded:

> '… 'well if I lose anything I will leave!' and then I would leave things outside on purpose and nothing would happen…Ocamo became something different, a tranquil village…I don't know to what point there was something of a [decision] 'we will not bother the doctors anymore'…'

This exemplifies the delicate politics of 'domesticating outsiders,' even those deemed beneficial, like doctors. This kind of brinkmanship – that Chagnon (1997:15-19) describes towards himself – is part of conventional relations with *criollo* potential affines. Leaders try to balance the relationship, for pushing beyond the limit, different for each doctor, will be detrimental to the community, left with no doctor.

By the time I arrived in August 2000, Alejandro had a harmonious relation with the community. His medical decisions were trusted and never challenged by the nurse as before. He struck balanced agreements with relatives when treating patients i.e. staying in the clinic or the community, alternating shamanism with biomedicine. He had also balanced the management of clinic resources. The motorist and a few others could occasionally use the boat for hunting/fishing. Influential Yanomamɨ occasionally borrowed gasoline and *huya* could charge their batteries in the clinic if

done discretely. Yanomamɨ were frequently sharing coffee or a meal with Alejandro in his house, he was often eating in Yanomamɨ houses and invited to *reahu* funerary ceremonies.

In January 2001 came Dr. Lucia. She stayed in Ocamo for 10 weeks then resigned. Lucia had some of the problems Carlos and Alejandro had encountered. She was initially overwhelmed by requests for clinic resources until it was getting out of hand. In comparison with other doctors she was slightly naïve and was easily manipulated by the old foxes of Ocamo. Minor impasses in the clinic aside, all was progressing well in medical contexts. Lucia wanted to instil some order in the clinic, making the nurse and the microscopist come everyday at specific times (agreed with them). This created some friction that was then augmented when she had several disputes with the motorist, the microscopist and finally the nurse.

Returning from an upriver emergency call with a patient, the motorist, she claims, began faking problems with the motor to avoid going to La Esmeralda, the agreed destination, and returning to Ocamo. Ocamo was closer than La Esmeralda and with a failing motor, the motorist claims, it was better to go back home. The next morning the doctor caught the motorist taking the boat to hunt upriver. Realising she had been deceived, she shouted at the motorist to stay. There was some commotion at the port and within a few days, when the Head of District (HD) visited Ocamo, the issue was discussed in a small operational health meeting in which the motorist resigned.

Not long after, the founding leader of Ocamo died. Boat traffic was intense as Yanomamɨ from all over gathered to mourn. At the time the microscopist had borrowed a motor and ruined an expensive component. He was in a debt he couldn't repay. In the midst of the founder's death, the microscopist borrowed the clinic motor to fetch relatives. But apart from fetching relatives he cunningly replaced the component he had ruined with the good component of the clinic motor before returning it. This triggered several weeks of discussion. The microscopist promised to undo his trick but never did. Lucia was distressed by the way the microscopist was so calmly making fun of her.

All this tension accumulated and a community meeting was summoned in Manuel's – one of Ocamo's faction leaders, the main rival of the nurse, the other faction leader – house. Manuel supported the doctor's claims that the microscopist had deceived her, whilst the latter and the motorist claimed the doctor was lying and that people mid-river were complaining because, during a visit, she had not taken medicine, failing to treat a patient there. They wanted to expel the doctor. Throughout the meeting Manuel appealed for 'the community' to be more helpful with the doctor, *huya* should help out, translate if necessary, fetch water from the river if needed. Ocamo should work together with the doctor and not against her; she helps cure us, we should help her too. Key words here were 'collaboration' (Sp. *colaboración* Y. *payeripraɨ*) and 'work well in the clinic' avoiding petty problems.

Lucia's last problem was the escalation of an incident in the clinic. After a misunderstanding with the nurse, she shouted at him and a commotion began. A crowd surrounded the discussion where the microscopist supported the nurse with one of the nuns and Manuel supporting the doctor. Shouts and insults came from both sides, ending with the nurse calling a meeting with all greater Ocamo that afternoon to expel Lucia. That afternoon it was decided she would stay, but after her tumultuous stay and news of her father's illness, Lucia resigned. Since April 2001 there has been no resident doctor in Ocamo (until at least March 2003).

These three cases share a pattern. New doctors arrive and during their first months the sector of Ocamo that most relates to *criollos* – health personnel, leaders, *huya* – see how far the 'rules of the clinic' and engagement with *criollos* can be stretched for personal purposes. These efforts hinder doctors' intentions of upholding established conventions of clinic resource management, organising what appears as a messy working environment, and establishing good rapport with the community. When too many incidents accumulate, one or several meetings ensue focused on reinstating known conventions and promoting a convivial environment: collaborate with the doctor; curb theft and trickery; not to shout at patients or nurse; clinic's resources are for patients not for personal use, etc. In two of our cases these meetings ended up in the doctors' departure, in the other, relations with the doctor changed dramatically. If the doctor stays, in time, rules begin to be overlooked and some flexibility prevails. In medical terms, trust in the doctor grows and balanced negotiations with patients and

relatives are normally struck. The cycle closes with the arrival of another doctor; if doctors overlap for some period, the old one is preferred for treatment, trickery falls on the newcomer.

I want to argue that this pattern resembles one that was internal to the village process of Ocamo itself. Barrio Viejo and Barrio Nuevo form two factions whose friction had recently been accentuated by a party-political divides. Tension was manifest in the crossing accusations of theft, malicious gossip and *huya* 'bothering' women.[108] In several meetings the need for unity against party divisions was stressed by Manuel, one of the faction leaders (and AD party local representative) constantly appealing 'we have to be together!' often in explicit opposition to the missionaries or politicians.[109] People from both sides of Ocamo began talking of moving to another site to defuse tension. In November 2000 there was a special meeting to discuss *huyas* bothering women. *Huyas* were out of hand, elders emphasised restraint and the need to 'live well,' 'live tranquil' without womanising, fights, and malicious gossip. Soon afterwards the nurse began making a new garden further upriver to move away from Ocamo. His daughters were coming of age and he didn't want them embroiled with the *huya*, he could foresee fights and wanted to avoid them. Some time in late 2002 Barrio Nuevo moved upriver.

Both these examples reproduce in 'modern' form 'traditional' dynamics that have been described for Yanomamɨ. The two factional leaders in Ocamo are classificatory affines. According to Lizot (1994:215-16), ideally a community is composed of two or more factions, each with a cognatic core with common ancestry. Relations internal to a faction are consanguineous whilst across factions they are affinal, as is the case in Ocamo. Hence, factional friction is affinal friction. Albert (1985:198-206) finds that each group of co-residence tends to have a cognatic core based on a series of repeated matrimonial exchanges. The accumulation of marriages outside this dominant core progressively strengthens 'adjacent' lines which, either by choice or friction, will

[108] The expression '*molestando las mujeres*,' 'bothering the women' refers normally to *huya's* secret relations with married women or to incest.
[109] This feature resounds with McCallum's (1990:426-29) description of 'idioms of unity and equality' in political meetings among the Cashinahua in Brazil. In both cases influential men, at the core of disputes, are those who appeal to community unity aiming to persuade people to follow their projects.

separate to form a new community where the 'adjacent' now becomes the core cognatic group.[110]

That *huya* shouldn't have 'illegal relations' is a known (ideal) convention of Yanomamɨ sociality. It is also part of probably every *huya's* life. Elders complain about the disharmony caused but remember well their personal adventures. Equally, people know gasoline is for patients not for everybody; you shouldn't steal from doctors, etc. At some point the meeting is convened, moral order is brought to the fore and depending on the doctor and leaders, s/he might leave or stay; if the latter, the relationship tends to a workable equilibrium.

We shouldn't be surprised if relations between factions resemble those with doctors. They both exhibit the same dialectic involved in the necessity of dangerous Others for social continuity. Doctors share this outsider condition with affines, here I have tried to show this commonality expressed in temporal cycles of relationship quality (harmony-disharmony). Just as people speak of 'living well' amongst themselves they speak of 'living well with doctors' or the equivalent 'working well in the clinic.'[111]

VI. 1. 4. Collectivising doctors, differentiating Yanomamɨ and obviating meetings

Let me put this dynamic in the theoretical framework proposed in Chapter V. Doctors are oriented to organise, make rules, establish conventions and standard procedures in order to make the collective. They are constantly trying to regulate the management of resources; define clinic working hours, treat people in order of arrival at the clinic, etc. Establishing a workable environment is their everyday orientation. In this context Yanomamɨ are seen as disorganised, 'each trying to be first' in the clinic, impatient, 'they do whatever they want,' not as they are told or as agreed. Yanomamɨ don't 'collaborate,' hindering work in the clinic.

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[110] It must be stressed that fission lines can form between consanguines rather than affines. In Barrio Viejo, for example, one influential man, brother of the nurse, was often supportive of his brother's opponent. For an analysis of several cases of affinal and consanguine fission among the Parima Yanomamɨ see Alès (1990).

[111] This is a literal translation from Spanish '*vamos a vivir bien*,' 'let us live well' or '*vamos a vivir bien con los medicos*,' 'let us live well with the doctors.' Such an emphasis resonates with what other authors find elsewhere in Amazonia, a striving to uphold a convivial ambience at community level (see Overing & Passes, 2000b:2; McCallum, 2001:115; Gow, 2001:222).

Yanomamɨ – specially *huya* – on the contrary, are constantly marking themselves off from this *fabricated* collective. Their 'bending of clinic rules,' or attempts to be privy to the clinics' resources are forms of learning the extent of their individuation (power), in this respect, not unlike the differentiation of *huya* through their love adventures. In sustaining secret relations with women, youngsters respond to their passions but do so conscious of the consequences – exchange of club blows with offended husbands or at least public verbal reprimanding. Depending on one's political standing youngsters can select less 'costly' relations but the point is that this is a period of life where Yanomamɨ learn how far they can manipulate convention depending on their courage and who will defend them, learning the manner and extent of their individuation.

But differentiation can take many forms. A simple example is the use of *criollo* items in body décor. Once in Pashopeka (upriver), a woman asked me for toilet paper. She took the piece and tore it in long strips and placed them in her earlobes. A few minutes later all the women wanted paper to match her originality. In differentiating actors from the rest, 'bending clinic rules,' secret romances and toilet paper body decoration are of a kind. This individuation is also the road to leadership.

The all-important difference is that clinic conventions are *fabricated* not *innate* in the sense that *criollo* potential affinity is – which is an innovation on the conventional relationship to enemies. This encounter, then, pits Yanomamɨ *innate* conventional potential affinity against doctors' *fabricated* conventional rules of engagement producing the cyclical dialectic we described above.

Only when things 'get out of hand' are the doctors' collectivising endeavours matched by Yanomamɨ intentions: this happens in the 'ritual' meeting. Rituals run counter to people's normal orientation to differentiate, they are collectivising moments when the moral conventional order is explicitly performed (Wagner, 1981:chap 4). The Yanomamɨ *reahu*, as we saw in Chapter V, is a collectivising scene where the ideal of the local group without affines, co-residents without outsiders, is stressed by the symbolic obviation of the consanguine/affine and co-resident/guests distinctions.

Ocamo meetings, where elders and leaders recall the virtues of moral life, of 'living well,' are 'ritual' in their collective moral orientation. Seeking to 'calm' internal factional divisions they are also a matter of obviating innately-present alterity even among co-residents (affines and outsiders). Meetings with appeals to 'live well with doctors,' to 'collaborate,' are equally obviating devices, calming the intrinsic friction with *criollo* potential affines. They are attempts at making the doctor a worthwhile 'included third,' an ally not an enemy, thus securing a valued *criollo* resource (healthcare).[112] Obviation is literally an 'overlooking' rather than permanent dissolution. The innate antagonism never ceases, hence communities fission over and over; meetings discuss the same issues again and again, and so on.

VI. 1. 5. Where is society?

An important difference between internal village dynamics and relations with doctors are the means to resolve conflict, another aspect of the powerlessness of doctors as potential affines. Elders' morning harangues, *patamou*, among other objectives, aim to persuade younger people into moral behaviour (Lizot, 1994:216; Alès, 1990b:223).[113] Periodic *wayumi* fruit-collecting stays in the forest, where factions may go their own ways, also relieve tension (Lizot, 1998-9.:14). Feasts with their ritualised dialogues, material exchanges or organised combats contribute to the regulation of conflict and peace between communities (Lizot, 1994). On an individual level, what tempers excessive individuality are obligations to defend your kin.

Doctors have none of this at their disposal. They occasionally despair, not being able to punish damage or theft. There is no law, police, or higher instance to make people 'pay.' Some attempt the closure of the clinic, until the culprits appear. This was one, albeit undesirable, response of a Mavaca doctor after a second breaking into her house. It took a couple of days but eventually the doctor was informed of the culprits. The most common measure is to exhort community leaders from whom an

[112] We shall see below that meetings, in a divided Ocamo, also served for leaders to measure themselves against each other. In such circumstances, one group supported 'the doctors,' appealing to harmony with them, whilst the other, necessarily opposed, would stress the negative side of typical *criollos*: the doctor is lying, not working well, mistreating people, etc.

[113] Interestingly one Ocamo leader told me how, in the past, there were no meetings, 'only *patamou*.' Our analysis of meetings as bringing 'the moral' to the fore, echoes the moralising effect *patamou* is supposed to have, suggesting a certain transference of roles.

authority that would embody the coercive power of the community is expected. However, as so many have stressed (Lizot, 1994; Alès, 1990b; Rivière, 1984, Clastres, 1977), leaders themselves can only appeal to moral persuasion and results often fall short of doctors' expectations. Among the Cashinahua '[n]o amount of moralising by the leader can put a stop to occasional petty thievery, adultery, drunkenness, gossip, laziness and so on. Such, to the Cashinahua, is the normal human condition' (McCallum, 1990:425). 'Bothering' doctors, I would argue, falls under the category of 'petty things,' hence even influential men are relatively powerless in curbing their occurrence.

The same Mavaca doctor was once visiting an upriver community. Whilst treating several children with malaria she realised a *huya* had tossed the quinine pot into the river:

> '…'why did he throw it in the river?!' I was hysterical…[motorist explains] 'he was angry because you didn't want to treat him fast, because you were seeing other patients'…I called for the Captain and began to complain, I told them I would not come again…it cannot be that one comes to help and you don't collaborate, and these things happen and you say nothing…[motorist] 'doctor, never mind, you know *huya* are like that very *hoashi*' ['troublesome, undisciplined'] and I said 'oh! That's fine then, he is very *hoashi*!' …[she looks for the captain who is taking *yopo*] I go to the house where all the elders were but no-one paid attention claiming they didn't understand Spanish… 'I don't know if you are understanding me or not but I am telling you I will not come to Washewë again…'…one began saying [translated by her motorist] 'he says its ok, they understand, the doctor won't come, that's fine don't come, we will be patient…''

This is an emphatic example of Yanomamɨ not 'collaborating,' experienced by the doctor as helplessness in lacking enforcement means. '*Huyas* are like that, *hoashi*'[114] expresses how they are expected to be troublesome. Their discipline is not in a village leader but in measuring the consequence of their actions, the 'power of society' is the

[114] The word comes from the verbs *hoashimou*: 'to tease' and *hoashiprou*: 'to be undisciplined' (Lizot, Unp.:107).

conviction of an offended opponent to stand up for himself. The doctor, faced by the futility of appealing to the ‘captain,’ issues an empty threat ‘never to come again.’

We are reminded of the 16th century missionaries on the Brazilian coast trying to convert the Tupi. Viveiros de Castro (2002) stresses that the real enemy of conversion was not having to fight another creed, but rather the lack of any doctrine. Hence, ‘[r]eunion, fixation, subjection, education. To inculcate faith, it was first necessary to provide the people with law and king.’ (190).[115]

Images of Yanomamɨ as unruly, ‘doing whatever they want,’ converge with the often futile appeal to leaders in the search for stable conventions that will ensure the minimum for ‘living in society.’ The constant need for meetings, rehearsing the same issues gives them a sense of pointlessness, Yanomamɨ are fickle in their agreements: not only missionaries need law and king to do their job.

VI. 2. *Yanomamɨ: ‘malcriados,’ ‘vivos,’ ‘unpredictable’: the ‘inconstancy of the savage soul’ all over again*

Yanomamɨ ‘doing their own thing’; the constant search of community control; insistent requests despite persistent denial; pointless meetings;[116] brinkmanship and visible displays of anger occasionally accompanied by a threat, ‘I’ll burn your house!’ all contribute to conjure in doctors the image of children. The disregard for doctors who often underline how they ‘are here to help’ points to irresponsibility, for disregarding them, Yanomamɨ are harming themselves, working against ‘their community’s welfare.’ Lack of ‘collaboration,’ ‘children,’ ‘irresponsible,’ are finely conflated in the term ‘*malcriado*,’ perhaps the most common word to typify Yanomamɨ. The term designates children or juveniles who don’t know how to behave due to bad upbringing. Evoking the misplacement of non-social children’s behaviour in a young or adult person who should conform to rules of society, it encapsulates the *criollo* perception synthesised from numerous behaviours, a true equivalent of ‘the inconstancy of the savage soul’ ascribed to the Amerindian peoples of Brazil

[115] Ramos (1998:16) underlines, the lack of letters ‘f,’ ‘l’ and ‘r’ in the Tupi language was congruent with the missionaries observation: they had no faith ‘*fé*,’ no law ‘*lei*’ and no king ‘*rei*,’ hence, something had to be done.

(Viveiros de Castro, 2002). Let me refer to other frequent adjectives resounding with 'inconstancy.'

'Ever-changing': Doctors are baffled by Yanomamɨ's swift passages from anger to laughter; from confrontational behaviour to visiting the house wanting to share a coffee; from profuse displays of sadness in mourning only to be seen the next day cheerful in the doctor's house. As a friend put it: 'they are ever-changing in character and feelings.'

'Unpredictable': After an important protest involving the health system in La Esmeralda, the HD was particularly affected having been publicly criticised by many he considered close friends (see Chapter VIII):

> 'at this moment I feel more than ever that Yanomamɨ culture…is something totally cryptic, totally indecipherable, incomprehensible…there is no way you can predict their behaviour…on the other hand, when we have…tried…to have someone that shows interest to get involved with us, from one day to the other / or only for a while / or for ever, that interest is lost …'

Lack of persistence was a common feature highlighted by missionaries both in conquest Brazil and in today's Upper Orinoco: 'they are keen to learn, and good, but left alone they quickly lose interest' (paraphrase) was a feeling among missionaries that have 'tried everything' in terms of productive projects for the Yanomamɨ, none 'catching on' for long.

'*Vivo*': The term designates people who are quick to make the best of a situation, frequently when it involves 'beating the system.' Realising the tricks they have been subject to and becoming alert to them, doctors see some interface Yanomamɨ as smart tricksters; 'they are smarter than we are' reflects doctors' awareness of Yanomamɨ ability to take advantage of *criollos*.

'We are the jungle': An expression of an Ocamo doctor making the equivalence between *criollos* and the forest as mere sources of Yanomamɨ needs. It encapsulates a

[116] Again, high doctor turnover does nothing to counter this tendency.

most common self-appraisal of doctors from the Yanomamɨ perspective, potential affinity as self-representation:

> '…[Yanomamɨ think] they are doing us a favour…we are here because of them…'

Or

> '…they will always see as '*shomi*' ['different'] and in greater or lesser degree without hostility but as a source of things, doctors may be of use health wise, or gasoline, or a bit of kerosene, a can of oil, pasta…also the mission…'

Or

> '[*criollos* are] someone whom they can get something from in a given moment…they have us to live off us without giving'

Reverberation of images of 'the Other' are characteristic of inter-ethnic situations (Taussig, 1987:240; Albert, 2000:241). The image of naturalised Indian that doctors have when they arrive in the field (Chapter II) is congruent with their experience of disorder and absence of conventions for society. Prefigured as natural, Yanomamɨ enter doctors' world as disorder, which, as nature itself, needs to be worked upon to counter its innate entropy. 'Inconstancy' compels the need to 'make society,' to 'civilise' in this sense. But 'we are the jungle' reflects doctors' feeling of being controlled, subjected to a Yanomamɨ agenda extending the Western relation to nature to the Yanomamɨ, as doctors come to see themselves as a form of inert use value, producing the paradox of (Indian) nature harnessing (*criollo*) nature. The 'inconstancy of the savage soul,' is, however, the persistence of the relation to exteriority, from 16th century Tupi, to 20th century Piro and Yanomamɨ: the 'constancy of the potential affine' allowing the 'constancy of becoming.'

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Thus far we have seen how doctors' generalised and disempowering potential affinity finds daily expression in the meeting of doctors' efforts to make convention with

Yanomamɨ's efforts to differentiate. Each resisting each other's intentions, they become reciprocal motivation. The cycles of harmony and conflict are mediated by community leaders in 'ritual' meetings, seeking to expel alterity from the local scene. This process resonates with the Yanomamɨ village dynamics of conflict accretion, resolution and fission. Affines are necessary for Yanomamɨ village continuity in the same way *criollos* are for propelling a 'becoming *napë*' trajectory.

The second part of this chapter examines the impingement in medical relations of being *napë*. Here the performative aspect of the '*napë* transformational' context will become evident.

VI. 3. *Doctors as napës: medical contexts*

I cannot provide an exhaustive analysis of the complexity of everyday life in the clinic here. Following the theme of this chapter, I will first draw on an everyday circumstance, asking for medicine, to exemplify the impingement of being *napë* in even the simplest of situations. Next, I will draw on an extraordinary case (but familiar to any Upper Orinoco doctor) to exemplify the performative complexity in doctor-patient relations and 'patient negotiations.'

VI. 3. 1. Asking for medicine

Occasionally doctors have impasses with Yanomamɨ who arrive at the clinic with a specific remedy in mind 'give me Ampiciline!', or when they are examined and told they don't need medicine when the person thinks s/he does, or when they are given the 'wrong' medicine: 'no! I want the white pill' or 'give me an injection!'

There are two issues provoking the impasse. First, often Yanomamɨ approach the clinic having already performed a self-diagnosis and selected the appropriate remedy. Diagnosis is a step which other Amerindians also consider part of the patient's discretion (Buchillet, 1991b:35-36). This is disquieting for doctors who prefer to evaluate the patient and only then prescribe. Reactions to these requests vary from an instructive explanation to more blunt responses: 'who is the doctor here?' Once an argument, the discussion becomes a minor power-play. But this is not just a matter of

stubbornness. As mentioned in Chapter III, doctors may appear stingy and, depending on the case, insensitive to a patient's suffering, both important breaches of morality. Accusations like: Y. '*doctora a shi imi!*,' Sp. '*doctora esta mezquinando la medicina*.' 'the doctor is stingy,' are frequent. Yanomamɨ may also be faking an ailment to get some medicine to keep (usually pain killers). The deceit is necessary because doctors normally fear misuse or abuse of certain medicines.

The second issue is one of form. Yanomamɨ often demand, rather than ask, for things: 'give me X!' rather than 'can you give X?' Frequently the doctor is requested to see a patient: 'you have to go to my community now!' regardless of what the doctor is doing at the moment. This lack of courtesy can be seen as another instance of Yanomamɨ 'bossing the doctor around' in disregard of other patients that might need attention at the moment.

But from the Yanomamɨ perspective, I would argue, this is conventional behaviour towards *criollos* on a continuum with Yanomamɨ's more public and hence political engagements with *criollos* where they 'speak without fear' (Sp. *hablar sin pena/miedo*). 'Speaking without fear' is a requisite for leaders to defend their communities against *criollos* – missionaries, anthropologists, doctors included. A friend recounted to me an episode when he was accompanying his sister in the hospital. He was angry because the doctors were not treating her well and decided to address the Director straightforwardly:

> 'I am Yanomamɨ from the Upper Orinoco, I am not Yekuana, I am not Piaroa, I am not Guahibo, I am Yanomamɨ, I am person!' I am not going to speak with shame/fear [Sp. *pena*]. No, 'Yanomamɨs have strength, we have to speak with no fear,' 'well that's so you get scared, so in the future you attend the Yanomamɨ that come over here properly…'[117]

This episode reflects expected effectiveness of speech as a means for influencing others. One of Ocamo's leaders always commented about another influential man who never 'spoke clear,' or 'strong': 'who is going to listen to him?' This man had no

[117] Note the emphatic correlation of being person, a moral human being, and being Yanomamɨ in comparison with the other ethnic groups mentioned.

power to influence others. But the circumstance of doctors not treating a sister well, sheds light on two things. First, *criollos*' typical amoral behaviour requires assertive speech. Their concern for Yanomamɨ cannot be taken for granted, so one must instil fear to have them treat you (morally) well. Second, 'speaking without fear' as a device to get people to act morally or as a means of political influence – 'the moral' always has a point of view – is, on the other hand, on a continuum with conventionalised forms of action among Yanomamɨ. The following comment is clarifying; speaking about a hypothetical possibility of borrowing a motor from a community:

> 'If you ask for help they can give it. If you speak without fear they will surely lend it, if you speak clear, without fear, because the Yanomamɨ are strong like the *napë* are also strong. If you go with fear they won't lend it…'

To effect the lending one must be assertive in the request, a convention which is quite the opposite of Western courtesy. This brief discussion illuminates how even mundane events are infused with the implications of doctors' *napë* signification. Yanomamɨ's assertive speech towards doctors, a milder version of public 'speaking without fear,' aims to either actualise a moral relationship with *criollos* or manipulate them to one's advantage. In either case it is *criollos'* 'enemy' or 'provider of objects' status which is being assumed and sustained.

There are two continuities here: everyday requests and public-political speech, both 'speaking without fear,' and the forms internal to Yanomamɨ sociality and those with *criollos*. Compelling moral action is necessary in both cases, more so in the second because *criollos* often resist Yanomamɨ agendas, as our discussion of 'patient negotiations' below will make clear.

VI. 3. 2. Performance in doctor-patient relations

In this section I will be particularly focusing on 'the moral' in doctor-patient relations to bring up the performative character of being 'Yanomamɨ' or '*napë*' in medical contexts. The following is a recollection of the case of a dehydrated baby from Tumba (greater Ocamo). Let us call this example the 'Tumba case.'

'…they went to fetch us [doctor and student] in the afternoon because the son of Clarisa had a lot of diarrhoea, the boy had already been to the clinic a few days ago and we had given him oral rehydration sachets [ORS]…when we arrived in the *shabono* it was dark, we realised the floor was covered with sachets…they hadn't provided the ORS, the baby was gravely dehydrated, I was alarmed…his veins were collapsed, I couldn't catch the vein [for an intravenous solution (IV)] when I finally could catch one…the student lifted the solution and involuntarily pulled the catheter out…this caused some complaints…well they were really bothered when I tried to catch the external jugular on the neck, they didn't like it, they would say 'why? If you had already caught a vein on the foot, it was the student's fault'….So we prepared syringes [needleless] to pass some rehydration orally to see if we would expand a bit to then attempt an IV again, but when we would turn around the women would take the glasses and would toss the oral rehydration behind us, I still don't understand well why…Well they didn't want that, they didn't let us give him ORS so I asked to be taken back home [Ocamo]…The next day someone from Tumba came to say the baby is really grave…remembering the scene of the last night I said I was not going to go, that they should bring the baby…the messenger said 'there is no gasoline,' 'but why did you use gasoline to come on your own instead of bringing the baby?', they left, [after another attempt to have the doctor go to Tumba]…at six in the afternoon they decided to bring the baby but in a huge canoe with almost all the community, around 20 people, the people came shouting, they were angry…[they treat the child in the clinic amid a great commotion. With a nasogastric sound they managed to re-hydrate the child, but]…we couldn't make ourselves understood with the mother because apparently she couldn't understand us and she spoke only Yanomamɨ and it happens that in a moment of anger she got up and said [in Spanish] 'pinching, pinching, pinching, [to catch a vein] now I am really angry, if you kill my child I will kill you!'…all those days trying to communicate with her…'

This account is an intense instance of what frequently happens to a lesser degree, in many cases with gravely-ill patients. The first issue I want to address here is one that doctors find paradoxical: people requesting the doctor but not letting them perform, not 'collaborating' or even sabotaging procedures.

We must first stress that both doctor and student were newcomers, they still needed to prove their abilities and hence distrust is here relevant. It is also important to note that many Yanomamɨ don't believe in the efficacy of ORS simply because it doesn't stop diarrhoea; some complain it produces more diarrhoea and makes children vomit. Contrary to ORS, intravenous solutions are widely accepted because they 'make you strong,' 'clean you inside' or 'prevent you from drying up.'[118] This is why the women don't use the ORS and allow the doctor to attempt the IV procedure. But this – remaining with 'the medical' – still falls short of explaining the lack of communication and 'collaboration.'

Let us first pause on the state of illness and the emotions surrounding it. A gravely-ill person tends to 'disconnect' from normal social life. They retire themselves to their hammock and hardly speak to anybody. As seen in Chapter III, non-engagement in social exchange is to behave like *pore*, the ghost of the dead, characterised in myth as someone who lives in isolation and denies Yanomamɨ plantains, an elementary cultural food. The gravely-ill are characterised by Yanomamɨ as suffering a generalised loss of sense, inability for straight thought and speech, of not being able to recognise relatives.[119] The feeling is condensed in the expression 'not to feel oneself person.'[120] Dying is an other-becoming, a ghost-becoming (dead liberate ghosts), so 'not feeling oneself person' you feel like a ghost and act accordingly, closing off to social exchange.

Relatives of patients (and patients themselves) feel at once angry/frustrated and sad. Death provokes mixed feelings of anger and sadness. During mourning people visibly express the profound grief, yet at other stages, they instigate each other for revenge. Linguistically, the term *hushuo* means 'to be angry' and 'to be mourning a death' (Lizot, Unp.: 125). Being *hushuo* is also an other-becoming. An angry person also behaves like *pore* in their social detachment.[121] Yanomamɨ recommended doctors, when a relative got visibly angry, always to leave them alone, typically they silently

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[118] Albert (1985:349) describes the importance of blood as a prime symbol of biological vitality. Excess or lack of blood is associated with biological stagnation or dynamism respectively (see also section III.1.1).

[119] Recall (section III.1.2.) the relation between the spectral form *pei no porepɨ* and consciousness.

[120] '*No sentirse persona*.' In Yanomamɨ the expression is the negation of a compound verb '*puhi yanomamɨ*.' Albert (Ibid.:175) reports very similar expressions for 'becoming ghost.'

[121] Again I thank Javier Carrera for bringing this point to my attention.

leave the scene, probably kicking something on their way. At an extreme, people can 'lose control.' A friend told me of his occasional fits of anger. When he sensed this he would tell his wife and mother to leave the house in fear that he would not recognise them as relatives or human beings and strike them. This bizarre behaviour he blamed on the jaguar *hekura* he harboured in his chest that would take him over. In his anger he would become his *hekura* and see people as prey. Finally let us recall that the negation of social exchange of both illness and anger/sadness is amoral. Angry or ill you are less human/moral.

The second issue to address is a mode of action whereby people cajole, or tease one another into response. I here take my lead from Wagner (1981) and Strathern (1990). If conventions are innate and prior to human agency it follows that conventionalised relationships are also innate. For example, the avoidance a son-in-law has towards his mother-in-law. The establishment of a relationship is then seen as the revelation or drawing out or something that was already there. In this context people are constantly pressing each other into actualising moral relationships. When an offended man challenges another to an exchange of blows, he is pressing him to respond morally; not to do so shames the person. People say they don't speak to their mother-in-law because of shame (Y. *kiri*; Sp. *pena*). In Wagner's words:

> 'People shame each other into responding, doing, giving, receiving. The elicitation of male roles through female ones (and vice versa), the initiation of a collective task or undertaking, the presentation and acceptance or rejection of wealth in 'reciprocity' are all acts of explicit or implicit shaming, or moral challenge and response. 'Are you a real man (woman); are you a genuine human being? Then respond morally to this moral situation!'' (Ibid.:95-96).

Now, following Strathern (1990:36), revelation is also a matter of self-knowledge. In avoiding a mother-in-law one knows oneself to be a good son-in-law. The typically Amerindian idea that if one mistakes a supernatural being for a human, one becomes that kind of being reflects this well: responding to this being, I must be one too. I was told about the *urihit*^{h}*erimi*. A friend described them as forest-dwelling beings that live under a lagoon in houses; they look just like Yanomamɨ and if you follow them they lead you to their lagoon; as soon as you step in it becomes a house, there you marry

and live, becoming an *urihit^{h}erimi*.[122] When I responded in Yanomamɨ to children that called me 'doctor' saying 'I am not a doctor,' a common reply was 'ah! so you are Yanomamɨ then?' In a way this is saying: 'responding in Yanomamɨ (morally) to me (I know myself to be Yanomamɨ), you are also Yanomamɨ.' As Vivieros de Castro's perspectivism suggests (1998:483), in responding to another in a moral way, you share a point of view. This applies equally between myself and my young Yanomamɨ interlocutors, as between lone Yanomamɨ and *urihit^{h}erimi*. Again, the quotidian and the extraordinary overlap.

Revelations have then a performative aspect in that they constitute a measure of one's efficacy. For instance, a common way Yanomamɨ spoke about giving advice was: 'let us see if s/he accomplishes my word.'[123] That is, if the person follows the advice, behaving in a suggested way, the advisor's word will have been actualised, knowing him/herself effective. In this way many actions are personal probes of one's ability to influence others. The brinkmanship we noted at the beginning, many times expressed as relentless requests for goods; assertive addressing of doctors, are all teasing *criollos* to actualise a conventional relationship and, more than a test on *criollos*, a self-test of one's ability to make a relationship manifest.

The last point to recall is the ambiguous meaning *criollos* carry. Powerful yet dangerous, hiding real intentions, doctor's knowledge and ability must be displayed and is not taken-for-granted.

We can now propose an explanation for the paradox. Patients and relatives, in their gravity and anger/sadness, are in an ambiguous state between humanity/morality and non-humanity/amorality. The healer's performance must reduce this ambiguity evoking humanity in those who feel half and half. Doctors can do this by reducing their *napë* ambiguity, performing in a Yanomamɨ moral way. Doing so, patient and relatives know themselves to be human and are prompted to act morally: to communicate and 'collaborate' with the doctor.

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[122] According to Lizot (Unp.:442) *urihit^{h}erimi* refers to all what lives in the forest; all the *hekuras* that live in the forest as opposed to those who inhabit a *shapori's* body.

[123] '*Vamos a ver si cumple mi palabra*.' I don't know the exact Yanomamɨ equivalent for this expression although I strongly suspect the literal translation would be 'lets see if s/he listens.' When people don't do as they are told, it is simply said 'they don't listen.'

In the Tumba case the doctors are not performing morally. First, they are speaking Spanish which doesn't prompt the mother to communicate. It is not that she didn't understand; at the end of the account we learn she understood everything. She didn't want to communicate in Spanish. This I found in other circumstances of ill or angry people. Not to speak Spanish is an 'external' door in closing off to social exchange. Had the doctors spoken in Yanomamɨ they would have succeeded in communicating, not because people would have 'understood' but because speaking in Yanomamɨ is moral and evokes moral/human responses. Lizot reminds us of the tale of a child adopted by a group after a raid. One day in the forest, the child kills a young companion and eats him. Upon his return, he is asked about his friend; the child doesn't respond and only hits his teeth with his finger indicating what he has done, '[i]t should not surprise us that someone that behaves like this [a cannibal] should not know how to communicate and that instead of replying when queried, hits his teeth with his finger' (Lizot, Unp.b.:15). This cannibal child is of course a stranger. In the tense circumstances of close death, to speak Spanish evokes alterity, distrust, the antisociability of *pore*, of ghosts.

Second, the doctors try to use the ORS that relatives had discarded. Closed off to normal communication, the women topple the glasses meaning 'realise we don't think this is good!' It is conventional knowledge that ORS is not useful or even detrimental in these cases. As with not speaking Yanomamɨ, lacking this knowledge of convention is a sign of non-humanity. The doctors', negative *napë* meaning comes to the fore, 'can this person be trusted? Does he know what he is doing?' These anxieties are compounded by the student's mishap in pulling out the catheter. Displaying lack of awareness of conventionalised knowledge, the doctor is not performing morally failing to evoke a moral response. The women toppling the glasses are teasing the doctor into conventional action (the use of IV). When the doctor then attempts the jugular vein the observers are further enraged, not just because this is an unfamiliar procedure they wouldn't trust to a newcomer; it is also frustration in the inability to make the doctor do the conventional: 'get the IV hooked up! not the jugular nor more ORS!' The amoral, that is, non-conventional performance of the doctors is reciprocated with equally unconventional/non-human communication. Instead of

speaking the women topple the glasses, like an outsider child signals his cannibalism banging his teeth with his finger.

Another example: a woman aborting attended by a student in Mavaca. By the time she called me the student was angry, not being able to convince the woman to let her do a vaginal examination. ‘I know her, she speaks Spanish,’ she complained, ‘but she won’t speak to me! How can I help if she doesn’t explain what she has!’ Once again a patient seeking help but not ‘collaborating.’ When I came, the student backed off ‘you deal with her.’ The woman’s mother told me an abortion had been induced sometime ago. The student then realised that parts of the foetus remained in the uterus and needed to be removed. Speaking Spanish the student had not been able to make the woman tell her this crucial information. In Yanomamɨ I prompted the woman to the clinic bed. Whispering to her in Yanomamɨ she non-problematically told me she wanted the doctor to give her an IV solution. Once the IV was hooked up, I spoke to the woman along the lines of: ‘I know you don’t like to be touched inside, I know this is shameful but the doctor needs to know if there are bits of baby inside, she needs to take them out so you can feel better.’ She then moaned that she would allow it if the other people around were taken out of the clinic.

I didn’t know this woman. I was visiting in Mavaca, we cannot appeal to a previous relation to inspire trust. The only two things I did differently from the student were to speak in Yanomamɨ and know what her problem was. Speaking Yanomamɨ I performed morally and she responded morally: speaking. In this simple way I achieved something the doctors in neither these cases managed: communication. Moreover, being aware that Yanomamɨ women dislike the vaginal examination was part of the moral performance. It is conventional knowledge that women are careful not to expose their genitals to sight because it is shameful. My *napë* ambiguity reduced by my ‘Yanomamɨ performance’ elicited her moral response and hence she ‘collaborated.’

In general, establishing doctor-patient rapport is achieved by ‘performing Yanomamɨ.’ In this way doctors obviate their *napë* meaning, infusing humanity and trust. The effect is to equally obviate the ghostly meaning of being ill or angry; the achievement of rapport is the collapsing of two types of alterity, *napë* and ghost,

meeting at a 'being Yanomamɨ' point. When this doesn't happen, when conventions are not performed, friction is more likely sometimes leading to a cycle of frustration/anger between doctor and patient and impairing the efficacy of the medical intervention.

This doesn't mean doctors should perform as a *shapori*. This would appear foolish. Doctors must retain their *napë* meaning in showing competency for identifying a disease and matching it with the correct remedy. Yanomamɨ recognise certain procedures of doctors' performances as validating displays of *criollo* knowledge necessary for this identification and matching (see Chapter VII). Doctors must then be morally Yanomamɨ but *napë* in knowledge. 'Performing Yanomamɨ' establishes a moral continuity fomenting moral relationships; what must be obviated is *napë* amorality, not *napë* knowledge for curing.[124]

VI. 3. 3. Controlling doctors

The Tumba case also exemplifies how instead of 'doctor-patient relations,' we should speak of 'doctor-group' relations. Relatives clearly negotiate procedures almost step by step. Once in the clinic, 'almost all the community' came too. The size of a negotiating group varies from case to case depending on the person, gravity and what the medical intervention entails (e.g. leaving the community to be treated in the clinic or not.) The close attention on doctors' performances in grave cases is rooted in outsiders' ambiguity, often aggravated by the distrust of newly arrived doctors or students. Moreover, Yanomamɨ are aware that medicines can be both beneficial or detrimental if misused (cf. Alès & Chiappino, 1985:39).

Three circumstances are particularly requiring of control: when patients are flown to Puerto Ayacucho, when upriver patients are taken to Ocamo, or with new doctors. Every patient sent to the clinic or hospital comes with a 'companion,' normally a relative knowledgeable of the *criollo* world so they can mediate. These companions, help the patient, translating, securing food, etc. But their mediation goes beyond

[124] I am aware that a comparison with the performative aspects of Yanomamɨ shamanism, seeing the involvement of audience in *shapori's* performances in the way that Schieffelin (1985) has in his analysis of Kaluli seances in Papua New Guinea, would enrich this discussion. Alas I don't know enough of Yanomamɨ shamanism to safely engage in that exercise.

facilitating communication; they are delegates of the group to ensure doctors' performances are not harming the patient. Yanomamɨ health personnel not only help in medical procedures; nurses and others, considered more knowledgeable in medical and *criollo* matters, are responsible for controlling performances. So it is that the observers in the Tumba case forbade the doctor to catch a jugular vein, control is about sticking to convention. Let me exemplify the circumstances requiring more control.

Going to the hospital

A friend who accompanied a patient who finally died in the hospital in Puerto Ayacucho speaks of what he told his people upon returning home:

> '…ɨhɨ tëhë ya kuma 'doctora pë / kama pë ishou tikoo ɨhɨ kuteenɨ hariri / haririprarei tëhë 'kihamɨ prahaɨ hamɨ u! wa haropë' doctora pë kuu ha, hutihehe!'

> '…so I said 'the doctors / sadly they attack/harm/kill so when you get ill, if the doctor says 'over there, far away [hospital] you will get better,' don't go!'

Going to the hospital is a gamble, you might recover or die, so here 'companions' should be particularly alert.[125] Clearly unknown doctors' intentions and abilities are not taken for granted. My friend continued his account of how he was questioned once back home:

> '…weti t^{h}ë ha wa aheteonomi?' pë kuma. Bueno kamiye dos yamakɨ praoma cama kë kɨ ha…'ɨhɨ uku katitiwë' ya puhi ha kunɨ ya wã hanomi. 'Napë wa kahikɨ tai mrai!'…ya puhi mohotio kuoma ''hei ukunɨ a norami owëherayou' ya puhi ha kunɨ ya mamo shatitao petaoma' ya kuma. 'Inaha kama napë pë ishou kuaaɨ ha prahaɨ hamɨ pë hutihehe'…pë kuma hei pata…'

> '…'why were you not close?' [to the patient/doctors] they said. We were both lying on the bed [him and patient]…since I thought 'that liquid [IV solution or

> blood][126] is correct/good/normal' I didn't speak.' [people respond] 'Don't you don't know how to speak Spanish!'…I was oblivious to what was happening, 'since I thought 'with that liquid he might recover' I was only staring' I said. Given that is the way the *napë* harm/attack, don't go far away [hospital]'…said the elders…'

Going to Ocamo

Another friend from Ocamo told me of a classificatory elder brother from upriver that came to the Ocamo clinic with a gravely-ill child.

> '…my elder brother told me 'younger brother, my son has diarrhoea, he is also very feverish and has breathing difficulty' then they nebulised the child, they hooked up an IV, they injected him – to lower the fever – I was there so I told him: 'elder brother, it won't happen' [he won't die] my brother replied 'keep an eye on him'…don't worry brother I will be watchful…I was asking 'doctor what is that for? Is it to lower the fever?' [doctor] 'yes' 'but you lower the fever to cure the diarrhoea with blood?' [doctor] 'yes'…'

In Ocamo

Finally, the situation of new doctors/students. After a fight, several people from the Padamo river arrived at the clinic bashed and wounded. One man was of particular concern to doctor and student. Struck on the chest in harpoon fashion, his lung was perforated, a pneumothorax was developing (misplaced air from the lungs impeding their normal functioning by collapsing them). The doctors feared he would suffocate and die if the pressure was not released, it was too late to request a same-day flight to the hospital and he wouldn't make the night. They began to improvise a contraption with medical material (empty solution container, catheter, adhesive) to pinch his chest to release the misplaced air. The nurse, microscopist and motorist were explaining to the man and his relatives the doctors' intentions. After some discussion, the nurse said

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[125] The term doctors use for the accompanying relative is '*acompañante*' which translates directly as 'one who accompanies.' People in Ocamo use the term *nohi t*^{h}*aporewë* which translates to 'one who takes care of' or 'one who surveys' that connotes much better the role assigned to the *acompañante*.
[126] This man (40 years aprox.) was flown to the hospital from Ocamo. He came from upriver and was severely anaemic, had tested positive to malaria and had strong symptoms of hepatitis. The liquid my friend talks about could have been either blood (transfusion) or an intravenous anti-malarial medicine.

the man didn't want his chest perforated, he felt he could make the night. Amid the clinic commotion the doctors' desperation was noticeable; they feared the worst and were forbidden to carry out what they considered a simple procedure. The microscopist later told to me, 'he can't do that, we have never seen that done here,' the motorist added that had the doctor been the Head of District, older and trusted as a 'real doctor,' they would have allowed the unusual procedure. Finally, reflecting the responsibility of mediators, the patient's relatives warned the nurse that, if the procedure went wrong, he would be responsible, opening the possibility of retaliation.

Experienced Yanomamɨ health personnel have an important strong trust-infusing role. People trust that, so long as the nurse is alongside the doctor, the latter's performance is beneficial. The nurse will not allow unknown or dubious procedures, he will explain to the doctor what he can and cannot do on behalf of patients and relatives.

But this control according to conventions acquired through years of medical presence is an aspect of the management of transformation-progression that, through delegated interface Yanomamɨ, guides the trajectory of 'becoming *napë*.' In this sense, doctor-group relations in medical contexts are political acts of a kind with many meetings where Yanomamɨ are also seeking to harness *criollos* and guide their destiny. Testament to the general 'defense and control' of *criollos* we have been discussing is that it is not only health personnel that survey the doctor but also leaders and other interface Yanomamɨ.

VI. 3. 4. Patient negotiations

The last typifying feature the Tumba case exhibits is the negotiation of where to treat the patient. Yanomamɨ ideally wish to be treated in their communities or as close as possible for multiple reasons. First, in the case of small children whose body-soul-aspects integration is frail, separation from the safety of the house can be detrimental because of the threat of spiritual aggression. Second, gravely-ill patients must be treated by a *shapori* because they are normally credited the primary curing role (see Chapter VII). Once taken from the community, the availability of a trusted *shapori* is

reduced.[127] Third, given the chronic shortage of gasoline in the clinic, upriver patients can spend long periods in Ocamo waiting to be taken back home, a sense of out-of-placeness and hardship can develop quickly. This feeling is compounded by the sadness of being separated from relatives back home. If bonds of affect are created out of all forms of mutuality, separation triggers intense feelings of sadness/concern.[128] Fourth, people from other communities might be reluctant to stay in Ocamo, fearing some kind of sorcery aggression. Finally, as Alès & Chiappino (1985:39) note, Yanomamɨ try to make doctors into *shaporis* in aspiring to have them at the community's service. Ideally each community would have a clinic, nurse and doctor of their own, retaining their autonomy.

Of course some Yanomamɨ, conscious of the advantages of close doctor supervision or the technological devices, willingly go to the clinic or hospital. But this is a trade-off, convincing patients and finding companions is normally a long negotiation.

Doctors' motives for treating patients in the clinic are also multiple. Long-term treatments and/or 24 hour supervision is only possible in the clinic. In greater Ocamo arrangements to come and go are simple, but with upriver patients it is logistically impossible. Equally, the clinic, stocked with medical supplies and electricity-dependant equipment, allows more resolutive capacity than in situ treatments upriver. A crucial limitation is the lack of Yanomamɨ health agents with whom treatments could be left behind and radio communication established. Consider the following doctor's comments on an upriver visit when she encountered several sick children:

> '…you want to help them but they don't let themselves, its very hard…[trying to convince a patient the motorist] would say: 'doctor be patient, if they don't want to go, what can we do about it?'…I would like to bring those children to Mavaca to feed them and make sure the medical treatment is fulfilled because the mothers might not do so. I would give the children the quinine and they would vomit it, and again…I had to inject Irtopan [anti-vomit] so he doesn't vomit, wait half an hour…[verifying the medicine is not vomited] then give him

[127] We shall see in Chapter VII that some people can arrange with a *shapori* to perform his shamanism at a distance when they are in the hospital.
[128] We could say that if illness triggers isolation, then isolation is depressing, a kind of illness too.

> the medicine again…who guarantees that a mother is going to do this?…that quinine is so bad [sour, very strong on children]'

In Ocamo itself, doctors prefer the clinic because of work comfort (e.g. better light, bed, radio to call for help) and quick availability of medicine and equipment. When it occurs, the only way to treat several gravely-ill patients is to have them reasonably together. Finally, the clinic is chronically short of gasoline and greater Ocamo communities and some mid-river have motors. Doctors often consider it is Yanomamɨs' responsibility to bring patients to counter a perceived passivity regarding their health fostered by *criollo* paternalism. This 'education' can be compounded with an element of response to the feeling of being controlled; a power-play ensues where whoever moves, loses.

So two opposed ideals of where and how to be treated set up a Yanomamɨ - *napë* confrontation of variable intensity. Specially upriver, Yanomamɨ motorists normally help doctors convince people, but their interest varies depending on kin connections and the quality of relationship with the community. Nurses and motorists are also more sensitive to Yanomamɨ valuation of individual autonomy and often recommend doctors: 'she doesn't want to come, let her be, its her decision' or 'lets try again tomorrow.' 'But she is too ill!' or 'We can't come tomorrow!' doctors reply continuing their convincing endeavours.

Personal autonomy, so highly valued in Amerindian societies, tends to work against doctors' intentions. When convincing others to go to the clinic, Yanomamɨ would often resign: 'we can't oblige her/him,' reflecting the moral obligation to respect personal decisions whatever the outcome. Nowhere is this more tantalising for doctors than in 'life or death' circumstances where doctors are trained to 'do everything to avoid death,' but Yanomamɨ may not agree on this 'everything.' I witnessed several cases where doctors would try last resources with dying children even when relatives had resigned efforts. Leaving the clinic to take a child to a *shapori* whilst doctors do whatever possible to avoid death was also cause for considerable distress. Doctors normally follow patients to their houses and continue working alongside *shaporis*, a preferred arrangement for Yanomamɨ in grave circumstances. Occasionally it was

shaporis working with doctors in the clinic. All these are terms negotiated whilst proceeding on critical patients.

I want to connect our discussion of agency and effectiveness in medical performances and 'patient negotiations.' Given that doctor and Yanomamɨ hold conflicting ideals, every outcome is a concession of one party crediting the other with controlling power. Here people (doctors and Yanomamɨ) don't 'decide' they 'succumb' to a resisted agenda. Let us consider the opposite situation when Yanomamɨ are convincing doctors to do something they often resist: give something. When asking for something likely to be denied, people visit the doctor and speak of friendship or do some favour before bringing up the request. If denied long negotiations ensue. If the person succeeds, s/he is credited the agency (power) in overturning the doctor's initial denial. An object has been extracted (by a Yanomamɨ) rather than given (by the doctor). A Yanomamɨ once complained to me: 'Yanomamɨ are always taking my manioc cakes from me for money.' What seemed as a normal transaction was felt as a forced extraction. All these cases are tests of one's ability to control another, akin to 'direct' or 'fearless speech.' In the '*napë* transformational' context a Yanomamɨ ratifies his condition against a *napë* who is ratified as stingy or 'provider of objects,' depending on the outcome.

Convincing patients is an equivalent situation but here doctors are in the active role, Yanomamɨ resist by 'not letting themselves.' Resistance often has an element of not crediting doctors with the ability to control. Reluctant patients don't 'go' (themselves), they are 'sent' (by doctors). Doctors may react, 'resisting Yanomamɨ control,' but this is seen as 'playing it the Yanomamɨ way.' The clearest instance of this dynamic is when Yanomamɨ don't recognise themselves as patients, when they are treated without apparent reason, for example during preventative programmes in upriver communities. People might request something in return from the doctor: 'you want to extract a tooth that is not bothering me? give me soap!' I once accompanied doctors to a community with almost no active contact with doctors. While attention to sick people was welcomed, mass vaccination plans were thwarted by rejection of what was seen as a pointless, pain inflicting procedure for children. When the third child was being vaccinated, her father, gripping her as she cried in pain and fear, impeded the doctor requesting something in return. Both these examples are attempts at

switching from resistance, ‘not letting yourself,’ to an active extraction of one’s own. The exchange is a matter of matching each other’s ability to overpower resistance, a counter performance with a cancelling effect. In the end the question is: ‘what (object) is my compliance (discomfort/pain) worth (substitutable) for you?’

Control of their performances and negotiating patients’ therapeutic path is received with variable degrees of understanding by doctors. The sense of being surveyed can be understood as part of the inter-cultural situation, as is the case of the following student’s statement regarding the inversion of the doctor-patient power relation:

> ‘for example in the city…you more or less can take the initiative in the doctor-patient relation and guide it, and it is very easy, for example, to impose what you think and what you want to do…here [Upper Orinoco] the relationship is inverted, it is really they [Yanomamɨ] who lead the relation and it is they who decide…what it is you are going to do and up to which point you will do it…here you cannot come and impose what you want, they impose what they want, and they concede a bit and you can go a bit further when they trust you…’

For others this control is an uncomfortable pressure they could do without. In particular when Yanomamɨ with no health training assertively enquire about doctors’ performances or when new doctors are disallowed by the nurse, this can be interpreted as challenge or sabotage.

If bio-medical practice is an evident instantiation of Foucauldian bio-power, regulating bodies the state has moulded into docility, here, where the doctor-patient relation is ‘inverted,’ we find something like ‘reverse bio-power’ (some kind of kin of ‘reverse anthropology’). Controlling performances are equivalent ‘techniques of discipline’ (Foucault, 1979) making ‘docile doctors’ whose innate *napë* ambiguity is filtered by convention.[129]The subject (doctor) – object (diseased body) ‘normal’ relation is in effect inverted: the diseased body is here a controlling subject, the doctor more like a tool. Doctor’s lack of control in medical contexts is rooted in this absence of a state, akin to the absence of society already discussed in non-medical relations,

[129] Let us recall that Ocamo has had semi-permanent doctors for the last 18 years. Missionaries have always provided primary medical care. This is not about not being familiarised with bio-medicine, its about controlling doctors’ performances according to local convention of what can or cannot be done.

compounding the experience of powerlessness. Hence, most doctors consider Yanomamɨ 'difficult' patients, the medical expression of their being '*malcriados*,' and see themselves as 'the jungle,' an objectified controllable use value. But doctors' perception is a consequence of their ideological constraints, the doctor-group exchanges are subject-subject relations, all negotiations, medical or not, sustain 'Yanomamɨ' and '*napë*' as subject positions.

VI. 4. *Doctors as pivots or relations*

The final role of potential affines is doctors' pivotal value in relations among Yanomamɨ. Doctors become political capital, another meaning attached to them against their intentions. The pivot quality of *criollos* is again related to their lack of real kinship, implying they can be put 'in between' any pair of opposed Yanomamɨ or strategically used to enhance a leader's image when 'speaking without fear.' I will give three examples of modes of action involving *criollos* as pivots.

VI. 4. 1. Acting through *criollos*

In the most simple of ways doctors could be set up to further a person's intentions against another. This is a strategic way of acting through *criollos*, diverting attention from oneself. Lucia's motorist once recommended her to change the woman that was paid to clean the doctors' house. Being the nurse's wife, he argued, she already had an income whilst other women didn't, it was better to distribute wealth. Lucia was easily convinced, she said she would talk to Isabel (the cleaning woman). What Lucia didn't realise, and what the motorist knew, was that Isabel was outside the house listening to this conversation. When the motorist left, Isabel entered angrily recriminating with Lucia for 'speaking ill of her,' how could she say behind her back she wanted someone else to work…Lucia was set up by the motorist, who perhaps wanted someone else to earn some cash. The mere suggestion of another cleaning woman, for whatever reason, was not supportive of Isabel and was immediately interpreted as intentional harm.

Another set-up occurred when a small group of tourists covertly arrived in Ocamo and went to Manuel's (faction leader) house. Tourism being illegal in the Upper

Orinoco, these men were willing to pay their way through Yanomamɨ gatekeepers. This subterfuge was spotted by an influential Yanomamɨ of Ocamo's other faction who, instead of acting himself, prompted the doctor to intervene in Manuel's house. The doctor followed suit earning himself a stiff discussion with Manuel and his supporters who warned him to 'keep out of Yanomamɨ matters.' Acting through the doctor, Manuel's rival attempted to thwart his income, avoiding the more conflictive implications of direct action.

VI. 4. 2. Political enhancement

Another way of using *criollos* is to publicly criticise them, demonstrating a leader's ability to 'speak without fear' to them. Let me give a personal example. I had just returned to Ocamo from upriver, having hired an influential Barrio Viejo man as assistant. This man had ongoing frictions with Manuel. At the port, out of the blue I was reprimanded by Manuel. He said I had been taking pictures of people up-river and that I had no permit for that. I was surprised. I didn't even have a camera during my stay in the field and Manuel had also seen my permits. There were two messages here which had in fact nothing to do with the content of Manuel's attack. One, he was telling my assistant in the background that he was aware of his actions, 'don't you think you will always get the *napë*.' Two, 'speaking without fear' to me and criticising his opponent in front of a small audience present, he was enhancing his leadership image.

Interestingly doctors interpret these events as tests of *their* strength. A student told me of an episode when she was providing plenty of food for a family from Lechoza (greater Ocamo) whose child was recovering in Ocamo. She had a long dispute with them at the port when they decided to leave, claiming they weren't being fed. The nurse and others intervened criticising the family, urging them to stay, which they finally did. The doctors of the other health posts then explained:

> '…what the doctors that are already here sometimes tell you [is that] these are tests they put you to see up to what point you concede and up to what point they can / I don't know if 'control' [Sp. *manejar*] is the right word…up to what point you concede, if your character is strong or weak…they are testing you…and

> what you must do is not concede…I don't know if they do that in part to measure strength to see who has a bit more power.'

Lechoza and Ocamo people are mutually *shomi*, 'different,' 'others,' they distrust each other as outsiders, for this reason the former avoid being in Ocamo. These patients were leaving because of this unease and the argument had little to do with the doctor's nurturing and more to do with displaying discontent towards the Ocamo residents; these were the real interlocutors for whom a test, if any, was intended.

My final example is more complex: a community meeting with the doctors. In Ocamo meetings to discuss health were particularly caught up in the village's political dynamic because Ocamo was divided and one faction leader was the official nurse. This meeting combines two aspects of our discussion so far. First, the mediation of leaders in the management of relations with *criollos* through control and translation. Second, it illustrates how health meetings can become political spaces, putting the local health system in between opposed groups.

VI. 4. 3. A health meeting in Ocamo

Let us recall the case where Lucia shouted at the nurse in the clinic: that row escalated finally leading to this meeting. The row began between the nurse and Lucia but Manuel, the opposed faction leader, had got involved and sided with Lucia. Getting involved in the clinic fight Manuel was seizing an opportunity to challenge his opponent whilst simply appearing to support Lucia's cause. Let us also recall that Lucia had recently had a long-lasting dispute with the microscopist and the motorist. These three health personnel are kin and belong to the same faction, they all wanted to expel Lucia.

The meeting meant two different things for Lucia and the Ocamo people. Lucia thought up an agenda for the meeting that included: information about past meetings (clarify the motorist resignation and the microscopist suspension), disorganisation in the clinic, the Yanomamɨ Health Plan, borrowing of clinic resources. She wanted to inform, dispelling rumours and reset working rules. The nurse's objective was to expel Lucia, hence the meeting had clear *criollo* vs. Yanomamɨ connotations.

Symptomatic of this opposition was the debate for location. The nurse wanted to hold the meeting in his brother's house, Lucia in the school, a *criollo* space, where it finally happened. This was not only favourable to the doctors but would also balance the factional element towards Manuel's side who would 'defend' Lucia.

Agency was also disputed. The doctors gave a formal introduction to the session saying they had called for a meeting for a series of reasons (above agenda). Next the nurse explained his point of view:

> '…I called the meeting, not the doctor, I made the meeting that is why we wanted it in [brother's] house but the doctor then decided that it had to be here, but I called the meeting as representative [of Ocamo] and of health [personnel] also. We had a problem in the morning [Lucia tries to interrupt] but we haven't come to speak of things of outside [reference to Lucia's agenda] we are going to speak of the things that are happening here…'

The nurse was reclaiming the authorship of the meeting and its objective from doctors. It is him, as *political and health* representative who has displayed influence in holding the meeting. The presence of people from all greater Ocamo was evidence of his leadership. This explicit emphasis on the '*criollo* controlling' nature of the nurse's action was compounded in his preface to the meeting which was not translated to the doctors. Here he emphasised that whilst they collaborated with *criollos*, these call Yanomamɨ 'animals' (*yait*^h^*akarawe*),[130] that they should 'overtake' (*he toretou*) *criollos* to change this. *Criollos* were now thinking straight because educated Yanomamɨ are now alert/not-easy-to-deceive (*moyawërayoma*). He highlighted that he had been in Caracas speaking for the Yanomamɨ. This advice and his stress on representing Yanomamɨ beyond the Upper Orinoco suggests the nurse as a prime mediator because of his experience, setting himself aside as one who can see through *criollo* appearances, hence he can 'speak without fear.' Continuing the above quotation:

> '…the problem is here, I don't have to fear anybody because I speak the truth…[further on after a short intervention from one of the nuns] now we are

going to expel the doctor if the people are not afraid, because I know we are very fearful here…'

Running through his interventions, the nurse's emphasis against the doctor was that she was scolding/reprimanding (Y. *hɨra-* Sp. *regañar*) Yanomamɨ health personnel. His issue was the confrontation in the clinic:

'…it was very shameful…because you could see it publicly that is why I told her today we would have a meeting'

Initiating a public confrontation, Lucia had inadvertently shamed the nurse into responding with the orchestration of the meeting to expel her. Manuel's involvement only compounded the pressure to respond to a leadership challenge. Much of the meeting rehearsed the incidents of the motorist and microscopist. But several said they saw the doctor working well. Consider the Tumba representative:

'…I see she is working well, she is all the time visiting the communities, because of this I like her…you [nurse, motorist, microscopist] say she is bad with you but with us she works well, if she were bad your son [of nurse] wouldn't be able to play in her house [Lucia was fond of having children playing in her house], she wouldn't give them food either…I see many children in her house, as if they were her own…'[131]

Kinship ties and political alliances guided much of the discussion for and against the health personnel. Towards the end the collective decision was supporting the nurse. A mixture of kin and Yanomamɨ solidarity were involved. Others abstained from taking factional sides and argued for 'living well,' letting Lucia stay. Yet others, from the faction opposed to the nurse, rather than arguing for Lucia to stay, expressed their opposition by challenging the nurse:

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[130] According to Lizot (Unp.:479) *yait^{h}akarawe* means 'unknown; without a name.' My Yanomamɨ translator used the term 'animal.'

[131] Note that the positive qualities highlighted are a) that she visits all the communities, which is in keeping with the ideals of community autonomy and b) that she is caring with children, that she shares her house, her food. Recall from Chapter IV the importance of sharing time and food with others in the creation of sociability.

> '…listen to me Gonzalo [Head of District], take the doctor with you and lets see if Jose [nurse] moves, I want to see you two [nurse and microscopist]. Now we will expel her at once, now I want to see you…They are kicking her out now, I don't agree, I saw her working hard and I like her but now she is already expelled because I want to see you two…If you get lazy we will reprimand you…'[132]

Doctors were left out of the equation as the nurse was challenged into moral action: 'lets see if you can fill her shoes!' The HD considered it was unreasonable to leave Ocamo without a doctor just to challenge the nurse. A one-off row with the doctor wasn't enough to fire her, even less so if most had no complaints. The meeting ended and Lucia stayed, but a couple of weeks later she resigned. In Ocamo this was taken as the realisation of the nurse's objective. Not long after, two people died in greater Ocamo and the nurse was blamed for having done away with the doctor.

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Let me tie up the analysis of the meeting with the rest of the chapter. The organisation of this meeting was a vivid expression of leaders' abilities to control *criollos*. Expelling the doctor is a powerful demonstration of political influence that both validates a leader as a community mediator and challenges his opponents. As instances of managing *criollos* in a historical trajectory of 'becoming *napë*,' assertive speech 'you must go to my community now!'; assuring doctors stick to convention; patient negotiations and meetings are political acts of a kind in their definition of different aspects of 'Yanomamɨ' and '*napë*' positions. As so they also share the performative quality of testing an agent's effectiveness.

The meeting also exemplifies the use of a *criollo* institution as a pivot between factions, a collective instance of the *criollo*-mediated action between individuals. With collective 'in betweenness' *criollo* spaces can easily be reclaimed as sites of mutual measuring up. But meetings with *criollos* also tend to deploy a fundamental Yanomamɨ – *napë* opposition where the former strive to dissolve internal differences

[132] This extract, in contrast to the rest, was translated by a Yanomamɨ assistant straight into Spanish. All other Yanomamɨ texts are either originally in Spanish or transcribed first into Yanomamɨ and then

enhancing their abilities to control or extract benefits from *criollos*. Correspondingly in these meetings *criollos* are represented as deceitful, non-trustworthy, and resisting Yanomamɨ intentions. In our example there is a tension between internal factional and generalised Yanomamɨ solidarity. This probably explains the outcome. Allowing the nurse to expel Lucia whilst challenging him into moral action, satisfies an opposed faction maintaining Yanomamɨ solidarity. Moreover this choice has the potential to shame an opponent – as finally happened – it is, in fact, a stronger and perpetuating political statement. In Chapter VIII, we shall see in the Mavaca Yanomamɨ conference, a similar tension between party and pan-Yanomamɨ solidarity. In both cases the 'in-betweenness' of *criollo* potential affinity, that opens a space for playing out internal oppositions, is in tension with the outsider meaning of *criollos* compelling Yanomamɨ solidarity.

Finally, the meeting illustrates a certain 'mixing up' of contexts from doctors' perspective. *Criollos* expect to sustain a 'rational' argument that separates kinship and politics from health issues. Their rationale is based on a morality that requires the obviation of personal relationships (e.g. the welfare of the community). Yanomamɨ are as capable as any other to sustain such arguments but their moral conventions explicitly situate people in personal relationships impinging on choices and modes of action. Gonzalo, aware of this, emphasises that the doctors value the microscopist for his work and as a person, they are not angry with him, he is simply suspended for his misbehaviour. Also aware of the *criollo* – Yanomamɨ opposition, he adds that suspension is a response to anybody's misbehaviour, the same applies to *criollos*, in an effort to de-politicise the meeting and focus on health issues.

Criollo-Yanomamɨ discussions frequently form sequences of moral understanding followed by bewilderment. Interface Yanomamɨ can skilfully expound '*criollo*-consonant' arguments to their advantage. In the meeting Manuel's support for Lucia deployed arguments congruent with her understandings. However, towards the end, once it had been decided Lucia would stay, she suggested the new clinic cleaning woman, one of Manuel's wives, should be changed because she had a new-born child

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translated.

and shouldn't spend time in the clinic lest it get ill. A friend describes Manuel's position:

> JA: Why does Manuel defend the doctor?
>
> '...weti t^{h}ë ha? Pë suwepɨ Claudia a rë kui e ohotamou ɨhɨ rë kë, trabajo e t^{h}ë kua ha…a niya shimiaɨmi…ma kui ultimo doctora a wã wayoma...'ambulatorio a hamɨ ihiru pruka pata t^{h}ë pë hariri…waiha a kuaaɨ tëhë infecta a niya haririprou' ɨhɨ tëhë Manuel e kuu 'doctora inaha wa kuu tëhë wa niya përɨomi hëyëha, kamiyë inaha ya kai puhimi…kamiyë reunion asamblea grande ya t^{h}ë niya t^{h}apraɨ, hɨtɨtɨwë ya t^{h}ë niya koapraɨ wa përɨo mãõpë, inaha wa kuu mai.'…'
>
> '…why? His wife Claudia is working, since she has a job…he won't expel her…but in the end the doctor said…'there are many sick children in the clinic…then when she goes to work [her baby] will get infected and ill' so Manuel says 'doctor if you speak like that you won't live here, saying this I don't want you either…I will make a large meeting, I will fetch everybody [in Ocamo and upriver] for you not to live here, don't speak like that.'…'

Lucia was expected to conform to a morality of political support; mixing up what for her should not be together, personalising her position. On his part, the nurse, unaware of Manuel's wife's new post in the clinic, exclaimed 'Ah! now I understand!' In general Yanomamɨ deploy in their relations with *criollos* a composite 'logic' that combines depersonalised ideals like 'living well,' with obligations of kinship and political solidarity.[133] *Criollos* are attuned with only the first part of this 'logic,' the second is seen as an irresponsible misjudgement of priorities. On their part, Yanomamɨ ascribe to many *criollo* decisions an intention that they themselves don't. The application of a generalised morality is often seen as deliberate support for, or harm to, someone. As Vivieros de Castro notes 'no difference is indifferent, because all difference is immediately relation…' (2002:165). Being 'in between' doctors cannot get away with being 'on nobody's side.'

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Thus far we have described doctors' integration into the Yanomamɨ 'becoming *napë*' historical trajectory. We have just analysed how, not belonging to any kinship network, doctors are in between relations among Yanomamɨ. But they are also in between down–upriver relations. This is the last way in which the health system contributes to the *napëprou* of Ocamo people: their continuous differentiation from upriver communities.

VI. 5. ***Upriver differentiation***

Ideally doctors run fortnightly visits to 'intermediate' communities and monthly visits to 'distant' communities. In reality this schedule is not normally accomplished for reasons already expounded (see section I.6. and IX.1.1.). Upriver visits again pit Yanomamɨ and doctor agendas against each other. Doctors plan their visits on medical grounds trying to fulfil visit or control programme (e.g. onchocerciasis) schedules or responding to news of ill people. Yanomamɨ crews see more than a medical visit. For the motorist and his helper(s), the trip is always an opportunity to visit relatives, exchange, spread and collect news, negotiate political or marital alliances, and hunt. Yanomamɨ try to impose their multiple-purpose project on the doctor's single-purpose medical trip. Concomitantly doctors are constantly negotiating the trip plan as they go often stressing they are the bosses: 'this is a health trip, not for you to visit your mother-in-law!' Again companions' multiple objectives are seen as a misjudgement of priorities; health cannot compete with other objectives. Many doctors learn to amicably give and take with their helpers, the latter also resign their motivations to the needs of gravely-ill patients, but a subtle power-play is a lingering presence throughout the trip.

Let me now address how companions a) become mediators between doctors and upriver Yanomamɨ, in this sense playing the equivalent role of 'control and translation' of *criollos* as political leaders do in meetings and b) differentiate themselves as '*napë*' in opposition to their upriver compatriots. If Ocamo people feel themselves as Yanomamɨ/*napë*, their differentiation from both 'pure' Yanomamɨ and

[133] As we shall see in Chapter VIII *criollos*, in their inter-institutional relations, are also caught up in the often conflicting pulls of general morality and institutional solidarity. Moreover, in response to

'pure' *napë* is necessary; medical visits are opportunities to differentiate in the first way (see Chapter VIII for the second).

The *criollo*-controlling role of companions is most evident in the influence upriver people ascribe to them. For example, the origin of manufactured goods in Pashopeka (6 hours upriver) that came from the Ocamo priest and his Yanomamɨ helper through the SUYAO co-operative was credited to the helper, not the priest. From this upriver perspective, it is down-river Yanomamɨ who control the flow of *criollos* and their products. Suggesting the same holds for medical visits is the following comment from a mid-river community friend, criticising the new Ocamo motorist (recall the old one resigned). I had asked what he thought of a particular doctor's work:

> 'A ohotamou totihitaoma, totihitawë yai mihi a ohotamoma…Robertonɨ pë kai waroyoruu tëhë totihitawë yamarëkɨ payerimama, yamarëkɨ hiwehaɨ, yamarëkɨ koamaɨ…Roberto iha yamakɨ kuma: 'pei yamakɨ rë hariri medicina pë ta hipëa ma ta puhi!'…ɨhɨ tëhë a wã wayoma doctora pë iha, ɨhɨ tëhë medicina pë hipëamama…ɨhɨ kuteenɨ yamakɨ harou hooma…ɨhɨ tëhë Juan motorista a kua nomihɨkema...ɨhɨ tʰënɨ pei kɨ / yamakɨ kuma 'doctora yamakɨ hariri, yamakɨ prisiprisimou, yamakɨ kriimou, yamakɨ tokopɨ'…'ma wamakɨ temɨ…ohi tʰënɨ wamakɨ horehore hariri' doctora pë kuma…'prewë hariri' yamakɨ kuma ma kui a wã hanomi Juan…'
>
> 'She used to work well, that one really worked well…when she came with Roberto [old motorist] she would help us well, she would inject us, give us medicine…we would tell Roberto: 'we are ill, give us medicine, we really want it!'…then he would speak with the doctors, and make her give medicine…so we would recover once the doctors had left…Juan replaced him…so we would say 'doctor we are ill, we have malaria, we have diarrhoea, we are coughing'…'no you are healthy, its because you are hungry, you are not really ill' doctors said…'we are really ill' we said but Juan didn't speak…'

Overlooking the agency of the doctor, he criticised the new motorist for not interceding strongly enough on their behalf. If the doctor was not behaving, it was the motorist's fault for not pushing her to do so. With the previous motorist, 'she worked really well.' Companions in their mediating role are trusted to further the

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Yanomamɨ solidarity they also may deploy a *criollo* solidarity across institutions.

community's health needs. This imposes a responsibility on them but also allows them to appear as powerful, controlling the actions of doctors.

During visits companions do a lot to mark themselves as *napë* against the host communities. Invariably they are fully dressed – trousers, shirts, shoes, sometimes caps and sun glasses. Many also smoke cigarettes which is distinctly *napë* – as opposed to the Yanomamɨ use of tobacco wads. A Pashopeka *huya* who had been sometime living in Ocamo, came once as a companion on a trip to his community and, lacking cigarettes himself, was desperate to fabricate one out of normal tobacco leaves rolled up in a piece of notebook paper I provided him. Also standard among companions are shotguns, lamps and batteries, which many upriver communities don't have and relish. Companions also eat with the doctors, an act that not only means they 'know how to eat *napë* foods,' but in sharing food, they are displaying mutuality with *napës*, assimilating themselves to them.

There is also an element of subordination in a typical chain of command; a chain of decreasing *napëness*. Doctors instruct the motorist as 'head helper,' who will relay tasks like washing, finding wood, portaging, to other helpers. If mid-river helpers are collected on the way upriver, these are placed at the bottom of the 'command chain,' but they too might instruct a local upriver child or *huya* completing the relegation of a task.

All these are *napë* traits that, added to companions' abilities to steer motors and speak Spanish, constitute important differentiating markers. Ocamo companions deliberately 'perform *napë*,' displaying *napë* body/habitus and knowledge. Many times they also exchange or give away manufactured products – willing or reluctantly – putting them in the *napë* position of 'providers of objects.' Consider Lizot in relation to Yanomamɨ companions on medical trips:

> 'The Yanomamɨ companions frequently behave as little arrogant bosses. They despise and exploit neighbouring communities, often less 'evolved,' more 'savage.' For example, they don't accept loads on trips, they walk with shoes and clothes, to look like us [*napë*], they make the others work and they demand food without offering anything in return…very frequently the doctors' helpers…make the local groups where they are received call them '*napë*.'' (1998:30-1)

But this, however, is a matter of retaining a dual Yanomamɨ/*napë* image that enables companions to mediate on the community's behalf whilst also stressing a *napë* image, which crucially differentiates them as 'civilised' Yanomamɨ in opposition to *waikasi* that 'live like the ancients.'

'Performing *napë*,' obviating one's Yanomamɨness in an upriver community might be met with a counter performance. Upriver Yanomamɨ can see themselves from the Ocamo perspective as *waikasi*, 'real Yanomamɨ' (Chapter V). Their demand for objects involves 'performing Yanomamɨ' – lacking objects. Presenting themselves in need they are also appealing to the ethics of avoiding people's suffering pressing Ocamo companions into giving. The Ocamo equivalent is for 'civilised' Yanomamɨ to 'perform Yanomamɨ' when extracting objects from doctors. This demands obviating *napëness*, presenting oneself as a needy Yanomamɨ just like *waikasi* do upriver in relation to the more resourced 'civilised' Yanomamɨ (*napë*). There is then a subtle but important affinity between the ethics of care, to use Alès' (2000) term, and the '*napë* point of view' so strongly defined in terms of possession of objects by Yanomamɨ and *criollos* alike.

Finally, performances are instances of obviation not obliteration. Ocamo Yanomamɨ intentionally 'perform *napë*' but their innate Yanomamɨ 'side' must remain for mediation to be possible, just as *criollo* doctors should artificially obviate their *napë* 'enemy' signification but retain the *criollo* knowledge component of their being.[134] In both cases 'Yanomamɨ' is a collectivising moral continuity, whilst '*napë*' is a body(habitus)/knowledge differentiation.

Concluding remarks

We began describing the dynamic of doctor-Yanomamɨ relations in non-medical contexts, concluding that doctors' collectivising efforts met with Yanomamɨ's differentiating ones generating a cycle of harmony and friction akin to internal village dynamics. Recalling Amerindians' anthropological reputation for antipathy towards rules (Overing & Passes, 2000), our analysis allows us to measure up Yanomamɨ and doctors against one another. Rather than antipathy for rules (convention), what makes a difference is what convention does for the Yanomamɨ and what it does for the

criollos; provide a innate background of similarity (humanity) from which to differentiate in the former case, but a motivational objective to organise and structure what appears inchoate in the latter. Hence, *criollos* and Yanomamɨ experience each other's intentions as motivational resistance: the more disorganised Yanomamɨ appear, the more doctors strive to organise; the more standard procedures are set, the more ways to bend convention flourish.

In this relation doctors and Yanomamɨ enter each other's worlds as the form of 'the innate.' Doctors 'see' Yanomamɨ as part of nature: 'disorganised,' 'ever-changing,' 'unpredictable,' Yanomamɨ need working upon to be 'civilised.' In medical contexts, Yanomamɨ are 'difficult' patients, non-domesticated by the state to make them docile patients. Yanomamɨ on their part, 'see' doctors as part of conventionalised culture, potential affines: 'providers of objects,' 'enemies,' 'dangerous but necessary Others' for the process of 'becoming *napë*.'

Within this context of mutual motivation doctors' efforts to 'make society' and Yanomamɨ's 'becoming *napë*' are an encompassing misunderstanding. In meetings doctors' focus on depersonalised morality (e.g. 'community welfare') takes for granted the notion of 'community,' just as in personal cases the 'power of society' is sought in leaders. Such taken-for-grantedness is confronted with a factional dynamic where 'community' is being negotiated during the meeting. 'Community,' just as 'Yanomamɨ,' is a circumstantial 'us' made out of confronting a 'them.' As in so many meetings, 'them' are *criollos* (enemies) collectively defining 'the Yanomamɨ' (co-residents) on the '*napë* transformational axis.'[135] In medical contexts, this situation is reflected in the absent patient, the frustrated expectation of docile bodies. Doctors don't recognise the connectedness of Yanomamɨ social order and hence try to make these connections: leaders, communities, patients, responsibility, order…

Innumerable aspects of doctor-Yanomamɨ relations pit these projects against each other resulting in constant negotiation. Doctors want to be only doctors, not potential affines providing goods and political capital. Doctors want upriver trips to be only

[134] Equally a *shapori* must alternate being *hekura* with being Yanomamɨ if he is to be of use.
[135] This situation is congruent with Gallois' (1991:200) analysis in the Waiãpi context where their demands for a decent health service contributes to formation of an ethnic identity (cf. McCallum, 2001:119-27 for an analysis of the different senses of 'community' among the Cashinahua and its relation to the village economic co-operative.)

medical trips, not a medical, political, economic and kinship motivated trip. Nor do doctors want to be caught in the dynamics of Yanomamɨ factionalism. In short, doctors don't want to be the *napë* contributing to the 'becoming *napë*' of Yanomamɨ.

Next I tried to show the dynamics of obviation in both medical and non-medical contexts, involving both Yanomamɨ and doctors 'performing Yanomamɨ' and 'performing *napë*.' These performances combine aspects of both the 'Yanomamɨ conventional' and the '*napë* transformational' contexts. 'Yanomamɨ' is both 'human/moral' and 'lacking *criollo* body/knowledge.' '*Napë*' is both 'enemy/less moral' and 'provider of objects/knowledge.' In the crossroads of these meanings all performances, from the context of curing to that of exchange or mediation in medical trips, combine 'Yanomamɨ' as collectivising moral continuity and '*napë*' as differentiating body/knowledge. Language illuminates this double sidedness. To speak Yanomamɨ or Spanish has a moral connotation and a differentiating one. Exchange is also double-sided. To give objects is both moral and differentiating, it ameliorates suffering and makes you *napë*.

Finally, I want to underline the continuity between everyday relations and the more typical sites of political discourse. Requesting medicine, patient negotiations, upriver medical visits, inasmuch as they are sustaining 'Yanomamɨ' and '*napë*' positions are political acts of a kind with meetings with institutional *criollos*. This is in agreement with Gallois' (1991:202) suggestion that Waiãpi demands for healthcare must be seen as efforts to control Whites. However, her argument is that bio-medicine cannot 'respond to the diagnostics made by Indians' either in etiological or therapeutic terms, in such emptiness

> 'the Indians have, as sole alternative, the attempt to control – as passive acceptance or radical refusal – the introduction of therapeutic techniques that will be assessed in function of the traditional logic of relationship with Whites. This relationship today among the Waiãpi, adopts the form of confrontation, or at least of political strategy.' (Ibid.)

Indeed the introduction of bio-medicine must be seen within the wider framework of the 'traditional logic of relationship with Whites.' But, as we have shown through the

continuity between non-medical and medical contexts, this has little to do with bio-medicine's capacity to provide explanations. Along the same lines, we may only partially agree Conklin's (1994:162) suggestion that '[t]he key to the comprehension of the Wari' responses to Western medicine is found in the traditional medical system…'. Our analysis shows we must go beyond 'the medical' to explain doctor-patient relations and, more generally, the usage of a health system. The political character of *criollo*-Yanomamɨ relations means we cannot see doctors in places like Ocamo solely as 'doctors,' precisely because Yanomamɨ impose on them a 'holistic' quality that links them, against their intentions, to a wider socio-cosmological framework. Minor, everyday things, managing gasoline and boats, negotiating an upriver visit plan, 'organising' the clinic, sharing food in the house, asking for medicine, shouting at people, are more relevant to the articulation of the health system than Yanomamɨ and doctors' medical beliefs. To remain within 'the medical' to explain relations within the health system is tantamount to overlooking the crucial *napë* potential affine connotations of doctors we have stressed throughout this chapter. Equally, in Chapter VIII we shall discuss how this same political character of everyday *criollo*-Yanomamɨ relations, requires going beyond the explicit sites of 'inter-ethnic politics,' if we aspire a comprehensive analysis inter-ethnic relations.

Our next chapter complements this analysis, exploring the complementarity of shamanism and bio-medicine from Yanomamɨ and doctors' perspectives, presenting the conceptual and practical 'articulation of medical systems.'

Chapter VII: Articulation of medical systems

This chapter is devoted to the articulation of medical systems, exploring the practical 'place' and conceptual 'fit' of doctors, medicine and bio-medical procedures in relation to shamanism.[136] The questions explored here are of the type: How do doctors and *shaporis* work together? How do people conceptualise their roles in curing? Through the analysis of two cases of simultaneous doctor-*shapori* treatments we will suggest an inverse distribution of 'curing' and 'caring' roles between doctors and *shaporis* from the points of view of Ocamo Yanomamɨ and doctors. This supports the received anthropological knowledge that, from the indigenous perspective, bio-medicine supplements rather than competes with shamanism because the latter deals with causes of illness and the former only with its effects (Buchillet, 1991b).

However, an important qualification to this pattern will arise from the analysis of the role of doctors/medicine when treating illnesses considered *shawara*; here I will argue doctors are on an equal footing with *shaporis*. Ocamo Yanomamɨ extend their notion of *shapori* to include doctors as a *criollo* version of their own healer in his curing role. If interface Yanomamɨ assume the political role of *shaporis* on the '*napë* transformational axis,' *criollo* doctors and, to a lesser extent, Yanomamɨ nurses assume their curing role. Moreover, I suggest that given *shawara's criollo* nature, doctors are 'of a kind' with it, like *shaporis* are 'of a kind' with their helper spirits. This opens the possibility of a full set of analogies between *shaporis* and doctors. Inspection of these analogies will evidence Yanomamɨ's multi-naturalism in contrast with doctors' multiculturalism, which will prove congruent with the theoretical framework we have used thus far.

VII. 1. *Therapeutic options and itineraries*

Yanomamɨ along the Orinoco, being close to the health posts, have three sources of therapy: shamanism, *hërɨ* (plant derived substances used both for sorcery and medicine see section III.1.2.) and other symptom-relief procedures, and doctors'

[136] For discussions of this articulation in Amazonia see Kroeger & Barbira-Freedmann (1992); the contributions to the volume edited by Buchillet (1991); contributions to Santos & Coimbra Jr. (1994). On the Yanomamɨ see Alès & Chiappino (1985); Chiappino (1997); Lizot (1997); Semba (1985).

medicine. The specific route a particular person follows depends on a series of factors and may include, depending on the evolution of the illness, any or all the alternatives present. There is no definite choice pattern between doctor and *shapori* nor a set of diseases 'for *shaporis*' or 'for doctors' (cf. Kroeger & Barbira-Freedmann, 1992:141,150-1 for an opposite analysis in the High Amazon). Choices vary from person to person and, for one person, from case to case. Decisions are influenced by self-diagnosis, perceived efficacy, gravity, but also by practical issues like having a good *shapori* in your community or having transport to go to the clinic. People from Ocamo itself find it more comfortable to visit the clinic before calling on a *shapori*. As we discussed in Chapter VI, the degree of trust a doctor has developed is influential. One cannot but corroborate that regarding therapy selection Yanomamɨ share the pragmatism described for other Amerindians (Kroeger & Barbira-Freedmann, 1992:140; Langdon, 1991:217; 1994:138; Buchillet, 1991b:35).

I do, however, want to pause on the role of personal experience in therapy selection. Decisions are strongly influenced by previous personal experience or that of relatives from self-diagnosis (e.g. people learn which pill 'worked for them' and come next time specifically requesting it by name or colour) to choice of treatment. As discussed in Chapter VI, doctors are allowed certain known standard procedures, only experienced and trusted doctors are allowed variations. The accumulation of individual positive experiences in time becomes collective conventional knowledge. Let us recall the Tumba case where the doctor was forbidden to catch a jugular vein, or the pneumothorax case where the puncture of the chest was also denied. These are unusual procedures not to be entrusted to new doctors. Conversely, Dr. Alejandro was once trying to re-hydrate a baby whose father was closely involved in the Tumba case (mother's brother). The mother of the baby, crying for her child, pushed Alejandro's hand away from the baby's nose while he attempted to use a nasogastric sound. Alejandro then turned to the father: 'remember how we saved Clarisa's child,' the father, then prompted his wife not impede Alejandro. Equally, after the Tumba commotion Alejandro recalls how Clarisa became a 'clinic ally' of sorts, persuading other Tumba women to use the clinic when reluctant.

Recalling someone's personal experience is an effective argument in patient negotiations. Personal experience is also critical when it comes to going to the

hospital in Puerto Ayacucho. Recall the experience of the *huya* who accompanied a man that eventually died in Puerto Ayacucho (Chapter VI, pp. 175). He said doctors there sometimes attack/kill (*ishou*), recommending people not to go if they fell ill. Compare this position with the expression of desire to go to the hospital because of its higher technology and specialised doctors (Chapter IV, pp. 120). The multiplication of personal experiences can become collective knowledge but it can also remain as a number of individual and autonomous experiences that heterogenise peoples' choices rather than the opposite.

The primacy of personal experience in health-seeking paths seems to be but an instance of a more general characteristic of the Yanomamɨ or Amerindian lived world. Amerindian mythology is pervaded with episodes of trickery and deceit (recall the myth of Pore, or the tale of the cannibal child). Rumour and trickery are part and parcel of Yanomamɨ life, epitomised in the innate distrust of strangers. The forest harbours different kinds of beings that look like Yanomamɨ but turn out to be supernatural entities (e.g. *urihit^{h}erimi*). As we shall discuss below, a shamanic society is always open to interpret apparent events as actions (i.e. with an agent behind). In short, as Wagner would have it, the cosmos is 'tricked' and life is constantly revealing what appearances conceal. A 'tricked' cosmos demands that the ultimate form of veracity is personal experience, and even then, one may be misled.

I take my lead from Gow (2001:79-84) who underlines the privileged epistemological status of personal experience in the context of myth and other narrative telling among the Piro. Piro personal experience narratives are 'the most certain of stories' (82); the least certain are myths that tell what the ancients spoke about, and by definition no-one witnessed. In between are rumours which, however dubious, are known to have a living, if unidentified, source. As the Piro, when recounting a myth or events when they were children, Yanomamɨ normally cite an elder family member as its origin, adding veracity to something they themselves seemed to be willing to doubt. Gow suggests the primacy of personal experience in narration is linked to the equivalent status in kin-making through personal experience of caring and love. It is reasonable to propose the same for the Yanomamɨ. Moreover, as many quotes here show, when speaking about illness and non-human aggressors Yanomamɨ normally say they know little about the invisible world, only to proceed by

recounting ‘what *shaporis* say,’ often with great detail.[137] Finally, news recounted verbally is potential gossip and hence its veracity is more contestable than personal experience. In general speech is a means to influence others open to manipulation.

This has implications for the way doctors and missionaries attempt to instil changes of behaviour to improve hygiene or teach people that, for example, malaria is transmitted by certain mosquitoes. Doctors and missionaries alike comment on the amount of times they have explained, individually or in organised sessions, the same things to the Yanomamɨ with minimal effect. Inefficiency is then easily interpreted as: ‘Yanomamɨ don’t understand that…’ Some explain this inefficacy in terms of doctors’ and Indians’ different understandings of the body and its metabolism, suggesting to ‘put things in indigenous terms’ rending bio-medical concepts and procedures intelligible (Chiappino, 1997). No doubt this is helpful, but this continues to sustain the premise that the underlying problem here is one of ‘understanding’ or ‘cultural congruence.’ I don’t think understanding is so relevant here but rather that a) verbal explanations, *whatever their source or content*, are simply not taken for granted, they are not sufficiently convincing and b) this is emphasised if the sources are intrinsically non-trustworthy *criollos*. This explains inefficiency not in terms of content (understanding) but form: talks, charts, plays, written documents and representations, in general, don’t ‘count’ as true or believable. The real ‘educational device,’ resonating in form with *shaporis’* curing sessions, is having the crowd of commentators during doctors’ performances, multiplying personal experiences and their accounts. This is perhaps why recalling a trusted relative’s personal experience of a performance is such a persuasive argument. The best way of promoting the health system is its own expansion; more performances and less representations.

As shown in Chapter VI, we must note the moral or aesthetic aspects of doctor-Yanomamɨ relations. Just as speaking Yanomamɨ, beyond facilitating communication is evocative of moral relationships, the teaching effort must not just look for the ‘cultural congruence’ of content but also of form incorporating the epistemological primacy of personal experience.

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[137] Viveiros de Castro (2002:215) also notes that Araweté ‘declarations of the type ‘so say our shamans’ as citation forms mark a non-experiential relation of the speaker with the topic of the

VII. 2. *Complementarity of bio-medicine and shamanism*

No diagnosis rules out the intervention of either doctor or *shapori*. It is normal for patients to be treated either separately or simultaneously by doctor and *shapori*. Many have noted that bio-medicine does not compete with shamanism, on the contrary, they can complement each other.[138] This is possible because in Amerindian schemes of aetiology (causes) - therapy (curing and recovering), bio-medicine enters only as an alternative therapy added to an existing arsenal of therapeutic options (Buchillet, 1991b:35). Considering an aetiology in which the majority of illnesses are conceived of as an aggression on the ontological aspects of the person ('souls,' or 'vital images') by human or non-human agents, shamanism operates on the 'sphere of causes' (aggressor) whereas bio-medicine does so in the 'sphere of effects' (symptoms) (Ibid., 28-29). *Shapori*s battle with aggressors, acting on the ontological plane to eliminate their effects on a patient where bio-medicine curbs the effects, unable to access the causal plane. It is this different site of action – as stage in a process and as 'place' on the person – that, from the Amerindian perspective, makes the complementarity of shamanism and bio-medicine.

Referring to the Yanomamɨ, Alès & Chiappino (1985) argue that bio-medicine cannot offer nor challenge shamanic explanations of why a person is ill, and that the former is supplementary to, and no substitute for, shamanism. Albert (1985:181 ff:34) also notes that bio-medicine is assimilated to the category of therapy he calls 'empirical domestic medicine' (basically use of *hërɨ*), aimed at reducing symptoms of a disease and hence subordinate to shamanic cure.[139]

With the next two examples we illustrate this complementary relationship, to then discuss the articulation from both Yanomamɨ and doctors' perspectives.

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discourse.' But this is not, as he continues to say, a matter of 'not believing what you don't see,' but rather a matter of careful distinction between different relations to events.

[138] Medical pluralism, including shamanism and bio-medicine as well as other forms of healing, is well reported among Venezuelan Amerindians (Chiappino & Alès, 1997; Briggs, 2003); in Colombia (Langdon, 1991); in Brazil (Buchillet, 1991c; Gallois, 1991; Pollock, 1994; Conklin, 1994) and in Ecuador and Peruvian Amazon (Kroeger & Barbira-Freedmann, 1992).

Example 1:

Roberta had been feeling bad for several days, doctors providing different diagnosis and treatments. Lucia and the student think she has a non-metabolic problem, they suspect something is wrong in the household, sympathising with her suffering but finding it beyond their scope. In the night, Daniel, Roberta’s husband, calls for Dr. Lucia saying Roberta won’t wake up. In his house, he demonstrates Roberta’s lack of response as she lies in her hammock. Daniel explains that Roberta ate fish and manioc in the afternoon, lay down and hasn’t woken up since. Manuel, Daniel’s brother, arranges for Miguel, the *shapori*, to be fetched. In the meantime an IV is hooked up and Roberta begins to awaken. Miguel arrives attracting the attention of other relatives; he is told Roberta has just got back from visiting along the Padamo river. Not long after I interview Miguel.

> JA: How did she get ill:
>
> Z: ‘kihi pora pë hamɨ…pora pë hamɨ, t^{h}ë pë përɨhii, yai t^{h}ë pë përɨhii, sipara inaha si pë shatitia...’
>
> ‘Over there at the rapids…at the rapids, they live at the rapids, the *yai* live there, knives, like this [exemplifying the size with his hands] they are stuck…’
>
> Translator:
>
> ‘When Daniel’s wife was [inaudible] / he saw inside [her] what was stuck/inserted like a very small knife, these are really poisonous you see and because of this she was fainting a lot, so when you take them out she recovers’[140]
>
> JA: What was the IV for?

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[139] Langdon (1994:122) and Pollock (1994:156) describe similar analysis – with its variations - of articulation among the Siona in Colombia and the Kulina in Brazil.

[140] The translator’s version extends beyond Miguel’s. In this conversation Miguel tended to explain the particular case (e.g. that of Roberta) and then explain how he proceeds with other kinds of problems

'hei t^hë pë shatimapowehei, ɨhɨ t^hë pënɨ t^hë pë waisipɨ / t^hë pë yanɨkɨ pëtao…ɨhɨ eyemɨ hekura pënɨ 'ma, kihi kë t^hë yainɨ, kihi kë t^hë yainɨ…ukëprarɨnɨ, ɨhɨ t^hënɨ a yai temɨprariyo!' pë ha kutonɨ, ɨhɨ tëhë yai ukëprarihenɨ, aɨ kë a, aɨ kë a…aguja sharirë kuami t^hë t^hataamaɨhe, napë pënɨ.'

Those who hook up the IV,[141] those they only a bit / they only help to recover…the *hekura* say 'no, these [knives/darts], these are really responsible…when you extract them, then she will really become alive/well' so then they extract the darts, one, the other…only with the IV the *napë* [doctors] don't do anything.

Translator:

'…then the solution goes in but it won't cure like that, it is better to send the spirit [*hekura*] first, the spirit sees what is really poisonous, you have to take that out first, only then you can hook up the IV, then he will recover better. If you don't get that out [knives/darts] it will calm a bit but then it comes again. So he says.'

Example 2:

A man arrives running to the doctor's house (3:30 p.m.) because Cristina's baby boy has accidentally eaten bitter manioc. Lucia sends Juan Carlos (JC), the student, to Cristina's house. Later we meet JC in the clinic coming with most of Cristina's household. Lucia and JC get to work, the baby is stupefied and Cristina cries next to them. They check vital signs and all seems OK but, when left on his own, the baby's eyes are lost, his head falls back, he is almost unconscious.

Lucia decides to do an internal cleansing using physiological solution, they also try to catch a vein to set up an IV but on two attempts the baby undoes the job with his movements. The nebuliser is used to ease breathing. Later, JC tries to insert a nasogastric sound but Cristina disallows it seeing it discomforts her baby. I try to

like *shawara*. I am leaving this part of his answer out to simplify. The translator also fills in some gaps for my comprehension so his translations are also explanations.

communicate with La Esmeralda, seeking advice from the more experienced HD. Lacking the right antidote in the clinic, JC receives 'plan B' instructions to prepare a home-made antidote. Lucia continues to give the baby physiological solution orally, while others go to fetch Miguel (*shapori*) and decide to take the baby home. JC tries to keep them in the clinic but the grandmother grabs the baby and leaves. A vein has finally been caught for the IV. We leave the clinic and follow the crowd to the house. JC goes to the doctors' house to prepare the antidote.

Miguel arrives in Cristina's house as Lucia works closely on the baby – in his mothers lap – with an air pump to avoid suffocation. Initially Miguel is forced to stay at a distance from the baby because Lucia is working on him. Miguel begins to discern the path of the spirits involved in this event. Some time later Miguel gently nudges his way into the scene and Lucia steps to one side. By this time, amid a parallel *yopo* session, commentators and children playing, four weeping women have surrounded Cristina and her baby. 45 minutes into the session Miguel stands back, hands to his chest, holding an invisible something which he gently puts into the baby's chest: '*mai kë tʰë*' 'it wont happen,' he says. He sits with the men in the *yopo* circle and they continue to chat about other maters. Lucia remains ventilating the child and passing a home made antidote orally. An hour later the child looks better. Miguel leaves asking to be kept informed.

Dr. Lucia on the events:

> 'A man came to warn us of a very gravely-ill child, we went to the clinic, the boy was very depressed [physically]…even when his vital signs were normal…interrogating the family we realised that he was intoxicated with bitter manioc. We immediately tried to take the vein to administer a parentheral solution to dilute the effect of the poison and we also administered rehydration solution orally to clean the digestive path. After holding the general conditions of the patient another group or women, but elder ones…wanted to take the patient to the house to '*shaporearlo*' [Spanish verbalisation of the Yanomamɨ noun *shapori*]. I told them that as soon as we had finished administering the

[141] The expression used is *shatimapowehei*. The root is *shati*- meaning to adhere, followed by the causative particle –*ma*-, followed by the particle –*po*- meaning to hold something in a given position. Finally -*wehei* refers to the past tense of a transitive verb performed by more than two people.

medicine we would take him over, and this is how it was, we finished giving the treatment and we went to the house with the manual air pump…every now and then we gave him oxygen and we continued administering oral rehydration solution and after aluminium hydroxide for him to eliminate what was harmful…'

JA: What was the *shapori* doing?

'The *shapori* was lingering around the boy with other men. First they were speaking among themselves and the *shapori* danced and shouted, sometimes he sang something, its a song, its like a rite, whilst I was next to the patient he wouldn't get close. I was using the air pump because the child was a bit depressed, but when he was better I distanced myself a bit…the *shapori* got closer to the patient and then he began as if / he would touch him as if taking out something bad/harmful and afterwards they left. I asked 'why did he go?' because I still saw the patient being a bit poorly, they told me they already considered that the patient was better, that he would recover…then the patient expelled *via* the rectum a lot of whitish liquid that I suspect was the manioc…After expelling [the manioc] he began to react better and from there on he got a lot better…'

Interview Miguel:

JA: How did he get ill?

'pei mɨ amo a tërehërɨma, poreananɨ…'

'a *pore* [spirit of the dead] took his *pei mɨ amo* away…'

JA: How do you know what happened?

'…a mɨ amo tërehërɨnɨ hekura pënɨ tʰë pë nɨ ɨhɨpɨmahe. Pore kë a mayo! kama pë ha kutonɨ, ɨhɨ pë ha katitionɨ, a rë mɨ amo tërenɨ, a kõõrënɨ, a mɨ amo hipea kõkɨnɨ, ɨhɨ tëhë a temɨprariyo, inaha tʰë pë tʰataaɨhe hekura kë pënɨ, hekura.'

'…[a *pore*] took the *mɨ amo* away, the *hekura* recognise them/their trace. This is the fault/trace of a *pore*! they said, then they followed the right path, they got the *mɨ amo*, they came back, they gave the *mɨ amo* back again [to the child], then he got well/alive again, that is what the *hekuras* do.'

JA: What was the doctor doing?

'weti kë t^hë pë t^hama inaha?…kama pë t^hë pë rë horomaɨwei, ɨhɨ t^hë pë t^haprarë pëtaomahe...'ma, mihi naha t^hë kua mai kë, no warɨ kë kɨ kua ma rë mai! Hei kë t^hë yai rë kuinɨ a temɨprariyo'…'a hokëprouwë' ya kutarioma 'a niya temɨprou, hei doctoro t^hë pë rë hurirahei yaiwë t^hë pë huri pëta kurahei' ya kuma.'

'What were they doing, is that what you are asking?…those that reduce symptoms [doctors],[142] its only that what they were doing…'no, not like that, this is not *nɨ wari* [*shawara*] can't you see! With this one/in this way, is that he will become well/alive'…'he will awaken [i.e. recover]' I said, 'he is going to recover/be alive, those doctors that were rubbing/touching [the body, also as a form to reduce symptoms], really they were only rubbing/touching' I said.'

Translator:

The doctor that was there sitting, but she is not doing anything, this is not malaria, nor *shawara*, nor diarrhoea, this is not the case…when I do like this I fix his soul again, then his soul will recover/be alive again.'

- o -

[142] The expression '*kama pë t^hë pë rë horomaɨwei*' is clearly referring to the doctors and in a way suggestive of the inefficacy of their action. I have chosen to translate this as 'those that reduce symptoms' following Albert's (1985:181 ff:34) observation that bio-medicine enters the Yanomamɨ healing field as a form of 'domestic medicine' aimed at reducing symptoms and subordinate to shamanic cure (see our discussion above). In Albert's account the Yanomam term for this domestic medicine is '*hɨrɨmaɨ*.' Here Miguel says '*horomaɨ*' which is, in my experience, an unusual way of referring to doctors or Yanomamɨ nurses. The common term in Ocamo for doctors and nurses is '*he koamarewë*,' 'one who gives medicine in the mouth,' but '*he koamaɨ*' also means to mix a harming *hërɨ* substance in a person's food (Lizot, Unp.:70). Equally, the root '*he horo-*', can mean 'to cover or smear something or the hands with *hërɨ*' (Ibid.:67). Finally, the term '*huri-*', used at the end of Miguel's statement, also points to the use of *hërɨ*, meaning 'to use a magic substance to render someone ill (by touching them)' (Ibid.:122). All these terms indicate the association of medicine with the use of *hërɨ* substances (many times rubbed on the body or drunk like some medicines) to reduce symptoms, in contrast with the shamanic cure '*nohi rëaɨ*,' as Albert suggests.

The above two cases confirm our observations regarding the indigenous perspective on shamanism and bio-medicine. In both cases the prominent role is the *shapori's* who considers his actions as the causes of cure. In Roberta's case Miguel speaks of the doctors' actions in terms of '*waisipɨ*' 'a bit,' '*yãnɨkɨ*,' 'to slowly recover'[143] and '*pëtao*,' 'only,' 'just,' or 'in vain.' The *hekura's* action, in contrast, is referred to as '*yai temɨprariyo*' 'really become/transform healthy/alive.' The translators' choice of words, 'but like that it won't *cure*,' (doctors' action), whilst after the darts are removed, 'only then you can hook up the IV, then he will *recover* better' illuminates the supplementary role of the bio-medical intervention. The same use of '*peta-*' and '*yai temɨprariyo*' occurs in Miguel's description of Cristina's case.

But from the doctors' perspective it is them that, in Cristina's case, are prominent. They want to keep the baby in the clinic; Lucia tells the women they can take the child only once they have given the medicine; she only lets the *shapori* access the baby when she considers recovery has begun. These attempts at controlling therapy amount to her perceived prominence. It is the antidote, chest massage and air pump that saves the child. The expulsion of the white liquid is the sign of efficacy, the elimination of the cause. Here the *shapori's* role is subordinate to hers.

But the distribution of roles is never so tidy. On the one hand, relatives often debate as to which is the appropriate course of action. In Cristina's baby's case – as I enquired later –child and mother had gone to the lake, there he got feverish and began to vomit. Back in the house people enquired about the child's state and Cristina recalled the baby ate manioc (apparently mistaking bitter for sweet manioc) suggesting this was to blame. Some rushed to the doctors' house initially to get sugar. The child's aunt immediately thought of the *shapori*, whilst the father suggested they quickly take the child to the clinic. The grandmother then takes the child back to the house again for the shamanic session. In the end, sugar, *shapori*, antidote and doctor, all intervened. On the other hand, the cause of an illness may remain unclear until late in the therapeutic path so it is always better to have both *shapori* and doctor covering all possibilities (Semba, 1985).

[143] Lizot (Unp.:482) cites a series of connotations for the root *yãnɨkɨ-*; one of them is 'to recover from an illness.' Most others refer to being tranquil or doing things without haste. A Yanomamɨ translator I

But which role do doctors/bio-medicine play if *shaporis* are prominent? Alès' (2000) notion of 'care' is useful to explore this issue. Let us recall that it is ethically proper to ameliorate relatives' suffering, be it illness, hunger, sadness or hardship.

Some practical examples in medical contexts. When dehydrated babies need an IV set up, it can be extremely difficult to catch the vein because they are 'collapsed.' Doctors may try several times unsuccessfully whilst children who cry, scream, kick about in pain. Mothers often reproach doctors for inflicting such pain and occasionally leave with their baby or forbid the doctor from further attempts. The perceived unnecessary pain is, I think, underlying this reaction. It is partly what makes Cristina forbid JC the nasogastric procedure. Several Yanomamɨ also complain how doctors have no *kiri*, 'fear/shame,' when cleaning wounds, their hefty scrubs are too coarse, 'as if it didn't hurt.' Consider this man's speech in the Mavaca Yanomamɨ conference describing a trip to the clinic to advise the doctor of a patient back home (1 hour away). The doctor asked him why he had not brought the patient with him (recall the debates for location of treatment from Chapter VI):

> '…'y porque tu no trajiste paciente' conchale! si uno esta grave como yo voy a cargar ah? Weti t^hë ha? a rë gravei[144]/ weti t^hë ha ya no preapraramapë?'
>
> '…[doctor's reported speech] 'and why did you not bring the patient?' 'Damn! it, if one is gravely-ill how I am supposed to carry him ah? [now in Yanomamɨ] Why? the gravely-ill one / How am I supposed to make him suffer?'

He continues:

> '…pei mamo pë nini ipa shoayë a rë kui a no rë preaprarou he paroho shoai t^hë kua…'bueno yo voy a llegar el tal dia' y conchale paciente ya wãhã no wëyëɨ tëhë inaha a kupë? No! el tiene que preocuparse…'

---

worked with on other recordings translated this word as 'to recover slowly, bit by bit.' It would seem that the 'recovery' meaning assimilates the other 'tranquil' connotations.

[144] This man's speech mixes Yanomamɨ and Spanish phrases and sometimes words. In this case the root '*grave*' is Spanish; the added '*–i*,' is a mark of continuous present (Lizot, Unp.:129).

> '…my father-in-law is still suffering a lot because of pain in his eyes…[doctor] 'well, I will go there on such and such a day' damn! When I explain about a patient, is this the way a doctor is going to respond? No! he has to be concerned/preoccupied…'

The need to be, and show, 'concern' (Sp. *preocuparse*) is a common expectation of 'good doctor behaviour' reflecting the morality of tending for an other's suffering.

From the Yanomamɨ perspective, then, doctors/medicine, in their role of reducing symptoms, are requested in many cases as effective reducers of suffering. Supplementary to the *shapori* nonetheless there is a moral obligation to assist.

From the doctor's perspective, 'care' is also a valued component in healing. In this sense many consider the *shapori* important even when they don't generally believe in the efficacy of the *shapori* to cure (except when they see no biological problem). For them, the relevance of *shaporis* is a mixture of a) psychological aid where the 'power of the mind' can induce biological changes and b) creating favourable conditions for recovery, minimising disruption of the 'cultural context.'

> '…I respect the *shaporis* a lot and I let them perform many times but deep down one respects them without believing the *shapori* is really going to cure you or at least not believing the *shapori* is extracting a spell and curing, maybe with the *shapori* / like a placebo effect, I don't know, the patient is predisposed s/he is going to get cured and s/he does. I believe a lot in that…'

Or

> '…I was always very flexible with that [shamanism], I thought it was primordial, its is basic in the illness-healing process for them to be treated by their *shapori*…I would go at night [to patients' houses] to administer treatments, specially if they were children and they wanted shamanic curing…and with the *shaporis* / I would call them and say 'help me out! I don't know, this [patient] looks too gravely-ill, come and do shamanism on him/her'…[she comments on a specific case of a lonely mother with a sick

baby, she called for a *shapori*] I did it so the mother would feel more protected, so she wouldn't feel so alone…'

'I let them perform,' 'I was very flexible' are concessions granted on cultural grounds for the benefit of the patient reflecting the ascribed authority of doctors to decide the course of treatment. When the doctor considers the patient is at risk, this general concession is overridden by the maxim of patient welfare. Asked about how she felt when critical patients were taken to the *shapori* this friend commented:

> 'Powerlessness [Sp. *impotencia*] and anger [Sp. *rabia*]. It cannot be that they can't understand that they have to stay [in the clinic], that the medicine will cure them not the *shapori*…its difficult because at that moment you are angry and you shout…can't they understand that if you take him/her [patient] s/he is going to die? But then I think five minutes 'If I were Yanomamɨ and all the beliefs and all that being Yanomamɨ implies, how are they going to believe in *napës*, in medicine if they believe more in the *shapori*?' and then you can understand…'

On the simultaneity of *shapori* and doctor interventions this other doctor comments:

> 'I liked that simultaneity…I felt that when that happened it was because it was a situation of lot of trust both in myself as in the shaman…I felt good and happy in those circumstances, I thought it was the most successful thing / of course in the case when they decide to take the patient away…well, there it is hard to accept that, of course you are not going to be happy because if they take [the patient] its worse but in the end its their decision, the most you could do was to go with them too.'

Another doctor recalls the case of a baby with a respiratory infection, the son of a *shapori*; both he and *shapori* were simultaneously working on the baby until his death. Even when the simultaneity was unproblematic (*shapori* and doctor took turns at accessing the body of the child, as normally happened in Ocamo), his recollection reveals his was a matter of 'resigning to culture' with little perceived benefit. He had had a terrible time in Ocamo and this affects his appreciation:

> '…gee I am wasting time with the baby, I mean, as a doctor, as a scientist [I think] 'damn it! You goddamn Indian [*shapori*] what are you doing with that [Recalling another case]. We would go and that circle of crazy people [several *shaporis* curing], you are catching a vein and all those guys on top of you, sometimes they waste the time you have and then there is the fear that you can't work well because of all the people on top of you, I mean powerlessness (*impotencia*), basically that's the word, powerlessness, impression, anger and even laughter…in their culture they believe in that as I believe in my medicine and possibly they don't believe in mine and I of course don't believe in theirs but they are wasting time leaving a child to die…'

Generally simultaneous or alternate doctor-*shapori* interventions are unproblematic for doctors and Yanomamɨ alike, however, 'dropping the doctor' in favour of the *shapori* in critical circumstances inverts doctors' perceived order of importance: first the doctor, then the *shapori*. In Chapter VI we discussed Yanomamɨ controlling doctors' performances, here we see how Lucia attempts to 'run the show' and hear doctors' 'cultural concessions' or 'resignations.' In the end, doctors and Yanomamɨ are controlling each others' performances and choices. The environment of 'mutual allowance' is favourable so long as both parties coincide in the beneficial presence of each healer and the place and type of treatment. Depending on the doctor and the relatives, each side's threshold of tolerance varies. Critical cases tend to foreground the inverse attribution of curing-caring roles between doctors and Yanomamɨ that in less serious cases is inconsequential.

It must be stressed that doctor-*shapori* simultaneous or alternate interaction is very frequent. I never saw doctors telling Yanomamɨ not to go to *shaporis* or refusing treatment to those who went to one, as is reported by Briggs (2003:186) for doctors working among the Warao or Kroeger & Barbira-Freedmann (1992:320) in the Peruvian and Ecuadorian Amazon. The difference may lay in the racialised environment surrounding the situations described by these authors where the Indians are in daily or frequent interaction with a dominant *criollo* or *mestizo* society with deeply entrenched prejudice. It is also the case that the particular people rural doctors meet in Amazonas are influencing their attitudes to shamanism. Several long-time

doctors in Amazonas are sensitive to indigenous healing both as therapy and as part of indigenous people's right to difference.

Shaporis, also welcome doctors' presence. In Ocamo, when Dr. Lucia was 'kicked out' by the nurse, Miguel, the *shapori*, in a subsequent meeting expressed strong concern, he would now have too much work, in anger he threatened not to treat children from Ocamo anymore. In a later meeting in Ocamo with the HD and the Regional Health Director in Ocamo he intervened. Part of his (simultaneously translated) comment follows:

> 'He [Miguel] said that when the doctor was here…the doctor cured and, well, lets see who has more power to cure the patient…he is thinking a lot about the doctors…this is why we are asking for a doctor to work here again…we can work together, I will help him with shamanism and they can help me cure…I am very angry with these people around here that spoke ill of the doctors.'[145]

In the Mavaca Yanomamɨ congress, several *shaporis* from upriver called for doctors to visit their communities because they could not cope with the resilient *shawara*.

This brings us to the next important issue. Beyond reducing symptoms or aiding recovery there are circumstances where doctors' efficacy seems to match that of *shaporis*. This is the case of *shawara*. Recall Miguel's words on Cristina's child:

> '…this is not *nɨ wari* [*shawara*] can't you see.'
>
> '…this is not malaria, nor *shawara*, nor diarrhoea, this is not the case.'[146] (Translator)

This designates *shawara* as the field of doctors' curing efficacy. Consider the following statement by a Yanomamɨ nurse addressing the Mavaca Yanomamɨ conference. Recommending his fellow Yanomamɨ on the problem of '*Salud*,' 'health/healthcare':

[145] The *shapori* is from a greater Ocamo community, so he was in this way blaming the Ocamo people who are those who most exchange with doctors given their vicinity with the clinic and doctors' house.

> 'Mɨpra! shawara pëma a he tatomapopë[147] pehi weti pëma tʰë / weti naha pëmakɨ puhi kupë? Inaha! shawara a he tatomamotima pëmakɨ ihete nomaɨ kuyëhëhëapraropë'[148]
>
> 'Look! In order to make the *shawara* return on its path what are we / how are we going to think?' Like this! [this is what we need to think] Thing-for-making-*shawara*-turn-on-its-path so those of us who are close to dying can begin to recover'

The Spanish term '*salud*,' always refers to *shawara*, that is, contagious-infectious diseases which are ontologically *criollo*. Problems of *salud* are always regarding the health system: doctors, nurses, medicines.

Recapitulating, for Yanomamɨ, doctors' curing competency lies within the etiological category of *shawara*, for illness caused by other agents (human or not) their role is the reduction of symptoms and hence suffering (care). *Shapori* competence covers all these cases. Doctors, on their part, acknowledge the primacy of *shaporis* when patients have no apparent biological problem (e.g. Roberta), otherwise *shaporis* are supplementary: doctors cure, *shaporis* help. In many cases, each therapist credits him/her self with the primary curing role.

Let us pause on some aspects of this discussion thus far. Our cases exemplify the existence of two simultaneous realities in the illness-healing conceptual context: one Yanomamɨ (shamanic) and another of doctors (scientific). The separation is more than a doctor 'seeing' an intoxication, and Yanomamɨ 'seeing' a stolen soul-aspect. Notice the lack of communication between doctor and *shapori*. Lucia never knew about the shamanic interpretation held by the Yanomamɨ nor about her subordinate role. Doctors, then, are generally unaware of Yanomamɨ diagnosis and evaluations.

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[146] The translator enumerates *shawara* alongside malaria and diarrhoea but in all other usage it is clear that malaria and diarrhoea are types of *shawara*.

[147] This fascinating construction is as follows: the root *he tato-:* to retrace ones steps, to turn back on a trail. Followed by the causative -ma-, the particle –po-: to sustain or keep in a position, and finally pë: the future particle expressing volition (Lizot, 1996). So literally *salud* refers to 'make the *shawara* turn back on its path.'

[148] *Kuyëhë-*: 'to recover, to feel better.' (Lizot, Unp.:193). The next suffix –*hë*- is a pluraliser. Next is –*praro*-: a suffix meaning 'to begin to' and finally the future -*pë* (Lizot, 1996).

But mediating Yanomamɨ distribute different information to doctor and *shapori*. Roberta ate this, then fainted (version for doctors); Roberta has gone to the Padamo, where Yekuana live and demons are known to inhabit the rapids (version for the *shapori*). Cristina's child ate bitter manioc (version for doctors); Cristina's child ate bitter manioc, went to the lagoon and there began to get feverish (version for the *shapori*). The lagoon is outside the *shapono*, its part of the forest, typically assigned in Amerindian geography with the danger of evil spirits, contrary to the safety of the village.[149] Next, it is not only *shawara* that is etiologically *criollo* but everything surrounding it.[150] For instance, Ocamo Yanomamɨ when questioned about 'prevention' mentioned washing dishes, washing your hands, keeping houses clean, that is, *criollo*-consonant discourse. None considered food taboos surrounding illness or children's use of *hërɨ* necklaces to avoid specific diseases or make them 'grow fast,' as 'prevention.' All Spanish health terms '*salud*,' '*prevención*,' '*enfermedad*,' refer to *criollo* diseases, institutions and practices.[151] *Yai*, *pore*, enemy shamans, *hërɨ*, are divorced from the discourse of '*salud.*' All these distinctions evidence the co-existence of the 'Yanomamɨ conventional' and '*napë* transformational' conceptual contexts, complementing the gamut of associations of being '*napë*' and 'Yanomamɨ' we discussed in Chapter VI.

On their part, doctors generally considered Yanomamɨ did nothing to prevent disease, adding to ideas of irresponsibility mentioned in Chapter VI: Yanomamɨ don't take care of themselves.

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[149] Accordingly, it is usual for people to explain their illness as a sequence of places you have been: 'I went hunting in the forest came back and began to get fevers' or 'I went to visit such and such community, came back and began feeling a headache.' This is an instance of a more generalised Amerindian emphasis on historical-sociological (beyond biological) factors taken into account in diagnosis (cf. Gallois, 1991:184; Langdon, 1991:218; Alès, 1985:86).

[150] Gallois' (1991) distinctions in discussing the notion of 'Whites' disease,' so widespread in Amazonia, is here most adequate. *Shawara* is etiologically *criollo* as has been extensively discussed in Chapter III, nonetheless, it is a) very much explained in terms of indigenous ideas about illness (predation of 'vital aspects' and its physical manifestations) and b) therapeutically within the range of action of both *shapori* and doctor, the efficacy of treatment depending on the power of the healer and the strength of the *shawara*.

[151] Noticeably, Ocamo Yanomamɨ don't use an explicit term like 'White man's disease,' even when *shawara* is etiologically *criollo*. Instead the Spanish term '*enfermedad*,' without any further qualification conveys this meaning. One could say that the qualifier 'White' or '*criollo*' is here implicit in the use of Spanish.

Summing up, Yanomamɨ divide the illness-healing conceptual space in equally real *criollo*/Yanomamɨ causes, therapies and types of information (acceptable to doctors or not) and practices (e.g. prevention), whereas doctors' space is divided more along the lines of real (*criollo*) causes and therapies and 'beliefs' (Yanomamɨ). Ocamo Yanomamɨ generally know about doctors' conceptual space, whereas the latter are normally oblivious to Yanomamɨ's divisions. This reflects the historical experience Yanomamɨ have of doctors, who themselves, ever-changing, are 'stuck' with an incipient and coarse view of Yanomamɨ conceptualisations.

Practically this is important to note because doctors too often believe Yanomamɨ 'don't really believe in medicine' or 'they see us only as dispensers of medicine.' Congruent with *criollos*' difficulty with Ocamo Yanomamɨ's 'civilised' being – this is 'culture loss' – doctors often assume that belief in shamanism and bio-medicine are either/or choices. You cannot be Yanomamɨ *and napë*; or believe in bio-medicine *and* shamanism. Our analysis reveals something else is the case: both 'care' and curing are important for Yanomamɨ who credit bio-medicine with efficacy in both realms.

- o -

But we must account for the efficacy of doctors to cure *shawara* because it doesn't fit with our statements regarding bio-medicine's supplementarity to shamanism. This resounds with distinctions between 'White' and 'indigenous' disease Amerindians often make, crediting bio-medicine efficacy for treating the former (Kroeger & Barbira-Freedmann, 1992:141,150; Gallois, 1991:190 among the Waiãpi; Conklin, 1994:176 among the Wari'). But beyond the pragmatic adoption of a therapy that 'works,' little else is said about this. We can say more about this than pragmatism allows for.

Let us retake Buchillet's (1991b) distinction between the 'sphere of causes' (shamanism) and that of effects (indigenous 'domestic' and bio-medicine). Let us recall the division between the invisible/ontological and the visible/biological bodies (Chapter III). *Shaporis*' effectiveness requires access to what is both invisible and causal to undo a relation between an aggressor and the patient-victim. In this scheme,

doctors cannot access this invisible causal plane, limited to curbing the effects of the aggressor-patient relation.

Let me suggest that doctors' *shawara*-curing competence derives from their access to that causal plane in the same way as *shapori*s. What makes *shaporis* peculiar is their being 'of a kind' with the invisible world. *Hekura* helper spirits inhabit *shapori* bodies, *shaporis* become a number of *hekura*, their unity is a multiplicity. Crucially, *shaporis* take a non-human perspective when they see the invisible aspects of persons as bodies.

The claim that 'being of a kind' is the necessary condition to access the causal plane and be effective in curing needs sustaining. For this I rely on Viveiros de Castro's (ms:6-9) arguments regarding shamanic knowledge. Scientific epistemology[152] is objectivist. True knowledge is reached when the knower (subject) can discern what is his/her contribution in interpretation and what belongs to the known thing (object). Shamanic epistemology, in contrast, requires the knower to adopt the perspective of that to be known, becoming 'of a kind' with it. *Shapori*s don't objectify that to be known, on the contrary they personify it, meaning the relation between the knower and the known is a subject-subject relation. As Vivieros de Castro has it: 'The good interpretation is here the one which is able to see every *event* as being in truth an *action*, an expression of intentional states or predicates of some subject' (ms. 7). It is because *shaporis* can enter into social relations – dialogue, battle, deception, collaboration – with non-human agents (*hekura*, *yai*, *pore*) that they can regulate relations between them and 'normal' Yanomamɨ.

This sheds light on doctor's *shawara*-curing competence. *Shawara* is *criollo* in nature and character, so are doctors, which makes them 'of a kind' with *shawara*. Now, if this echoes the relation between *shapori* and illness-causing agents it doesn't mean it is a reason Yanomamɨ give for their effectiveness. Let us now discuss how Ocamo people speak of doctors as *shaporis* to see how their practical associations are consistent with this analysis.

[152] Viveiros de Castro uses 'objectivist folk epistemology' but I think my substitution for 'scientific epistemology' is not unwarranted for it is surely science in 'the West' that is the analogue of shamanism in Amazonia.

VII. 3. *Doctors as shaporis and vice-versa*

Ocamo Yanomamɨ always told me doctors and *shaporis* were 'the same' in spite of the etiologically-dependent roles Yanomamɨ attribute to doctors. Let us discuss the things doctors do and the ways Yanomamɨ speak of them to propose an explanation to this apparent paradox.

Doctors normally perform a limited set of procedures in the field. This list includes ways of administering medicine – pills, syrups, creams, injections, oral rehydration, intravenous solutions – and procedures to identify problems, like the use of stethoscopes, thermometers and microscopes. A salient procedure in the clinic is nebulisation. Patients are interrogated with simple questions in Spanish or Yanomamɨ: 'How do you feel?' 'fever?', 'diarrhoea?', 'pain?' Medicine is provided with simple instructions: 'this pill is for the fever, this other red one for parasites,' 'take this in the morning, afternoon and night.' Finally, it is common for doctors to look up in pharmaceutical and other manuals correct dosages and schedules for treatment. All these are conventional procedures in Ocamo people's eyes.

VII. 3. 1. Doctors and the 'inside'

In what way, then, are doctors and *shaporis* the same? First, they are similar in that they access to the person's 'inside,' '*pei hushomi*.' Injections, IVs, stethoscopes, microscopes (having taken blood samples for malaria tests), X-rays (in the hospital) are doctors' entry to where *shawara* is devouring a person: the blood, flesh. When doctors use a stethoscope to discern a type of respiratory affection they hear what *shaporis* see.

> JA: Do they say [*shaporis*] how they see the illness [Sp. *enfermedad*]?
>
> 'Yes…the *shaporis* say if there is *shawara* they break it and kill it first…little by little if there is another illness, well they kill it too. Doctors don't, doctors don't see it, they only hear it with the stethoscope, they only hear it, but *shaporis* do, *shaporis* do see…'

This statement is from the unofficial Ocamo nurse, he has not done the Simplified Medicine course. In the same conversation I asked whether *napë* and Yanomamɨ thought differently about illnesses (I thought he would be 'between two worlds'). I wasn't clear enough but he responded:

> 'Well doctors are *igualito* 'exactly the same,' they do exactly the same, as the *hekura* see it [*shawara*], the doctors also see it.'

The point is that the *shapori's* privileged capacity, seeing, is functionally transferred to doctors, not because they see as *shaporis*, but because they both identify aggressive agents and act correspondingly. The use of microscopes to identify malaria parasites (there are three possible strains which must be identified to administer the appropriate therapy) is a matter of discovering an aggressor.

> JA: When they take malaria slides what do they see there?
>
> '…ëyëha ɨyeɨye pë tërei tëhë tʰë pë niya mɨɨ…ɨhɨ tëhë pë niya kuu 'ma! Vivax wa wayu pou'...ɨhɨ tëhë doctor pënɨ remedio kë kɨ niya hipëaɨhe…'
>
> '…when they take blood from here [ear] they are going to look…then they are going to say 'no! you have vivax'…then doctors are going to give medicine (pills)…'

In the expression '*vivax wa wayu pou*,' vivax is a type of parasite, '*wa wayu pou*' meaning something like 'you are under the grip of an aggression/powerful substance.' Parasites, tiny creatures visible in the blood are easily assimilated to *shawara*, tiny blood-eating demons. An emphasis on injections and IVs, in describing doctor's actions, suggests these internal operations are considered particularly effective. The final typical analogy between doctors and *shapori*s is the use of books:

> JA: Those *shaporis* and doctors: are the same '*mashi*' or different '*shomi*'?[153]

[153] *Mashi* in this context means 'to be of the same sort, of the same species.' Its opposite is *shomi*: 'to be other, to be different, to belong to another community.' (Lizot, Unp.:409).

‘ma, mihi mashi kë pë…’

‘no, they are the same…’

JA: But do doctors call the *hekura* spirits like the *shapori* does?

‘Ma…Medico a rë kuinɨ a puhi nakoimi. A rë medico ohotamowei pero a nakou con libro kë kɨ hamɨ t^{h}ë taaɨ: ‘aa! Hei t^{h}ënɨ ɨhɨ t^{h}ë wayu tëhë hei t^{h}ënɨ t^{h}ë niya sheprаɨ con esa a puhi rii kuu. Como ese mismo shapori / shapori asi esta pensando esa.’

‘Ma…the doctor doesn’t call [with his thought]. Doctors work but s/he calls with the book s/he knows/recognises it: ‘aah! This one is the cause, when this is the pathogenic substance/power/effect [referring to *shawara*] with this one [a particular medicine looked up in the book] s/he is going to kill, with this one’ the doctor thinks. Exactly like the *shapori*, like that s/he is thinking [the doctor].

Or

‘shapori pënɨ aɨ wayuwayu a nɨ ɨhɨpɨpouhe, aɨ pënɨ aɨ t^{h}ë wayu t^{h}ë nɨ ɨhɨpɨpouhe kurenaha shapori.’

‘*shaporis* recognise/know some types of *shawara*, some others [doctors] recognise the pathogenic substance/power like the *shapori* does.’

JA: Do doctors call the *hekura* spirits like the *shapori* does?

‘ma…pë ohotamou libro kë kɨ hamɨ t^{h}ë niya taeaɨ parɨo kurenaha hekura pë / ka e t^{h}ë hamɨ pë waro tëhë kurenaha, libro kë kɨ hamɨ t^{h}ë niya buscandomaɨhe, t^{h}ë tarareihe tëhë ‘fermedad hei wa wai t^{h}apou’ ania kutou inaha igual shapori pë kuu, ‘kahenɨ hei wa t^{h}ë wayu thapou’ inaha shapori pë kai kuu.’

‘no…they work with the book, they are going to search first, like the *hekura*, like when the *hekura* arrive, in the same way in the book they will search, when they find it s/he [doctor] will say: ‘this is the disease [‘*enfermedad*’ in Spanish

always referring to *shawara*] you have' like this the *shapori* say: 'this is the pathogenic substance you have' this is how *shaporis* also say.'

VII. 3. 2. Coming to know; knowledge ranking

A *shapori's* knowledge is acquired through the years. During initiation a number of helper spirits (his sons) are put in his chest by elder *shaporis*. In time he learns about the different entities of the cosmos, their chants, paths, smells, etc. This happens in constant conversation and imitation of elder *shaporis*. Ocamo Yanomamɨ are aware of doctors' lengthy education, they learn to recognise diseases and provide correct medicines in hospitals in *criollo* cities, a process analogous to *shaporis*' life-long learning.[154] Ocamo Yanomamɨ also have nurses, medical students and rural doctors as representatives of different degrees of medical knowledge. Medical students are compared to apprentice *shapori*s, sometimes it is Yanomamɨ nurses spoken about in these terms.

An important distinction is made between rural, 'graduated' doctors and students. Students do not know illnesses and medicines as 'graduated' doctors do. So whilst doctors are *taɨrewë*, 'people who know,' students are *taɨmirewë*, 'people who don't know,' opening another area of analogy with *shaporis* of different power and status. Ocamo has one *shapori* considered the 'real' or 'great' and for some the only *shapori*. His greatness resided in the *hekura* he commanded, he knew all the levels of the cosmos, and many illnesses.[155] Of the other *shapori*s in greater Ocamo, one was recognised as good, but couldn't travel to the first level of the cosmos, where sun, moon and other life-threatening *yai* demons live. He had accompanied the great *shapori* Miguel, but was too physically depleted and afraid of the enterprise. Another was Miguel's apprentice, he accompanied him in curing sessions, and was referred to as a 'medical student' or 'nurse.' Finally, some are considered 'false' *shaporis*, people who do as *shaporis* but command no power. This is a scale that people build according to the efficacy they perceive in *shaporis*' performances and may vary from

[154] Consider Kroeger & Barbira-Freedmann (1992:204) on the shamans in the 'high Amazon' of Peru and Ecuador: 'they consider themselves the same as doctors, although they recognise that they work within different traditions. Like the doctors, they have studied several years to obtain their qualification, and are proud of their knowledge and wisdom.'

[155] Given that I was interested in medical contexts this is what was emphasised to me. Lizot (1985:115) points out that *shapori's* renown is based more on his capacity to strike enemies with his *hekuras*.

person to person. This 'ranking' is used as an interpretative basis for doctors and medical students.

> JA: Medical student?[156]
>
> 'well there is medical student '*pasante*' and there is Yanomamɨ '*pasante*' *shapori*, those that are *horemou* [*horemou*: to lie, to trick or deceive. It has connotations of 'look alike,' to do in vain.]…just a lie, those [*pasante shaporis*] are not real doctors. With *pasantes* [*shaporis*] you are just doing like shamanism, its not proper shamanism, the illnesses won't pass.
>
> JA: And the medical students are the same?
>
> 'the same, its better with the doctor, these are doctors these are like *shaporis*.'

So whilst students may be compared to 'false' or *shaporis*, a doctor like the Head of District, that Ocamo people know to have studied more than others (post-graduate), is the equivalent of the 'great *shapori*.' He was '*doctor yai*,' or '*tairewë yai*,' the 'real doctor, 'the one that really knows.' Consider the ideas ventilated in an Ocamo *yopo* session sometime after they found themselves without a doctor. A friend recounts part of the discussion:

> 'mira aɨ que vamos a reunir para llamar doctor Gonzalo no doctora no pasante, doctor yai pemakɨ nakapë' inaha pë kuma. Mihi Gonzalo a rë kui, tairewë yai pata a ma rë kui, heyeha doctor Gonzalonɨ yami a përɨopë'
>
> 'look lets get together to call doctor Gonzalo, not doctor, not *pasante*, lets call the real doctor' that's what they said. That Gonzalo, the great real one that knows, Dr. Gonzalo should live here on his own.'

It becomes apparent in the manner people speak that '*shapori*' and 'doctor' have become synonyms, referring not only to a specific person, but to a state of knowledge.

[156] This was a session where I would name things or classes of people and the informant was asked to say if this was something typically Yanomamɨ or *napë* or neither or both. It became interesting because as we progressed this particular friend began trying to give definitions, recalling myths to explain things etc.

As adjectives, '*shapori*' and 'doctor' are qualifiers of real, true knowledge and abilities.

> JA: those doctors, are they the same or different from *shaporis*?
>
> '…shapori kurenaha doctor pë kuaaɨ...aɨ shapori pë pehetimi, aɨ shapori pë peheti, aɨ doctor pë peheti, doctor pë yai rë kui pë peheti. Pasante pë rë kurenaha, aɨ shapori pasante pë kuwe ɨhɨ ke! Doctor pë rë kui naha, aɨ shapori, shapori pata pë rë kui, doctor kë pë mashi.'
>
> '…doctors work like *shaporis*…some *shaporis* are false, some are real/true, some doctors are real/true, real doctors are true. Like there are medical students, there are also some *shapori* students, you see! Like doctors some *shaporis*, the powerful/important *shaporis* and doctors are the same.'

The alternation from '*shapori*' to 'doctor' resembles the way '*shapori*' may refer to a shaman or to his helper spirits, who are one and the same in curing sessions. So '*shapori*,' 'helper spirit' and 'doctor,' in this inter-cultural medical context, become analogic alternatives for each other.

The analogical construction of doctors as *shaporis* is elicited in different instances of comparison. Let us resume the points of analogy.

A peculiar capacity: *Shaporis*' diacritical capacity is to see the 'inside' of the person. This is analogous to doctors' ability to see inside a person's body with their tools (stethoscope, microscope, etc).

A mode of action: finding/identifying and then eliminating aggressors. In Ocamo people's descriptions of *shaporis'* and doctors' activities were identical in form: typically the healer asks, searches around and finally 'ah!, this is it!' Identification is followed by remedial action: fight a demon, cut the *shawara* to pieces and through it to the *amahiri* (*shaporis*) or provide medicine to kill the *shawara* (doctors).

The source of abilities: Ocamo people may say doctors are like *shaporis*…other times it is *shaporis* that are like doctors. In this latter form, *shaporis* are said to have '*aparatos*,' 'technological devices,' just like doctors. In the case of *shaporis* each *hekura* with its tools endows them with a specific capacity appropriate for the circumstance. *Hekura* spirits are then '*shapori*'*s aparatos.*' *Hekuras* and their tools are the *shaporis*' books, stethoscopes, microscopes, nebulisers, X-rays and medicines that endow a doctor with the ability to identify and fight the cannibal *shawara* demons.[157]

Acquisition of knowledge and status: Shamanic learning through continuous apprenticeship with elder *shaporis* is comparable to students who learn from more knowledgeable 'graduated' doctors either in hospitals or in the Upper Orinoco. The status credited to different *shaporis* – 'false,' 'apprentice,' 'real' – is extended to medical students (sometimes nurses) 'false' or 'apprentices' and graduated doctors with different degrees of education. '*Shapori*' and 'doctor' become synonymous qualifiers of true knowledge of diseases.

VII. 4. *Extending multinatural and multicultural conventions*

One could dismiss these analogies as Yanomamɨ efforts to render complex notions amenable to my understanding, as is common in relations with *criollos*. But most of these conversations were held well into fieldwork when people knew I wasn't particularly after *criollo*-amenable explanations. Instead, let us retake Wagner's (1981) ideas to thread this discussion with the last two chapters. Let us recall the innate character of conventions equivalent to the category of 'culture.' Viveiros de Castro's (1998) 'perspectivism' suggests Amerindians' culture is the shared condition of personhood. In its innateness it is equivalent to Westerner's nature. As the theory goes, the many animals and beings credited with souls in Amerindian cosmology see themselves as humans (Indians) with kinship, houses and ceremonies, as expected if culture is shared. Animals with soul are typically ex-humans who in mythical times

[157] These analogies have been reported elsewhere. Consider the statement of a Baniwa from São Gabriel da Cachoeira with reference to the *rezador* healer: 'Those healers that know really know how to pray [incantations] are just like x-rays, they say exactly what the illness is…' Souza Santos & Mendoça Lima (240). Elsewhere Conklin comments 'There are even shamans that consider their

were transformed into their current state, souls being their contemporary non-evident human status. Members of different species don't see each other as persons because of their different bodies (as habitus) which endows them with a distinct perspective on the world. By virtue of a different body/habitus, a jaguar, for example, may see an Indian as prey (e.g. peccary), as Indians see peccaries – themselves seeing each other as Indians – as prey. A mono-culture, then, proposes a multinature, an inversion of the Western multicultural thesis which stipulates the existence of one nature (only accessible through scientific knowledge) and many cultures, that is, many ways of seeing the one world there is.

My argument is that Yanomamɨ interpret doctors by extending their multinatural, mono-cultural convention. *Criollos* are ex-Yanomamɨ for they too are products of mythical transformations (see ff. 86, pp. 117). As such, *criollos* partake of Yanomamɨ culture, meaning they must have *shaporis* in the same way many Yanomamɨ assume *criollos* have food gardens in their settlements. Doctors are simply the form *shaporis* take if you are *criollo*. Of course, *criollos* don't know about the *hekura*, their knowledge is *criollo* knowledge epitomised in a) reading and writing and b) the creativity to make technological objects. But the difference between Indians and soul-bearing animals is equivalent to that between doctors and *shaporis*, a jaguar's Indian is a peccary as a doctors' *hekura* are books/tools/medicine. By extension of the unity of culture, doctors are analogous to *shaporis* in their curing – as opposed to political role.

Every extension of convention is innovative, hence doctors and *shaporis* transfer onto each other part of their characteristics. In this way people can speak of *shapori's hekuras* and their tools as *criollo* '*aparatos*' and manuals as sources of knowledge the doctor 'taps into' just as *shaporis* receiving their faculties from the *hekura*. Note the place of books and reading, for as we discussed in Chapter IV, this emphasis is but an instance of the more general set of notions placing formal education at the centre of the historical 'becoming *napë*.' This is a reflection of the 'knowledge component' of 'becoming *napë*.' If doctors are *napë shaporis*, this doesn't mean Yanomamɨ are excluded from bio-medical practice and knowledge, Yanomamɨ nurses are testament

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powers superior to those of Western doctors, because they need instruments to 'see' the illness.' (1994:168)

to that. But to be a nurse, you must have studied in school and done a special course, you must 'become *napë*.' Only 'civilised' dual Yanomamɨ/*napë* are nurses.

In Chapter VI we discussed how doctors could manage a better rapport with patients by 'performing Yanomamɨ.' This was a matter of collapsing two forms of alterity, *napë* and ghost, to a Yanomamɨ/human/moral meeting point. Here we stress the importance of doctors retaining a *criollo* identity, for their effectiveness relies on *criollo* knowledge, command of which they must display to deal with *shawara*. Doctors must then sustain a duality of sorts, being morally Yanomamɨ, obviating the immorality of being *napë* (bad communication, stingy) yet stressing *napë* knowledge (read/writing use of *aparatos*) to kill their 'own kind.' Doctors cannot 'play' *shapori* in knowledge terms. Doctors are already *napë shaporis* when they perform as doctors *and this is precisely and wholly their value*.

This situation closely resembles how in the context of education, Indians often disregard inter-cultural schooling models, considering the school is not for learning about their culture – this was one line of thought among Orinoco Yanomamɨ. Often the aspiration is for the 'real thing,' national-style education (Hugh-Jones, 1997:104); other times it is explicitly cast as a means to 'become civilised' (Rival, 2002:161). Equally experiences that promote the institutional mixing of shamanic and bio-medical practices tend to fail or be flatly rejected (Lobo-Guerrero, 1991:276; Gallois, 1991:203; Jackson, 1995b). These mixtures run counter to the indigenous appreciation of White institutions and practices as means to 'become White' and tap their resources. Much of their value, as differentiating options, as means to progress, as political capital, is lost if White institutions 'become Indian.'[158]

Now we *criollos*, when it comes to doctors and *shaporis*, extend our multicultural convention. Beyond the simple equivalence of both being healers, we tend to see *shaporis* as doing something different, working on the psychological or symbolic planes, depending on one's inclinations. Doctors work on bodies and their evocations of the 'power of the mind' find ultimate explanation in psycho-neuro-immunology –

[158] It must be noted that neither Lobo-Guerrero nor Jackson cast the failure of the experiences they describe in the terms I am presenting here. They refer rather to issues like the secrecy of shamanic knowledge and the problems this brings when trying to institutionally teach it in school-like manner.

occasionally discussed by doctors in Ocamo. The extended convention here is that of a unique biology, part of a single nature. This premise assures them the efficacy of their medicines, and makes them respect (culturally) *shaporis* without crediting them their own degree of curing efficacy. Here the form of difference is a cultural variation on a natural substrate.

Yanomamɨ on their part express much of their historical change as body/habitus transformations (Chapter IV). This would support the idea that the form of difference is a natural variation on a cultural substrate.[159] As Vivieros de Castro (2002 b.:140) stresses this doesn't mean Amerindians subscribe to a different biology or physics, but that their concept of body is different, as we have shown in Chapter IV.

VII. 5. *Napërami and the extension of the invisible world*

Alongside the transference of qualities between doctors and *shaporis*, the latter have symbolically incorporated *criollos*, expanding the invisible world they draw from. Nowadays *criollo* 'vital images' (*no uhutɨpɨ*) and *criollo hekuras* (also *no uhutɨpɨ*) proliferate in *shaporis*' repertoires. *Criollo* items can be employed in both curing and attacking. A shotgun can be used to kill *shawara* or injure the vital aspects of enemies. *Criollo* transport (boats, planes) can be used to escape once the attack has been perpetrated. A *shapori* travelling to the burning first level of the cosmos may protect himself with ice. All these *criollo* items seem to be treated as the tools *hekuras* normally have.

Together with *criollo* items also come *criollo hekuras*. I learned of the *napërami* (*hekuras* of *criollos*)[160] through friends that had seen them in shamanic sessions. *Napërami* attributes include their Spanish speech and use of *criollo* objects. In some

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[159] There are some comments and practices that seem to indicate medicalisation as part of 'becoming *napë*.' For example, a friend married to an upriver woman said if she got diarrhoea he wouldn't suggest her to go to the clinic because 'they are accustomed' and it will go on its own. Consistent with people 'become accustomed' to *criollo* food, so do they get used to medicines, both being body transformations associated with 'becoming *napë*.' I have taken this lead from reading Vivieros de Castro's (2002b:137-8) discussion of a case of a Piro woman presented to him by Peter Gow.

[160] Albert (2000:255 ff. 44) speaks of the *napënapëripë* 'vital images' of Whites among the Brazilian Yanomam. Other examples of shamans' incorporation of White objects in their repertoire include outboard motors and gasoline in the Yaminahua shamanic songs (see Townsley, 1987:15-16). Buchillet (1991c:166-67) comments on the Desana incorporation of Whites' technology both as objects of disease and in shamanic curing incantations.

accounts they have mirrors enabling the sight of *shawara* at a distance or its enlargement enabling the identification of a type of *shawara*. In other accounts the *napërami* are doctors who give medicine to the *shawara* killing it or preventing it from reaching the community. The following is an account of a session in the Upper Ocamo:

> 'ok the little *napë shapori* has to talk to him, with the *shawara*: 'look why do you have to be here, you have to be over there where / where they make [Sp. *fabrican*] so now I am going to inject you and you will leave' this is how the *shapori* says /
>
> JA: I am going to inject you?!
>
> 'yes! I have heard it in Pashopeka…they [Pashopeka t^h^eri] heard that around here [Ocamo] there was *shawara* a great *shawara*…[in Pashopeka a *yopo* session begins and howler monkey-spirit comes followed by jaguar-spirit]…then the rest [public] those that had heard that there was *shawara* around here told him [*shapori*] 'hey *shapori* they say there is a great *shawara* over there do us a favour, over there give them medicine so that they don't come over here'…then the *shapori* said 'ok so lets prepare' and then he began to speak Spanish 'ña ña ña ña ña'…so then he [*shapori*] sent him [*napë hekura*] over here: 'ok go with the aeroplane, get in and go there' and then the plane [Sp.: *avioneta*] took off fiuu! Heeeee then the *shapori* says 'ok, all the doctors have gone' and then they arrived where the *shawara* was and then when he [*shapori*] was too drugged he would take a small spoon then he would prepare / he wasn't preparing medicine but rather he was doing [gestures of a person giving spoons full to another person's mouth] 'this is for malaria' he would say 'this is for cough,' 'this is for injecting,' how many doctor *shaporis* came! …[again *shapori* speaking] 'well now no *shawara* will be here, now with the wings of the night owl…he is going to put himself like this [wings spread open but rising from the ground upwards] so the *shawara* hits against it so it cannot pass over it, and now we will be fine when the *shawara* comes, it will be short, only 3 or 4 days and then it will pass'…[later in the conversation I ask how the *shapori* sees the *shawara*]…they have like a microscope…for example it is as if

> it were a microscope but large [arms making a wide circle] then when they put the *shawara* there they can see [the type of *shawara*]…'[161]

Pashopeka has been visited by the onchocerciasis programme personnel for several years. For their entomological work they use microscopes *in situ* to dissect mosquitoes. These entomologists said they encourage Yanomamɨ to see through the microscope to make their work more understandable. This is probably why the *uhutɨpɨ* of the mirror has more easily been associated with sight-enhancing faculties (due to distance or size).[162]In Ocamo I heard of the use of mirrors with similar functions. One informant, however, described how the *criollo hekuras* had taught the Yanomamɨ ones:

> '…for example, there is a *shawara* you cannot see, you can see like dust but can't see [discern well] then the *shapori* uses a mirror so that it can be seen larger, that's what they say…[I ask if this was like this a long time ago] Yes, it was like this before, you know why? Because of the teachings of the *napë* spirits. Don't you see how the missionaries taught me how to write, in this way the spirit [of the *shapori*] also learned. *Napë* spirit and Yanomamɨ spirit…'

This man is referring to both his uncles and grandfather, all *shaporis* who were too old for the missionaries' schools, however, they paralleled the educational process in some measure learning from *criollo* spirits and acquiring *criollo* technology.

An important newcomer is the *hekura* of the Christian God. The great *shapori* 'founder' of Ocamo was a close friend of Padre Cocco. No doubt this privileged contact with the missionaries led this *shapori* to call upon the *hekura* of God, considered very powerful, a last resource when all else fails to cure someone. When he died, this *hekura* was passed to his younger brother Miguel, who now calls upon him.

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[161] In a later visit to Pashopeka a local informant confirmed the arrival of the *napëramɨ* with medicines and mirrors.

[162] Mirrors seem to have a special place among manufactured objects. I was once told of a technique to harm pregnant women by tossing pieces of glass/mirror along her path. This was enough for the mother to begin to feel pains and bleed the unborn baby which presumably has been cut to pieces.

The final aspect of *shaporis*' extension is the incorporation of the clinic and hospital as sites of action. In Ocamo *shaporis* were often working in the clinic itself (although this is not their preferred environment).[163] *Shaporis* could also send their *hekuras* to the Ocamo clinic or the hospital in Puerto Ayacucho. Alongside the doctor, then, the patient was confident that his/her *shapori* was doing 'long-distance' shamanism on them. Doctors are completely unaware of this 'spiritual assistance.' This 'special service' (apparently limited to the shapori's close relatives) beyond providing the patient with reassurance also served to calm relatives' anxieties at home – they were kept up-dated through the *shapori's* reports on the patient's state.

Summing up, *shaporis*, whilst epitomising traditional knowledge, become *napë* in their own way. In their use of manufactured objects' vital images, their occupation of *criollo* spaces and their becoming *criollo hekuras*, they tap into the resources of an expanded world. In previous chapters we discussed *shaporis*' dual function, healing and foreign politics, disaggregation in the persons of *criollo* doctors/Yanomamɨ nurses and 'civilised' interface Yanomamɨ. Here we see *shaporis* do with the invisible parts of the *criollo* world what interface Yanomamɨ do with the visible ones: put them to the service of the community in both curing and foreign affairs. The healing-foreign politics divide is cross cut by the visible-invisible divide.

VII. 6. *Medicine as hërɨ and wayu substance*

The different role (cure or care) of doctors depending on the category of disease (*shawara* or 'the rest') is reflected in way people speak of medicines and medical products like IVs. Sometimes expressions like: *rohot^{h}omaɨ*, 'to make strong,' *payerimaɨ*, 'to help,' *nini mraɨ*, 'to eliminate pain,' *ɨye ɨyë pë mrai maopë*: 'to avoid the depletion of blood,' are used. But if an intrusive immaterial object is not retrieved, an ill person will only recover slightly with medicines. If a person's vital aspect is not recovered, the person will die. In the case of *hërɨ* sorcery, medicines only have temporary effect, and so on. With reference to *shawara*, however, medicine is also spoken in terms of '*sheɨ*' or '*shepraɨ*,' 'to kill' or '*hoyaɨ*,' 'to throw away.' That is, it kills or eliminates *shawara*. In short, it seems Yanomamɨ assign medicines a type of

[163] A doctor that had worked for more than a year in Platanal explicitly underlined to me how *shaporis*, in her experience, never worked inside the clinic.

efficacy according to disease aetiology rather than the specific function doctors ascribe them in their therapies (e.g. a pain killer reduces symptoms, antibiotics eliminate causes.)

As noted above medicines are associated with the *hëri* substances Yanomami use as 'domestic medicine,' sorcery and some types of beneficial magic. Several aspects of medicines favour this association. First, some of their most common forms of application – swallowing or drinking, rubbing on the body – are common modes of use of *hëri*. Second, in their ability to kill *shawara* often with side effects (e.g. quinine, primaquine and cloroquine used for malaria or Ivermectine used for onchocerciasis) that may include dizziness, vomiting and allergic reactions, medicines are *wayu* substances. '*Wayu*' designates any substance with powerful effects on the body like *curare*, *hëri*, *yopo*, tobacco; it also means 'pathogenic substance/power' causing illness or death (cf. Albert, 1985:172; Lizot, Unp.:469). Third, when asked about 'Yanomami medicine' Ocamo people spoke of hëri medicines that is *urihi hami* 'in the forest' naming a number of vegetable *hëri* and their uses in treating different afflictions (e.g. malaria, diarrhoea, respiratory difficulties).[164]

So if doctors are *napë shaporis*, then their medicines are *napë* forms of *hëri*.

Concluding remarks

In Chapter VI we discussed relations between doctors and Yanomami, emphasising the *napë* potential affine status of doctors and its relevance in both medical and non-medical contexts. Here we complement that analysis with the medical-only conceptual aspects of the articulation of medical systems.

We have concluded that doctors/bio-medicine have the role of reducing people's suffering (care) by reducing symptoms for all diseases except *shawara* where a curing role equivalent to *shaporis* is ascribed. However, doctors, in most cases, invert this distribution of roles. Doctors' *shawara*-curing efficacy is consistent with the same

[164] See Milliken & Albert (1996) for an extensive survey of Yanomam usage of plants for medicinal purposes. The authors register 113 species used for a long list of afflictions. In my recollection, not as

ontological premises as shamanism – being 'of a kind' with aggressors – and uses equivalent techniques – accessing the 'inside' of people, the causal plane. Extending the multinatural/monocultural convention, doctors are spoken about as *shaporis* but they are *napë shaporis* who draw on *criollo* knowledge and are limited to *criollo* diseases (*shawara*). Doctors' performances must then be morally Yanomamɨ but *napë* in terms of medical knowledge.

Yanomamɨ conventional extensions imply that doctors are '*shapori*fied' whilst *shaporis* are '*napë*fied,' this transference of attributes is equivalent, in fact a part of, the wider innovation of the 'Yanomamɨ conventional space' yielding the '*napë* transformational' context. In this inter-cultural medical context, the following analogies hold:

- *shapori* – doctor
- shamanic knowledge (from the *hekura*) – *napë* knowledge (from the *criollo* world)
- *hërɨ* and *hekura* tools – medicine and manufactured products (e.g. machetes, guns, transport).

The analogy between books and *hekuras* as sources of medical knowledge/abilities is fully consistent with our running argument of reading/writing as *shaporis*' sight and the *criollo* world entering the Yanomamɨ cosmological dynamic as analogous to the invisible spirit world. We have also complemented the accommodation of 'traditional' roles among new actors. The transformative substitutes of *shaporis*' political role are interface Yanomamɨ (mainly modern community leaders), their curing role is found in the *criollo* doctor and the 'civilised' Yanomamɨ nurse. Crosscutting all this *shaporis* retain both roles doing with the invisible side of an expanded world what both doctors and interface Yanomamɨ do on the visible.

In Chapter VI we discussed the inverse distribution *criollos* and Yanomamɨ make of what is 'innate' and what is open to human agency. Doctors and Yanomamɨ enter each other's worlds as the form of the innate – culture (potential affines) and nature

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rigorous of course, people spoke of a handful of species some with multiple applications. Some of the Yanomamɨ names listed by the authors (Ibid.:16) concord with those I found in Ocamo.

(lack of society) respectively. The conceptual medical articulation echoes the same inverse orientations. For doctors, the innate (shared) character of nature, of which the bodies are a part, means medicine works everywhere and should prevail over *shaporis*. *Shaporis* and doctors are different because cultures are different. For Yanomamɨ, the innate (shared) character of culture makes doctors and *shaporis* 'the same.' Different natures, in contrast, imply that doctors curing ability is limited to diseases of 'their own kind,' and that bodies may be distinct. In both cases doctors' and Yanomamɨ conventions are extended in interpretation and practice: fabricated conventions and multiculturalism (*criollos*); innate conventions and multinaturalism (Yanomamɨ).

Finally, in Chapter VI we discussed how 'becoming *napë*' and 'making society' was a meta-mutual misunderstanding framing Yanomamɨ and *criollos* interest in each other. A project that has doctors as potential affines, multipurpose upriver trips, doctors 'in between' opposed Yanomamɨ groups was constantly negotiated with a project of only being doctors, medical-only trips, disentangling factional politics and health. Discussing the conceptual articulation of bio-medicine and shamanism we find an equivalent mutual misunderstanding. The two medical systems co-exist unproblematically but the articulation produces different pictures from each perspective. Complementarity is inversely ascribed by doctors and Yanomamɨ; mediating Yanomamɨ distribute medical information according to each healer's knowledge and world; *shaporis* and doctors infrequently communicate and don't share mutual evaluations; conceptions of diagnosis and treatment are often not shared by patients and doctors; Yanomamɨ extend a meta-convention of cultural continuity with natural discontinuity whilst doctors do the inverse with their multiculturalist extension. Doctors see *shawara* as naturally occurring infecto-contagious diseases. Yanomamɨ see infecto-contagious diseases as *shawara*, social relations with cannibal demons. Most doctors and Yanomamɨ are unaware of these translations.

Amid these profoundly distinct 'realities,' *shawara*, an ontologically *criollo* aggressor whose form of action, predation of soul-aspects/blood, is wholly Yanomamɨ is a true pivot between worlds, falling within the competence of both *shapori* and doctor. These tiny cannibal demons, in their resemblance with bacteria/parasites/viruses, facilitate an avenue of affinity between doctors' and

shaporis' actions. In the wider context, *shawara* is the trade off and irreversible quality of 'becoming *napë*,' working as a political hinge between Yanomamɨ and *criollos*, defining the latter as both 'enemies' and 'sources of solutions.'

We must see how the conceptual articulation of medical systems reflects the same character of the wider Yanomamɨ-*criollo* relationship: the transference of attributes between 'Yanomamɨ conventional' and '*napë* transformational' (innovational) contexts; the extension of inverse conventions producing 'parallel' projects and realities; mutual misunderstanding hinging on selective affinities.

The following chapter addresses direct relations between the state and the Yanomamɨ. These are relatively infrequent public events where higher state officials and Yanomamɨ punctually meet. I will focus on health debates in these encounters and their relationship with the everyday life, thus inserting these extraordinary events into the main arguments of the thesis.

Chapter VIII: State-Yanomamɨ direct encounters

The presence of state-related institutions like missionaries, and the health system since the mid 1950's, has prompted the creation of modern political representatives and community leaders together with novel formats of political debate: meetings and political demonstrations. Meetings with *criollos* are an expression of collective awakening and integral to the *napëprou* historical trajectory. As we saw in Chapter VI, meetings sustain leaders and senses of 'community' and are structurally and processually integral to the cycles of harmony-disharmony that keeps doctors as *napë* potential affines oscillating between enemies and allies. Meetings both differentiate Yanomamɨ against *criollos*, presented as non-trustworthy and resisting Yanomamɨ desires, and seek to control the latter and their resources when obviating their innate difference in the production of agreements to 'collaborate' or 'work well' with doctors.

In this chapter we shall widen the scope of actors to include higher state officials and their institutions. At this level Yanomamɨ politics incorporates the inter-institutional politics of missionaries, local government, military and health system. This at once connects the local with regional and national processes and gives 'the Yanomamɨ,' as the site of institutional objectives, the potential for being the object of inter-institutional relations. I will here analyse a series of meetings and a demonstration. These events take us away from the everyday relations between doctors and Yanomamɨ and into the explicitly political realm. My analysis underscores continuities with the everyday, making these events collective instances of relations we have already examined. It also shows their complementary role as 'down-river differentiations' in the sustenance of the '*napë* transformational axis,' contributing to the definition of the Yanomamɨ 'side' of 'civilised' Yanomamɨ. We shall also explore important discontinuities found in the multilayered, inter-institutional politics at play and Yanomamɨ's experience of decreased ability to control institutional *criollos* in comparison to their local management of doctors.

VIII. 1. *A general pattern*

Encounters with institutional representatives in the Upper Orinoco exhibit a pattern I will summarise. Roughly these encounters are flash visits (one or two days) to La Esmeralda or a Yanomamɨ conglomerate (e.g. greater Ocamo) where Yanomamɨ explain their problems and demand solutions and institutional delegates 'listen to the Yanomamɨ' or enquire 'what the Yanomamɨ want,' or 'consult' on a particular issue or project. Response to Yanomamɨ demands normally takes the form of a commitment or promise – 'commitment' (Sp. *compromiso*) being a key word deployed by *criollos* and Yanomamɨ alike. Institutional representatives often counter-demand some form of commitment from the Yanomamɨ. For instance, Ocamo was visited for a few hours by the Regional Health Director (RHD) in November 2001. A meeting was organised where Yanomamɨ requested a new permanent rural doctor. The RHD and the Head of District (HD) committed themselves to address the unusually long absence of a doctor in exchange for some commitment of Ocamo people to basically 'live well' with doctors when they came.

VIII. 2. *'Health' in Yanomamɨ – criollo institutional encounters*

'*Salud*,' and education are central issues Yanomamɨ discuss with institutional representatives in part because they are integral aspects of the historical process of 'becoming *napë*.' Education contributes to the knowledge component of this process whereas health is fundamental to counter the spread of *shawara*. Yet it is also the case that health and education are simply the two services with long-term, permanent presence in the Upper Orinoco constituting the main avenues of management of *criollos*. In contrast, in Brazil, alongside health and education, there has been a stronger emphasis on land rights given the threat of large-scale projects and the invasion of gold miners (see Chapter I). The biosphere reserve status of most of Yanomamɨ territory has kept non-Yanomamɨ occupation and developmental projects at bay.[165]

[165] As in the Colombian Amazon, where indigenous land rights were granted through the figure of the *resguardo* in 1975 the relatively low presence of land rights in Venezuelan Yanomamɨ indigenous politics is in part due to the fact that the land issue was partially resolved before it became too much of

Health and education are also central concerns of the regional and national indigenous movement. ORPIA has several lines of action which include 'health' and 'education'; the new constitution includes rights to intercultural bilingual education and the right to 'an integral health that considers their [indigenous] practices and cultures.' (Art. 122). Yanomamɨ increased participation in regional and national indigenous forums contributes to align representatives' concerns with those of more experienced indigenous leaders. Finally, in response to these developments, concerns with 'community participation' have become increasingly important in the way the Ministry of Health and its institutions relate with the Yanomamɨ. In short, the centrality of health is the result of both Yanomamɨ and state drives.

VIII. 3. *Factors in Yanomamɨ agency and the multilayered political arena*

In this section I shall summarily discuss three meetings to illuminate a) the factors that impinge on the character of Yanomamɨ agency b) the intertwining of Yanomamɨ political management of *criollos* with the *criollo* inter-institutional politics that pivots around 'the Yanomamɨ.'

In March 2001, a handful of Yanomamɨ representatives (including the Ocamo nurse and two *huyas* doing the nursing course) were invited to participate in discussions of the Yanomamɨ Health Plan in Puerto Ayacucho. Tens of *criollo* representatives of a plethora of institutions attended the two-day meeting: government (regional and national), missionaries, military, health and environment Ministry, Members of Congress, NGOs. Here Yanomamɨ participation was minimal. The *criollo* majority, agenda and location implied that Yanomamɨ participation and assertiveness, so strong in the local contexts, was low. Some of the topics and level of discussion, all done in Spanish, also seemed to be beyond representatives' experience. In this context, representatives, nurses in particular, are requested to present 'the Yanomamɨ perspective,' mirroring the situations where they translate the *criollo* world in mediation with their communities or upriver 'real Yanomamɨ' settings. Here they

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a problem. As in Colombia attention to other claims to rights have taken centre stage (on the Colombian case see Jackson, 1995; Hugh-Jones, 1997). Rival (2002:154) also comments on the primacy of education in the early 90's amongst the efforts of the Ecuadorian indigenous organisation, surpassing the land and other issues in relevance.

translate the Yanomamɨ world for *criollos*. Their dual Yanomamɨ/*napë* being is a requirement in both cases.

A common site for Yanomamɨ meetings with institutional officials is La Esmeralda. Let me describe two meetings I observed held in what is known as the 'Yekuana hut.'

In August 2001 the (Nation-wide) General Commander of the National Guard (NG) was accompanied by a Vice-President of the National Assembly, the indigenous leader Noeli Pocaterra, and one of the three indigenous representatives to the National Assembly, in a meeting convened to discuss an accusation made by Yanomamɨ supporters of the AD Upper Orinoco Mayor, that a GN of *Plan Casiquiare* had threatened Yanomamɨ with his pistol. The General Commander was there to 'consult the community' regarding the accusation and how to address it. The meeting was held in Spanish, the audience was mixed with Yekuana, Arawak and Yanomamɨ. Several spokespersons for communities, economic co-operatives and ORPIA, all Yekuana and Arawak, read out formal statements vehemently rejecting the accusation, fully supportive of the NG, praising his unrelenting commitment to the welfare of indigenous people.[166] Some added harsh criticism of the Mayor considering this one more of his attempts to manipulate Yanomamɨ through his representatives and supporters. The HD and Salesians also supported the NG and criticised the Mayor. Yanomamɨ participation was comparatively low, one representative read out supportive document also critiquing the AD Yanomamɨ representative who originated the accusation. Only one Yanomamɨ representative of the Mayor made a long intervention.

In broad terms the meeting was controlled by the Yekuana/Arawaks; Yanomamɨ were outnumbered and overwhelmed. Several factors contributed for this to be so. The site was, is in itself, a Yekuana space, La Esmeralda has little support for the Mayor, the meeting was held in Spanish limiting Yanomamɨ participation and favouring the Yekuana who are, on average, more articulate in Spanish.

[166] Recall the work of *Plan Casiquiare* from Chapter I. Part of the strategy of the Plan Casiquiare was to establish a new relationship between the GN and indigenous people that would break with the past.

The second meeting was in September 2001. More than 150 Yanomamɨ met with the newly appointed Regional (Amazonas) NG General. The large audience from several Yanomamɨ communities filled one half of the hut, in the middle of the other half several NGs sat on a long table with a Yanomamɨ translator/moderator. The meeting was held in both Spanish and Yanomamɨ. Here Yanomamɨ were emphatic in their statements, some harangued the General in a way that would be unthinkable for *criollos*. People spoke 'without fear' in Yanomamɨ and in Spanish as they vehemently presented education and health concerns to an official well disposed 'to listen.' In the end the General, among other things, committed himself to fly to Caracas with Yanomamɨ representatives to jointly deliver a report to Health and Education Ministry officials in the capital.

These two examples presented common features of meetings in the Upper Orinoco. That a General was confronted with health and education issues, beyond the military's scope of action, is symptomatic of inter-institutional rivalries. In this case leaders from the Mayor's 'camp' were utilising the NG to elevate genuine concerns, but in doing so, were also bypassing both the Salesian missionaries and the health system with whom the Mayor was in conflict (see Chapter I). The first example was also highly political as is evidenced by the alliance formed: some Yekuana and Yanomamɨ communities, ORPIA, Salesians, HD, La Esmeralda Prefect all in support of the NG and vigorously against the AD Mayor. In parallel, inter-ethnic politics was also relevant. Traditionally Yekuana have been dominant over the Yanomamɨ in economic, political and marriage terms (see Colchester, 1995:159) and are more experienced in dealing with *criollos*. The Mayor himself is Yekuana even though Yanomamɨ greatly outnumber Yekuana in the Upper Orinoco municipality. Ironically it was Yekuana opposition to the AD Mayor that was pitted against the AD Yanomamɨ.

Below we shall discuss at length the Mavaca Yanomamɨ conference of November 2001 as an example of maximum Yanomamɨ agency given the Yanomamɨ dominance in terms of location, language, agenda and number of attendants.

This was publicly stated by GN officials. This GN co-ordinator was an embodiment of this 'new relation.' For a contrasting picture of GN's relation to the Warao in the early 90's see Briggs (2003).

Summarising: Yanomamɨ participation is strongly affected in form and content by location or 'ethnic environment' – the *criollo* City, Puerto Ayacucho; the multi-ethnic town, La Esmeralda; or Yanomamɨ communities – the dominant language, and the balance of Yanomamɨ – *napë* present (recall that in opposition to Yanomamɨ, other Indians may be '*napë*'). These factors influence assertiveness, expressiveness and eloquence, and style impinging on the overall effectiveness – in terms of impact on *criollos* – of Yanomamɨ performances.

Second, Yanomamɨ – institutional encounters in the Upper Orinoco are fora where the local *criollo*-oriented political process is intertwined with institutional alliances and rivalries, creating a multilayered political arena. These encounters localise institutional rivalries bringing regional and national processes to bear. The AD Mayor clearly saw in *Plan Casiquiare* a threat to his hegemony given the material clout it displayed and some NG's – at least informal – criticism of his government (corrupt, manipulative, etc.). Given that *Plan Casiquiare* is the Amazonas version of a national social development plan fashioned by the government for whom AD politicians are arch-enemies (epitomising a corrupt 'old regime') this local rivalry has unavoidable connections with national politics and, in this sense, *Plan Casiquiare* competes with the AD Mayor. Similarly, as with other indigenous organisations in the Amazon (see Jackson, 1995 for the case of CRIVA in Colombia), ORPIA has traditionally been supported by the Salesians in Amazonas, an alliance which would tend to pit them against a Mayor in conflict with Salesians. But ORPIA's rejection of the Upper Orinoco Mayor's style of government is an instance of a regional opposition to the long-standing AD grip on Amazonas government, also reputed for its corrupt administration.[167] ORPIA's opposition to AD is further compounded by their alignment with the current government that has opened a historically unprecedented space for indigenous rights and politics in Venezuela. Finally, the Mayor was himself brought up in a NTM context. This has been used by the Mayor to cast the Salesian critique in terms of their long-lasting friction with NTM (see Gómez in El Nacional 19/7/2002).

[167] This grip was finally put to an end by Liborio Guarulla, the first indigenous Governor in Amazonas elected in 2000. The stronghold of AD in the region impeded this from been a swift transition, a number of legal disputes were sustained from the original election in July 2000 – where the AD candidate was first found winner – until February 2001, when a second partial election ratified Guarulla as Governor.

Finally, both the La Esmeralda meetings exemplify Yanomamɨ's pivotal role in inter-institutional politics. The Mayor's attack of the NG takes the form of an alleged incident involving Yanomamɨ; the conflict with the health system and Salesians takes the form of a Yanomamɨ plea to the new NG General. Both are instances of the AD municipality acting through the Yanomamɨ. I have little doubt the strategy aims to disguise a political objective through the legitimacy of the 'voice of the people.' This doesn't mean Yanomamɨ leaders are manipulated by the Mayor. These leaders are very much aware of their role, their mediation is part of political – clientelist relationship where they and their communities are benefited with goods and – albeit few – jobs. This is one of the alternatives for Yanomamɨ, specially those with leadership aspirations, to further the *napëprou* trajectory. In this way their mediation is double: on behalf of communities (between Yanomamɨ and *criollos*) and of the AD Mayor (between institutions).

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In what follows I will discuss two important events occurring in 2001, analysing form and content and integrating these sparse events into the everyday life within the health system. I will be linking these events with our running discussions on a) the performative character of relations b) the dynamics of obviation in the making of 'Yanomamɨ' and '*napë*' positions along the '*napë* transformational axis' c) the *napëprou* trajectory.

VIII. 4. *Fluvial ambulances in La Esmeralda*

In April 2001 a group of Yanomamɨ protested on the occasion of the second Presidential visit to La Esmeralda. Together with a number of boats and motors, six 'fluvial ambulances' were lying in La Esmeralda waiting to be donated by the NG's *Plan Casiquiare* in response to Yanomamɨ petitions to the President during his first visit the year before. Official deliveries were part of the programme of the President's visit. Each ambulance was identified with a specific community's name written along its side: three of these read 'Ocamo,' 'Mavaca,' and 'Platanal.' For some time local health authorities had insisted to the NG on the technical inadequacy of the

ambulances – inappropriate for river travel, medically unequipped, motors were too large for the shallow waters of the dry season, high fuel consumption, etc. – but the ambulances were nevertheless taken to La Esmeralda for their delivery. However, in final acknowledgement of their inappropriateness it was decided, the day before the event and after crowds of Yanomamɨ had noted them, to substitute Yanomamɨ community names for other towns in Amazonas. This sudden change without consulting the Yanomamɨ was the motive of their protest.

Let me summarise the events. The day before the President's arrival, some Yanomamɨ leaders co-ordinated a large number of Yanomamɨ preparing a document complaining to the President about the ambulance incident. Most Yanomamɨ were in a provisional camp staying together under a large roof. On the day most Yanomamɨ remained in this area whilst the rest of La Esmeralda people were concentrated at the end of the airstrip (about half a mile away) where the official reception activities and the President's weekly radio programme were held. Yanomamɨ deliberately remained away to distinguish themselves. In the shelter they prepared to make an impact, gathering arrows, improvised clubs and painting themselves in black with charcoal. Whilst those in the co-ordinating role (a handful) remained in *criollo* clothing most of the rest emulated warriors. Another group added themselves to the crowd fully dressed but keeping the warriors a distinct group.

Next they paraded down the road leading to the stage where the President was addressing the crowd. Not far from it, the chanting crowd of striped-black-arrow-wielding Yanomamɨ were intercepted by military personnel. As more military personnel a few journalists and others arrived at the scene, the protest quietened and military personnel with the HD began negotiating with Yanomamɨ leaders. The HD attempted to explain the reasons for changing the names but was vigorously dismissed by the crowd: 'don't let him speak!', 'get rid of him!' Next uniformed high ranking officials of *Plan Casiquiare* and the 'Presidential Guard' (Sp. *Casa Militar*) attempted to spell out the problems, explaining they would buy other more adequate boats. One AD leader explained 'we requested [the ambulances], we suffer here for our people…we cannot accept more deceit… now the Yanomamɨ region is in need, first you have to be concerned.' 'Now I will explain why' one official jumped in, repeating the arguments. The Ocamo nurse explained: '…the headwaters of the Orinoco don't

have rapids as they do down-river…gentlemen stop this! We work, we have died here to deliver our needs, we have killed ourselves…'

Realising that appeasing efforts were failing one military official radioed for help. One elder from Ocamo stepped forward and, waving an axe in front of the officials, in loud assertive Yanomamɨ let the military men know he was a true leader, his words were then translated: 'he says 'I am the one suffering [inaudible] to request the ambulances and the boats for where the health problem is greater…'[168] Finally a clear official voice declared: 'You want the ambulances… Well Ok I am going to give them to you...but remember, you will be responsible for the maintenance and operation Ok?' The crowd responded cheering in victorious excitement. Then the document was formally read out by yet another interface leader '…we are doubtful about what the representatives of the Plan Casiquiare 2000 did, without consulting the Yanomamɨ…when the things come they are changing them. This is why we the Yanomamɨ are feeling sad for our ambulances!…'[169] Towards the end of the commotion an AD representative read out another letter directed to the President but unrelated to the ambulances '…we want the military to respect our people because we understand that *Plan Casiquiare* 2000 offends, we won't allow that because we are a sovereign people as it is contemplated in article 110 of the new constitution. They don't give us the treatment we deserve…we don't want [a list of names of: 2 ORPIA representatives, the HD, a Salesian co-ordinator in La Esmeralda, a *Plan Casiquiare* co-ordinator] these ORPIA people don't know what we want and what we need, we want you to solve this problem for us…' Closing the protest, leaders requested that officials sign their statements with copies to the President. The episode lasted 20 minutes.

Let us relate this event to our running discussions. The Yanomamɨ had a claim on the ambulances, recognising them as the result of their original petitions and having

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[168] In the video I took of this event the elder man's statement is not fully discernible to me. What is clear, nonetheless, is that the translation is more aligned with the arguments that the mediators are putting forth than the real content of the elder's speech. As I shall argue below, the warriors and protest mediators were complementing each other's actions. The former visually and the latter verbally were doing the same 'Yanomamɨ performance.'

[169] The expression 'we the Yanomamɨ are feeling sad!', quite unusual for a *criollo* in the context of a protest, is most likely a direct translation of the Yanomamɨ term '*hushuo*' meaning 'to be angry' but also 'to be grieving a death.' '*Triste*' in Spanish only translates the 'sad' component of this dual meaning.

seen their community's names on them. The decision to change their destiny without consultation was sufficient for leaders to push for a response to such an aggression. The incident confirms the deceitful nature of *criollos* seen as trying to deprive the Yanomamɨ from something that was legitimately theirs. Leaders seized the opportunity to attempt the extraction of the ambulances, giving the event its performative character: a test of the ability to overpower *criollo* resistance to a Yanomamɨ claim/desire. In its motivation, then, this event resembled many patient negotiations and daily requests to doctors, it was a collective instance of a common form of Yanomamɨ – *criollo* relation.

But there is more to this resonance. Not mixing themselves with the rest and adopting a distinctive warrior appearance was a deliberate differentiation aimed for the effectiveness of a 'Yanomamɨ performance.' Claims like 'we are suffering,' 'we are dying,' 'we are in need,' resonate with Yanomamɨ ethics of not letting people suffer – hence the reiteration of 'you must be concerned' – but it also does with *criollo* images of Indians as 'poor,' 'needy,' 'helpless,' that interface Yanomamɨ are aware of. The warrior attire and 'speaking without fear' was aimed at instilling fear, '*kirimaɨ*.' All these features stress Yanomamɨness at the expense of *napëness* (obviation) pressing *criollos* to respond by instilling a combination of fear – warriors appearance/ 'speaking without fear' – and compassion/pity – content of discourse.

Notably, even when some Yanomamɨ realised the inadequacy of the ambulances, regardless of their quality, it was an offence/attack to proceed in this way, the only acceptable redress being to return the ambulances. As already discussed some *criollo* decisions are interpreted with what *criollos* consider misplaced intentionality but Yanomamɨ see as part of the on-going dynamic of political alliance and harm. Expecting a 'logical' argument *criollos* encountered repeated intransigence complaining that Yanomamɨ 'don't understand the ambulances are no good.' The whole demonstration was an inverse assertion '*napë* don't understand they cannot decide the future of our ambulances.'

The protest was also an opportunity for leaders' political enhancement, hence Yanomamɨ leaders of both AD and 'opposition' and from all regions (Padamo, Ocamo, Mavaca, Platanal) took up the interface role besides their rivalries. Even

when they overcame their differences in uniting against *criollos*, there was a competitive air to their alternating interventions.

In the context of *napëprou* this 'Yanomamɨ performance' is quite the inverse complement of 'civilised' Yanomamɨ's '*napë* performances' in upriver medical visits. The protest interlocutors mediated between a group of Yanomamɨ who have intentionally obviated their *napë* bodies and a group of innate *napë yai*; *criollo* military and officials. Internal differences between 'civilised' and *waikasi* Yanomamɨ, as well as political ones, are obviated to maximally differentiate against *napës*. Interlocutors stress their Yanomamɨness in their discourse, needing to retain *criollo* attributes (Spanish, written documents, attire) to mediate both translating the Yanomamɨ perspective to *criollos* officials, and showing their ability to negotiate with *criollos* to their fellow Yanomamɨ. Interlocutors establish a moral continuity with the Yanomamɨ present through their discursive 'Yanomamɨ performance' but differentiate themselves from the crowd in displaying *napë* body/knowledge. This distribution echoes what we discussed in Chapters VI and VII where doctors should be morally Yanomamɨ but retain their *napë* knowledge; where Ocamo Yanomamɨ in upriver communities equally adopt *napë* attitudes and bodies but retain a moral continuity with *waikasi*, mediating on their behalf with the doctors.

Circumstantially, 'civilised' Yanomamɨ will 'perform *napë*' with reference to upriver *waikasi* and 'perform Yanomamɨ' in relation to *napë yai* such as the military and doctors. Each type of relation sustains one side of the dual Yanomamɨ/*napë* being of 'civilised' Yanomamɨ along a network of up/down-river communities in the contexts of the '*napë* transformational axis.' *Waikasi* also 'perform Yanomamɨ' when demanding objects from Ocamo Yanomamɨ. *Criollos* like state officials innately 'perform *napë*' by either providing objects/solutions (potential affine as ally) or resisting to do so (potential affine as enemy). That the emphasis on 'concern' figures as prominently in events like this protest as it does in everyday relations with doctors (treating patients, visiting communities, opening the clinic on time, etc.) is symptomatic of the underlying general need to compel *criollos* into moral action.

If the Ocamo health meeting discussed in Chapter VI was 'making community,' this episode was making 'the Yanomamɨ' in opposition to *napë* (other Indians and

criollos). In terms of modes of action, the difference from extracting objects from reluctant doctors, patient negotiations, the Ocamo health meeting and the Esmeralda protest is a matter of scale; all define opposed Yanomamɨ and *napë* positions. 'Position' referring to a gamut of moral, practical and conceptual attributes. The passage is from 'I' to 'us' and from 'you' to 'them.'

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Having outlined important continuities between the extraordinary and collective and the individual and quotidian in Ocamo and upriver, we now discuss the relevant differences and the *criollo* interpretation of events which holds similarities and differences of its own in relation to perceptions born from the quotidian.

VIII. 4. 1. Discontinuities and *criollo* interpretations

The multilayered political component, irrelevant in interpersonal doctor-Yanomamɨ relations, came at the end of the episode with the AD representative's document. It singled out all the local and regional rivals of the Mayor (ORPIA, Salesians, health system, and *Plan Casiquiare*). Again, an AD representative promoting two interests, disguising an institutional rivalry with the legitimacy of the general Yanomamɨ protest.

Asked about what happened a GN of *Plan Casiquiare* explains this was a strategy of the AD Mayor whose representatives were manipulating the rest of the Yanomamɨ like children, emulating what AD has traditionally done elsewhere in Venezuela. Lamentably many Yanomamɨ leaders are part of this 'old guard.' This view was echoed by other indigenous representatives in La Esmeralda in a later meeting (mentioned above). The HD also considered part of the incident was a retaliation of the Mayor in response to the recent suspension of his niece from her nursing post. But he also understood the Yanomamɨ reaction, in the circumstances: 'anybody would get angry,' expectations were created only to then be frustrated.

In this highly politicised environment local *criollos* extended the intentions of the AD representative to all the Yanomamɨ in the protest, homogenising their

motivations, even though the AD intervention seems to have been riding the wave others had begun. Specially for the GN, the presence of AD representatives reduced the legitimacy of the claim to an excuse to create trouble on behalf of the Mayor.

'Manipulation' here reiterates the double image of Yanomamɨ as '*vivos*' and children (Chapter VI). The GN's statement puts some Yanomamɨ – political leaders – on a par with *criollos* given their mastery of the political game. Here there is little space for cultural difference, this is pure politics as anywhere else. The rest are infantilised and cast as victims of their own leaders. But this analysis misses the double mediation of people like AD representatives, yes, advancing the Mayor's interests but 'community' interests too (to what degree is another matter) as this case clearly illustrates.

That Indian politicians' personal careers can frequently override the wider constituency's interests is no news (Jackson, 1999). It is also the case that *criollos* are less accepting of Indian displays of astute manipulation of the political game for it goes against the associations of Indians with a natural purity of character (cf. Conklin, 1997:725; Graham, 2002:187). But beyond this what is particularly troubling for some *criollos* in the Upper Orinoco like the HD, the GN co-ordinator, opposition Yekuana from La Esmeralda or ORPIA representatives, whose dedication to indigenous people is, in my experience, unquestionable, is how AD's political grip seems to have no regard for Yanomamɨ welfare, limited to the occasional hand-outs in return for votes. In the face of a precarious health situation, for example, the complicity of some Yanomamɨ leaders in AD's agenda is frustrating.

In this multilayered political arena, devices used by Yanomamɨ leaders to further their claims, like the incorporation of *criollo* images of Indians, appeals for 'concern,' adopting a warrior stance, are all but lost in the eyes of *criollos*. Mediators claiming to be 'dying' for their people are seen indignantly as manipulators, warriors are seen as manipulated children. The whole performance takes on a false character of theatricality. Those unacquainted with the local scene – Presidential Guard and higher nation-wide officials – were, in contrast, intimidated by the uncertainty of what might happen and, avoiding a potential commotion with the President, acceded to the protestors' demand. Since they called the shots the performance was effective.

VIII. 4. 2. Comparative discussion

Recently several authors have discussed the adaptation of indigenous political self-representation to Western ideas and notions about Indians (Turner, 1991; Conklin, 1997; Graham, 2002; Albert, 2000; Ramos, 1998; Jackson, 1991;1995; Vilaça, 1999). Let me address two mutually complementing articles. Conklin (1997) writes about the incorporation of Western notions of Amerindians into visual self-representations of indigenous activists, particularly in the context of international environmentalism. She notes the historical change in the usage of Western clothing and traditional adornments and paint. Previously Western clothes was used by Indians to 'hide' their ethnicity in view of the denigration naked bodies, paint and feathers provoked in national Whites. With a new audience provided by, amongst others, the Western environmentalist movement, and acknowledging a new indigenous sense of pride:

> 'It is equally clear that this shift responds not only to indigenous values and internal societal dynamics, but also to foreign ideas, aesthetics, and expectations about Indians. As some native South Americans have learned to speak the language of Western environmentalism…so some have also learned to use Western visual codes to position themselves politically.' (1997: 712)

Echoing Thomas (1994) (see Chapter II) she cautions about the perils of such a strategy with the potential to morally and politically displace 'inauthentic' Indians.

Graham (2002) writes about verbal performances of indigenous leaders among Western or mixed (Western–Indian) audiences. She defines a typology of linguistic interactions available to indigenous spokespersons to balance the symbolic effectiveness related to Westerner's appreciation for indigenous languages and themes (e.g. myth) as indexes of authenticity, with the problems of straightforward communication of content (of demands, for example). As an example of maximum symbolic gain, she summarises some of the performances that took place in the now famous 1989 Altamira demonstrations in Brazil.

Threatened by the imminent construction of a number hydroelectric dams, the Kayapó orchestrated, with hundreds of other Indians, an encounter/protest with government officials. The event that, as Turner (1991:307) describes, was very much planned with Western audiences and video self-representation in mind, was also attended by substantial numbers of journalists. The audience appreciated the use of native language even when the content of many speeches remained incomprehensible. Moreover,

> 'One of the most stunning displays…was staged by a Kayapó woman, Tuire, who approached the podium brandishing a machete. Gracefully and deliberately she symbolically swiped it against the cheeks of the director of the regional power company as she orated in Kayapó. Her gestures and speech were so symbolically powerful that no translation was necessary. None was offered and the audience roared with applause in support of her performance.' (Graham, 2002:207-8).

What does this 'Esmeralda protest' and its continuities with everyday relations with *criollos* illuminate when compared with the Altamira demonstration and Conklin's and Graham's analysis?

We must note from the outset some contrasts between Altamira and Esmeralda. First, no doubt Yanomamɨ organisers were conscious of the effect of a public demonstration but one cannot say it was 'media oriented' as seemed to be the case in Altamira. Second, the reaction to the protest had little to do with affinities with Western visual or discursive aesthetics. Local *criollos* understood everything as standard political manipulation; other official visitors reacted to the uncertainty of the outcome. Third, this was a Yanomamɨ-only event seeking differentiation from other Indians as well as *criollos*. Finally, the numbers of indigenous peoples and journalists are incomparable. But there are some commonalities. A shared and crucial condition for both events was the Indians' knowledge that their performances would not incite retaliation in the form of repression.[170] The image of warriors was deployed in the same way that Kayapó have capitalised on their reputation of 'savage killers' to instil

[170] Turner (1991:308) mentions that part of the emphasis on the presence of Brazilian and international media aimed at both securing the presence of state officials and precluding a violent response.

fear in White gold miners (Turner, 1987b). The episode of Tauire's machete brandishing resounds with the Ocamo elder waving his axe. Keeping these differences in mind, what I want to tease out is how an emphasis on self-representation and identity overlooks a number of issues which invite us to rethink the role of Western audiences in indigenous performances, at least in the cases here described.

First, our analysis shows that these performances occur in upriver contexts, to some effect, and down-river, to another. Going beyond the White-Indian interface and analysing a whole network, we realise these performances complement each other in constituting the 'civilised' condition of Orinoco Yanomamɨ. Such a condition requires constant differentiation from 'real Yanomamɨ and 'real *napë*' for its definition and sustenance in conceptual and practical terms (cf. Gow, 1993:336).

Second, these performances are essentially about 'putting people on their moral mettle' (in Wagner's terms), actualising a relationship. With *criollos* what is prompted is a *napë* potential affine relation. But in other contexts the same ploy is used internally among Yanomamɨ (see the Ocamo meeting in Chapter VI). Besides its choreographic effect, waving axes or machetes and speaking in native language are appropriate ways of addressing Whites as enemies, instilling fear to prompt a reaction.[171] Was Tuire staging her performance or reacting as she would, assured that officials wouldn't retaliate? Graham suggests the use of language in terms of symbolic capital (in the eyes of Westerners) or communication. In the course of this thesis we have emphasised the place of language as a Yanomamɨ index of humanity/morality. The Ocamo elder addresses the officials in Yanomamɨ not in search of *criollo* approval, but because he is angry and expressing himself in a human/moral/Yanomamɨ way, differentiating himself against *criollos*. As Wagner points out: '*As a matter of moral principle*, the giving of gifts is not 'economic,' and the elicitation of kin relationships is not 'kinship.' (1981:92, his emphasis). So we must add 'the moral' in the analysis of language choices in indigenous performances.

[171] I am certain the Ocamo elder was not particularly focused on choreography. This man is known in Ocamo for his fearless addressing of *criollos*. I was subjected to his intimidating performance in my initial permit-negotiating meetings in Ocamo. He also spoke without fear in the all-Yanomamɨ meeting with the GN in La Esmeralda I mentioned above.

Third, the dual Indian/*criollo* audience implies that mediators are constrained by the perspectives of both *criollos* and Yanomamɨ: translation and display of leadership qualities. We cannot, then, limit the analysis to Western aesthetics, but indigenous one's too. The interplay between moral collectivisation (Yanomamɨ) and body/knowledge differentiation (*napë*) also runs through a number of contexts along the river network.

Fourth, there are a series of selective affinities or 'inter-ethnic misunderstandings' (now to use Albert's phrasing) typical of these cross-cultural scenarios, one of which appears clearly here. [172] Here I am partly following Vilaça's (1999) own analysis where she stresses that the body's relevance in identity politics partly follows from its role in the socio-politics of identity and alterity in a perspectivist world. Similarly, as we have mentioned in Chapter VI, no doubt *criollos*' notions of Indians as 'needy' or 'helpless' are incorporated into Yanomamɨ performances but would this be so were they not to strike an affinity with the indigenous ethics of ameliorating suffering? Presenting yourself as suffering is typical towards all resident *criollos*, in particular in reference to being short of goods.

Let us suggest all this differentiation subsumed under 'Yanomamɨ performance' is less about self-representation than it is about self-knowledge and a mode of action, tests in producing a response: 'we are real Yanomamɨ, are you real *napë*?' Differentiating distances parties to a relation saying 'we are enemies' just as when I respond in Yanomamɨ to a child calling me 'doctor' I am saying 'we are similar.' We would be misled to see differentiating ploys as representations, they are 'becomings' pivoting between the 'morality of being human' and the '*napë* transformational' context.

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The second part of this chapter is devoted to the analysis of the Mavaca 2001 Yanomamɨ conference retaining our strategy of analysis, putting the extraordinary meeting in conversation with the everyday relations within the health system.

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[172] See Hugh-Jones's (1997) discussion of 'culture' in Tukano ethno-education debates and Albert's (2000) analysis of the convergence and dissonance between the Western category 'environment' and the Yanomamɨ concept '*urihi*.'

VIII. 5. *The Mavaca Yanomamɨ conference*

Following the publication of Tierney's (2001) '*Darkness in El Dorado*,' a special governmental commission was constituted to investigate the allegations of bio-medical, anthropological and political wrongdoing towards the Yanomamɨ. This commission – including representatives of the Health and Environment Ministries, Venezuelan Institute for Scientific Research (IVIC), Indigenous Affairs Direction (DAI) – grew concerned with not only the veracity of past events, but also the current 'Yanomamɨ situation.' During a trip of Commission representatives to the Upper Orinoco it was agreed to hold a conference of historical dimensions in Shakit^{h}a (Mavaca conglomerate) with greatest Yanomamɨ representation possible and *criollo* representatives from all institutions with a bearing on the future of the Upper Orinoco. The objective, apparently, was to bring these parties together so Yanomamɨ could explain their demands and expectations directly to high officials with the authority to commit their institutions there and then.

The meeting was held from the 19th to the 22nd of November 2001. In Shakit^{h}a a rectangular house built into the circular layout of the *shapono* with wooden benches and a stand for speakers, was constructed for the event. The first two days were 'Yanomamɨ only' discussions on the several themes of the conference defined during Yanomamɨ preparatory workshops. The main areas were Education, Health, Environment and Political Participation. 'Environment' included more precise themes: 'land demarcation,' 'permit regulation,' (for research) and 'economic self-management.' This thematic content reflects *criollo* and Yanomamɨ concern with recent developments. Venezuela's new constitution grants indigenous people land rights for which demarcation is necessary but had until then not been addressed by the Yanomamɨ. 'Permit regulation' was surely made more relevant given the debate on proper informed consent triggered by Tierney's book.

Equally 'Political Participation' subsumed discussions on 'indigenous organisation' (SUYAO), 'Yanomamɨ municipality' and 'local government' (Sp. *Juntas Parroquiales*) reflecting concerns with the role and interrelation of indigenous with party politics and the possibility of a special Yanomamɨ-only district or continuing with the current interethnic municipality (see below).

With the arrival of *criollo* representatives the second two days involved their formal presentation; the summarising of the main conclusions reached on each theme to the now mixed Yanomamɨ and *criollo* audience; the breaking up into theme-specific discussion groups and, finally, the drafting and signature of commitment documents.

Criollo invited representatives counted some 40 whilst the Yanomamɨ participating in the plenary of the conference varied within and from one day to the next from 60-70 to more than 200. The official list counted 52 communities and 142 delegates although some 500-600 people must have been in Shakit^{h}a adding delegates' companions and Shakit^{h}a residents (aprox. 140). Based on the official list and according on their location in relation to missions and health posts, 'Orinoco communities' were roughly half of the total.[173]

Holding the conference within Yanomamɨ land, the preparation of the agenda and the two 'Yanomamɨ only' discussion days were all choices to tilt the balance of power towards the Yanomamɨ side: *criollos* would 'dance to a Yanomamɨ tune.' On the other hand, *criollos* were warned that the conference was to 'listen to the Yanomamɨ.'

Taken as a whole the conference allows for some internal distinctions. The audience of the plenary sessions was largely Yanomamɨ from Orinoco, mid and upriver communities. Speeches were largely in Yanomamɨ. When the invited *criollos* incorporated themselves – still a distinct minority – translators were used for their presentation and some brief responses made in the plenary. Some Orinoco Yanomamɨ then spoke in Spanish directly to *criollos*.[174] This diverse audience was reflected in the speakers' performances in content and form.

First, Orinoco Yanomamɨ have long term experience of missionary education, the health system and party politics, in contrast with upriver communities. In terms of health these speakers referred to specific problems and people within the health

[173] In this case only, under the category 'Orinoco communities' I am considering all communities within short range of mission and health posts, including those in Parima and along the Padamo where there is NTM presence even when they are far from the Orinoco itself.
[174] Under '*criollos*' I am including three 'international guests': anthropologists Janet Chernella, Terry Turner and Fernando Coronil.

system in a way that upriver Yanomamɨ didn't. In the plenary, upriver interventions were comparatively fewer in number and shorter in length. Themes included reference to where they were from, the presence of *shawara* in their area, particular accounts of illness or suffering, the interest in coming to see what the whole gathering was about. Their requests were general pleas for increased exchange with *criollos* and down-river Yanomamɨ. Second, Orinoco Yanomamɨ could comment on the general direction of engagement with *criollos* and correspondingly on what should be discussed in the conference. Many of these propositions had a wide sense of 'the Yanomamɨ' in mind in contrast to upriver participants who generally spoke about their specific problems on behalf of their communities (cf. Ramos, 1998:128). Third, Orinoco Yanomamɨ, with their greater experience of *criollos*, were also assuming the role of mediators as 'cultural translators' representing *criollos*' ways and how *criollos* see the Yanomamɨ. These were elements of their speeches directed to the upriver component of the audience. To this we must add their more complete *criollo* attires, references to writing and ability to translate or speak directly in Spanish to *criollos* as reflections of their dual Yanomamɨ/*napë* being (see Chapter IV).

Fourth, Orinoco Yanomamɨ's speeches reflected the multilayered institutional politics. Debate of this nature was then a dialogue sustained mainly among Orinoco Yanomamɨ and comparatively irrelevant for upriver participants. Once *criollo* institutional representatives were present, some interventions were oriented to these *criollos* reflecting both institutional politics and fearless speech towards *criollos*. Finally, the ambience in the smaller health round table changed significantly. There were less people all sitting in a circle in one house. Greater intimacy and lesser publicity led to a) more upriver speeches, b) near absence of the inter-institutional politics of the plenary, c) the harsh criticism of doctors of the plenary was also significantly reduced, as was 'speaking without fear.' Upriver participants often recounted instances of suffering due to relentless *shawara* that *shaporis* could not curb alone, followed by requests to have doctors and nurses visit them; to have clinics nearer by; to be supplied with radios; to have nurses trained. The issue of Yanomamɨ suffering in the hospital in Puerto Ayacucho was also brought up by Orinoco Yanomamɨ. In general this ambience fostered more dialogue between *criollos* and Yanomamɨ as requests were heard and specific explanations as to the possibilities to address each demand were expounded.

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Having outlined some general features of the conference let me now highlight some of the discussions illuminating *criollo*/doctor-Yanomamɨ relations in the wider context of *napëprou* we have been exploring throughout the thesis. My extracts of the conference are largely, but not solely, taken from the health discussions.

VIII. 5. 1. The conference in the context of *napëprou*

Several statements by influential Orinoco Yanomamɨ indicate how the conference was a special opportunity to more precisely define the collective trajectory of an on-going 'becoming *napë*.' This historical moment was one where Yanomamɨ could directly negotiate their future with the *criollo* powers that lie beyond the Upper Orinoco whom they know can really have an impact on their lives. Let me cite two examples. The first is from the Mavaca nurse, a man regionally (Ocamo, Mavaca, Platanal) known for his nursing and political activities (at the time mostly associated with the AD Mayor). Early in the conference he recommended the audience:

> '..t^hë problema wayu ɨhɨ rë kë, thë wayu, weti thënɨ? Shawara a shiro ishotii. weti thënɨ? Pëmakɨ iro sɨkɨ ha titiopë pehi, pëmakɨ ihirupɨ napëpropë pehi ɨhɨ rë kë, hɨtɨtɨwë mihi t^hë nohi ta taeapotihe…pata pë iha t^hë ã ta hirakɨhe ɨhɨ rë kë. Yaurawë t^heri pënɨ t^hë taɨmihe, Sheroana t^heri t^hë taɨmihe…hɨtɨtɨwë pënɨ t^hë taɨmihe…'
>
> 'the problem is important you see. Why is it important? Because *shawara* is always attacking. Why is it important? So we can use clothes, so our children can become *napë*, you see, you have to think about all of this…You must explain this to the elders. The people from Yaurawë t^heri don't know, the people from Sheroana t^heri don't know [communities he is considering as 'far away' that don't interact much with *criollos*]…many people don't know…'

The Ocamo nurse is also known regionally for his politics (mostly associated with SUYAO and ORPIA). He recommended to focus on what would really solve their

health problems: training more Yanomamɨ health personnel. This he cast as part of a process with its own inertia:

> '…kamiyë pëmakɨ kopemou tëhë progreso t^hë ã rë kui ɨhɨ rë kë! pata kë pë: 'progreso' napë kahikɨ t^hë rë kui, napë urihi yoka hamɨ pëmakɨ huu waikiwë. Napë urihi yoka hamɨ pëmakɨ huu tëhë weti naha kamiyë pëmakɨ kuprou mai? pëmakɨ kuopë!…'

> '…when we prepare/train ourselves this is 'progress.' Elders: 'progress' is Spanish, we are already on the path/trail/way of the *napë*. If on the *napë's* trail why are we not becoming [nurses]? We have to be[nurses]!…'[175]

His emphasis is on a process already in motion putting the conference on an existing course, the continuation of a historical process. That 'progress' is explained as a trajectory along a trail is consonant with the notion of *napëprou* as historical transformation, for at least one way Yanomamɨ talk of the past is through their movement in the forest referring to the sites of old *shaponos*, gardens and events (cf. Rival, 2002:1). Travel elicits the telling of history; history can take the form of journey. It is fitting, then, that 'progress' is expressed as a trajectory.

Napë images (deceit)

Images of *criollos* as deceitful and non-trustworthy were deployed in different contexts. For instance, an Orinoco representative reflected on the Yanomamɨ *concejales* (municipal government) and their relation with *criollos*:

> '…hei pëmakɨ niya rë payerimarahei 'concejales' hei pë rë kui; ma pë pë nasi, pë pë ã haimi, pë rukëimi, mihi pëma pë nowa rë t^hawei mai. Pë rukëɨ ma kui napë pënɨ pë mɨrãmaɨhe, pë ha mɨrãmahenɨ t^hë t^hapramaɨmihe, einaha t^hë huu kuwë…'

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[175] A Yanomami translator helping me on this text gave me the general emphasis of the second sentence as 'we are already on the trail we cannot remain without studying.' The term *kopemou* he translated as '*preparando*,' 'training/learning.' The root *kope-* in its inchoactive form means 'to be finished/completed; to be ready' and refers to the completion of specific tasks like pulverising ashes, distributing game or sharpening arrow tips (Lizot, Unp.:179). It is then interesting to see this semantic broadening to include the whole process/task of education where 'completion' may be referring to 'completing education.'

> '…those were going to help us, '*concejales*,' these, they are liars, they don't speak, they don't enter/get in [with the *napë* government], with these we shall not speak/explain. They enter [the government] but the *napë* deceive them, once deceived they cannot work, this is how things are…'

Initially critiquing the Yanomamɨ *concejales* he concludes *criollo* deceit is responsible for the *concejales*' inefficiency. A similar conspiracy is evoked by an AD representative. He is also a nurse and vocal critic of the health system, mixing shared Yanomamɨ concerns with the Mayor's discourse:

> '… 'pata pënɨ medicina pë shimaɨmihe' pë kuu. Awei pë shimaɨhe porque yanomamɨ pëmakɨ oni waha rë kui todos a nivel nacional, todos a nivel internacional a hamɨ kihi motu pë urihipɨ hamɨ pëmakɨ oni waha pata huu piyëkou, huu piyëkou anɨ, aɨ napë pënɨ pëmakɨ payerimaɨ ohotehe, medicina a shimaɨ ma kuhei Caracas hamɨ kama t^{h}eri pë rë ohotamowei pënɨ t^{h}ë ka kahupraɨ pëtaohe…'

> '…'the bosses don't send medicine' say the doctors [in the Upper Orinoco]. Yes, they do send medicine. On behalf of the Yanomamɨ [in our name] at national and international level, to the land of foreigners [other countries] our name travels all over, because of this some *napë* want to help us, they send medicine but in Caracas, those who work [in Caracas? Or the Upper Orinoco?], they simply block it…'

Gow (2002:195) describes similar images of Amazonian river trader middlemen preventing the arrival of a flying steamboat of goods deployed by a prophetic Piro. In both cases, the speaker has, or claims to have, White knowledge (read/writing and extended travel) enabling them a privileged anthropology of Whites. Sangama, the prophetic Piro, stood in an equivalent relation to 'normal' Piro as 'civilised' interface Yanomamɨ stand in relation to upriver *waikasi*.

***Napë* images (concern)**

Doctors' real concern was also questioned in a series of personal experience accounts of illness and suffering. Recall from Chapters VI and VII the importance of the ethics

of care and the epistemological primacy of personal accounts. In combination statements of personal suffering and lack of concern were specially compelling on moral grounds, making the health system's critique particularly poignant and moving. One man angrily recalled an episode of poor response to an emergency situation criticising both doctors and Yanomamɨ health personnel:

> '…kihi a rë rorati La Esmeralda a rë përirië, radio a hamɨ ya nakaɨ ipa hariri pruka a kua ha ya hore nakaɨ, warë ã huaimi…ya hore nakapraraɨ…yanomamɨ ya pë kai hore nakaɨ. Kuami. hei ipa u rë kure ha ɨhɨ wenaha yamakɨ nomaa kurayoma? Pë ta hiripraahe! Pë ta hiripraahe!…39 yamakɨ nomarayoma…Ipa ihiru a mishia ha mrarɨnɨ, ya mɨa kai maroprarou tëhë, medicina pë kai huimamahe doctora hapa pë pë rë përɨoperei pënɨ…'

> '…That one sitting down [the HD was in the audience] that lives in La Esmeralda. I called [the doctor] by radio, my son was very ill so I called in vain, he didn't respond to my call…I called again and again in vain…I also called the Yanomamɨ in vain. Nothing. How many have died along my river? [Mavaca], listen! Listen!…39 of us have died…when my son's breath had run out [died], when I was crying/mourning, only then did the doctors that lived then [in Mavaca] come with medicine…'

Doctors finally arrived when the child had already died adding to the man's frustration. Mentioning the number of deaths along the Upper Mavaca was a crude reminder of the limited coverage of the current system. Recalling the grief and desperation of a child's death is powerfully evocative if we consider Yanomamɨ efforts to erase all trace of its occurrence.

VIII. 5. 2. Critiques and demands

Criticism from AD supporters was particularly harsh, also deploying images *criollos* unconcerned for Yanomamɨ. Doctors only come here to study us, to write books and theses. Doctors don't keep their clinic clean, they are unconcerned saying 'it doesn't matter, its for Yanomamɨ.' Because *criollos* only work for money they don't send us 'real doctors,' only students. The HD was accused of 'not working' and being money-driven.

The issue of medical students was a widespread critique among Orinoco participants. In Chapter VII we mentioned that medical students are recognised as trainees or people 'who don't know,' sometimes likened to *shapori* apprentices others to false *shaporis*, but always distinguished from 'graduated' doctors. Demands for real doctors took several forms:

> '…taɨmirëwë pë rë kui pë shimaɨ tikotihehe!…shawara a nohi rë ɨhɨpɨpou rë [?] totihiawehei, mihi pë yai ta shimahe!…'
>
> '…don't send people who don't know [the expression added the sentiment of 'which is lamentably what happens now']…those who know/recognise *shawara* well, these are the ones you must send!…'

Or

> '…doctor [Regional Health Director] iha hei tëhë pëmakɨ nakou. 'Graduado' pë ãhã rë kure, mihi mai. Kamiyë pëmakɨ ihamɨ tairëwë t^{h}ë ha taahërɨhenɨ, pë korayohërɨ, pëmarëkɨ nohi t^{h}apou taomi, pëmarëkɨ nohi t^{h}apou taomihe, doctor yai pëma a nakaɨ…prewë hɨtɨtɨwë hamɨ Mavaca, Platanal, Ocamo pë përiopë…'
>
> '…let us request [doctors] from the Regional Health Director. Not those they call 'graduated.'[176] They come to us, when the learn, they leave [to their homes], they don't care for us [the expression might be conveying that they either they don't know how or don't usually do it], they don't care for us. Let us request a real doctor…they will live all over in Mavaca, Platanal, Ocamo…'

In the first statement students are characterised as unable to recognise *shawara*, in the second case the fact of 'not caring' is linked to the transience of the students' stays in the area (Chapter II). The former example points to a lack of *criollo* knowledge, the latter to the Yanomamɨ morality of permanent co-residence, reflecting the moral (Yanomamɨ)/knowledge (*criollo*) combination constituting good doctor performances.

[176] The speaker here seems to have confused terms in Spanish. 'Graduated' doctors is precisely what he is asking for, while the description he gives of those he doesn't want is of students.

Perhaps the most frequent demand, besides sending 'real' doctors was the increase of Yanomamɨ health personnel – nurses and microscopists. Many, after having their say about the health system, ended with this request suggesting different numbers for each Yanomamɨ area. The upgrading of clinics and doctors' houses was also mentioned. Finally, specially among upriver participants, the expansion of health services into deeper hinterlands was an emphatic demand.

The emphasis on Yanomamɨ personnel comes as both a recognition of *criollos* inability – intentional or not – to solve Yanomamɨ health problems and a desire to manage the benefits of bio-medicine in their own terms. On the one hand, a dependency on *criollo* bio-medicine is recognised given the relentless force of *shawara*. Consider this Ocamo speaker – at the time already seven months with no resident doctor.

> 'Doctor pë kuami ha kamiyë pëmakɨ iha…pëmakɨ prewë puhi horihou! ɨhɨ weti ha? Yanomamɨ shawaranɨ pëmarëkɨ sheɨ nɨ motaɨ ha…ya puhi horihou.'

> 'We are extremely inpatient/worried because there are no doctors with us! Why? Because *shawara* is tireless in killing us…I am impatient/worried.'

On the other hand, dependency is balanced by an aspiration of autonomy achievable through self-management with nurses/microscopists. In short, this was a critique of the present as well as an indication of future direction. In wider picture, this combination of strong critique whilst thoroughly embracing the health system epitomises *criollos*' potential affine status: necessary enemies.

A final word on content. Several regionally known Orinoco Yanomamɨ were consistent in recognising a period of change in the balance of the relationship between Yanomamɨ and *criollos* and appealing on the audience to follow suit. The Ocamo nurse blamed the Yanomami themselves for 'not preparing ourselves' reflecting a more balanced relation with *criollos* who then are not solely responsible for health problems. Another SUYAO representative explained that they should not only 'request, request' from the coming officials but should also show they could give their own contributions. An AD leader explained, how in the past, Yanomamɨ were

unaware/oblivious/gullible (*mohoti*) but nowadays several Yanomamɨ – he named a list of politically influential Orinoco Yanomamɨ – were learning/smartening/alert (*moyawëhërɨɨ*). All these statements point in the direction of balanced and equal status: more capable of managing our problems, more experienced with *criollos* and balancing exchange relations hints at a shift from a paternalistic imbalanced relation, to one where Yanomamɨ can negotiate with *criollos* on more equal terms (cf. Hugh-Jones, 1997).

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We have outlined some of the features of the conference and the general critiques and aspirations in health terms. We will now comment on the flow of the discussion for it illuminates the tension between internal division among Yanomamɨ and solidarity in opposition to *criollos*, an equivalent tension to that described in Chapter VI in local Ocamo meetings but more complex due to the relevance of Upper Orinoco's multilayered politics.

VIII. 5. 3. Three dialects

Focus and effective speech

In health and other discussions there were critiques of both *criollos* and Yanomamɨ on different accounts. But these debates were intercalated with appeals to concentrate on the really important problems. Initially one organiser warned the audience not to deceive/trick each other (Y. *nasi himayou*) and to speak proper/direct/straight (Y. *shaririwë*). The next speaker made a long sequence of criticisms including doctors, Yanomamɨ and other *criollos*. He was followed by another organiser who again appealed to focus the discussion: 'doctors are not reaching some parts of our land, this is what we need to direct/properly demand (Y. *nakɨmaɨ*)…lets not mix up our words (Y. *ã heshiaɨ*).' This was one interplay between dispersal and focus seeking the effectiveness of 'proper speech.' We return to the performative: proper speech will influence others, dissolving differences in favour of a Yanomamɨ collective. After all, the point was to make an impact on *criollos*.

Yanomamɨ – *napë* opposition and beyond

An initial flow of criticism of doctors and *criollos* was broken by an Ocamo representative suggesting Yanomamɨ were co-responsible for their own health problems: 'Why are there no doctors in Ocamo? Ocamo is really bad now, why? Its our fault because of theft; disrespect! We don't respect the doctors…if we respect them [respect for property, that is], they will live well and tranquil and visit the communities…' A newly-trained nurse continued what was seen as a 'defense of the doctors,' asking how they could work in appalling houses and clinics; criticising theft; countering claims that people were sent who didn't know about medicine. Several then criticised the nurses, who were also unwilling/lazy (Y. *mohi*); didn't visit the communities as they should; were also money-driven, spending their time in Puerto Ayacucho and who, as trained nurses, turned their attention to politics. All these criticisms reflect the difficulties of adopting a generalised institutional relation to all Yanomamɨ. Nurses defended themselves and others appealed to Yanomamɨ solidarity not attacking each other and directing their efforts towards *criollos* instead. This was a second interplay: criticism, counter criticism and fusion in opposition to *criollos*. Several Orinoco participants argued beyond this opposition and its typical accusations emphasising the necessity of working together as a team, doctors and nurses alongside each other.

The call to overcome the Yanomamɨ – *napë* opposition is again symptomatic of the balancing of power relations with *criollos*, now in the form of co-responsibility and collaborative work, the recognition of faults and contributions on both sides that need to be harmonised to address the health issue.

AD and Opposition, indigenous and party politics

The third dialectic, between AD Mayor representatives/supporters and the 'opposition' was superficially impinging on Yanomamɨ mutual criticism during the health debate. It was in the Education and Political Participation themes where this division permeated most. A debate between an inter-cultural and a more Venezuelan-style model of education reflected the conflict the Mayor sustains with Salesians. A debate between retaining the current multiethnic municipality or demanding a new

mono-ethnic and Yanomamɨ-run one ended in a measure of support as leaders from each side apparently agreed to challenge each other to a kind of mock vote. Two long queues of 'fors' and 'againsts' crossed the central plaza with people of all ages being recruited to one or another line. The commotion climaxed when the Mayor's supporters realised the opposing queue was clearly longer and broke down leading the 'Yanomamɨ municipality' supporters to rejoice, circling the plaza in festive manner.

This on-going debate, for which the conference provided a forum, pits opposed partisans involving local and regional institutions. On the one hand ORPIA, SUYAO and Salesians, on the other the AD supporters. The AD Yekuana Mayor has little interest in supporting a Yanomamɨ municipality for he would lose control of the region. His supporters then argue (broadly) that what they have is already good for them and that it is the Salesians who, through the new municipality, are seeking to tighten their grip over the Yanomamɨ. Now, the new municipality is a possibility only because the municipalisation that ensued from Amazonas' rise to statehood was legally revoked in 1995 and new political-administrative boundaries more in-keeping with the ethnic distribution are pending.[177] ORPIA, who championed the legal challenge, counts this among their successes and has a proposal that includes a Yanomamɨ mono-ethnic municipality. This link bridges the sphere of indigenous organisations (regionally ORPIA and locally SUYAO) and party politics (AD) making these institutions competitors in the Upper Orinoco decision-taking arena.

The opposition between ORPIA and AD was evident on the final day when the ORPIA co-ordinator (Kurripaco from Puerto Ayacucho) addressed the audience in an institutional presentation. One by one he listed SUYAO Yanomamɨ representatives who stepped forwards for the sitting crowed to see. From the audience AD representatives vehemently requested that they too wanted to present themselves, it was unfair to only give stage to ORPIA/SUYAO people. A heated and jumbled discussion ensued which led to nothing besides letting each group know the other's willingness to contest decisions affecting the future of the Upper Orinoco.

[177] Statehood was granted in 1992 yet it was only by 1994 that the law delineating the new political divisions of the state in seven municipalities was approved, despite mounting opposition from ORPIA. In February 1995, the law was revoked by the Supreme Court (Bello, 1995:23-24).

VIII. 6. *Discussion*

As with the Ocamo meeting or the Esmeralda protest, the Mavaca conference exhibits the negotiation of an 'us' position of solidarity, making 'community' or making 'the Yanomamɨ.' These makings are in dialogic relation to *criollos* whose innate qualities of deceit, lack of concern, and resisting of Yanomamɨ desires are all rehearsed before reaching agreements on what to do with a doctor, the ambulances or a 'general way forward.' 'The Yanomamɨ' is by no means an easily-created, supra-local sense of similarity; internal differences of diverse nature are intentionally obviated as the three dialectics we discussed show. Relations that separate Yanomamɨ amongst themselves – regional, up/down-river, party political differentiation and antagonism – are painstakingly expelled to collectivise 'Yanomamɨ' against *criollos*.

I want to highlight the relative absence of key words like 'culture,' 'identity,' 'rights,' in the events described. This discourse was limited to aspects of interventions by some of the most experienced spokespersons. The overwhelming majority of health-related claims were cast in terms of the specific historical relation between Yanomamɨ and *criollos*. The key points were the 'morality of being human' and the consequences of 'becoming *napë*.' *Criollos*, known to posses unlimited resources and powerful knowledge, must share and not be stingy to reduce suffering. The *criollo*-originated spread of *shawara* gives *napëprou* a character of irreversibility 'we are dying out (Sp. *acabando*)' some say, 'how can we multiply/grow in numbers? (Y: *paraɨ*)' some ask. Yanomamɨ bodies have 'become *napë*' with *shawara*. This historical condition frames demands for more nurses, microscopists, health promoters, radios, clinics, doctors, as the only way forward to continue making 'becoming *napë*' a worthwhile trajectory.

The important gradient of difference, the extent to which Orinoco Yanomamɨ are 'becoming *napë*' in relation to their upriver counterparts, means that felt problems will seek redress on a mixture of terms. Here we must distinguish Orinoco Yanomamɨ, and among them, a few more experienced leaders. The latter are true cultural commentators with a 'wider view' enabling them to not only locate themselves in a historical process with multiple Yanomamɨ and *criollo* agents but also recommend which path to follow. Their privileged perspective furnishes them with

the network-like sense of the ‘*napë* transformational axis’ beyond the socio-centric sense of the ‘Yanomamɨ conventional space.’ They are also aware of ‘Yanomamɨ’ as the object of national and international attention and the interest of different institutions in their health, culture, environment, etc. All these aspects of Yanomamɨ life become objectified topics of debate subject to negotiation with *criollos*. As has been commented in the context of indigenous identity politics (Jackson, 1991; 1995; Hugh-Jones, 1997; Turner, 1991, Ramos, 1998, Albert, 2000) these leaders, seeing themselves as agents of a negotiable relation with *criollos* signalled by a discourse of ‘awakening,’ ‘collaboration,’ ‘co-responsibility,’ ‘request solutions but also give them,’ ‘progress,’ are speaking the language of political ethnicity rather than cosmological alterity (Albert, 2000:242), a passage nicely resumed in Turner’s (1987) phrase ‘from cosmology to ideology.’

In our thesis’ terms this amounts to a critical change in what is considered innate and what is open to human agency. The deliberate negotiation of a way forward, the general objectification of what being Yanomamɨ is and what it should be, are attempts at ‘making convention.’ However, like the artificial clinic conventions we discussed in Chapter VI, in everyday circumstances involving Yanomamɨ in places like Ocamo or upriver communities, these artefacts are confronted with the innate conventional relation to *criollos* subsumed by ‘potential affinity.’ Leaders are caught between guiding engagement with *criollos* through establishing convention – a move welcomed by *criollos* – whilst at the same time maintaining the potential affine status of *criollos* – closer to ‘lay’ Yanomamɨ expectations.

The language of constitutions, rights, ethnicity, environmentalism and multiculturalism should become more common as the morality of the modern multicultural nation state blends with a ‘morality of being human,’ the latter remaining for longer the terms on which upriver Yanomamɨ will describe their situations and pose their claims.

VIII. 7. *Commitment, concern and wait*

Emphasis on continuities with the everyday should not obscure important differences. We have stressed here the multilayered political arena as distinguishing collective

multi-institutional meetings. Another is the shift in Yanomamɨ's ability to manage *criollos*. In general encounters with higher officials leave behind more commitments than *criollos* can usually actualise. No ambulances, for example, were given to the Yanomamɨ.[178] My contacts with doctors and the new HD indicate that little progress had been made in transforming the Mavaca health demands into nurses, coverage, or radios; on the contrary, an unusually long spell of medical supply shortages was seriously affecting stocks in rural clinics. A compelling letter from a conference participant arrived in Puerto Ayacucho from Hokotopɨwei tʰeri – considered a 'distant' community:

> '[opening greetings]… Look doctor [RHD], remember that you committed yourself to provide a microscopist course, I am waiting [Sp. *pendiente*] for you in here in Hokoto, when is my course going to happen? I am concerned [Sp. *preocupado*] because there is no medicine this is why I am giving this information. But when are you coming for me, I am tired of waiting here in Hokoto. Look doctor, speak with Dr. [regional epidemiologist] on my behalf…so I can study to be a microscopist, I'm in a hurry. That's it, nothing else. [closing formalities] '[179]

This letter arrived *via* a doctor that went to Hokoto in January 2002 responding to news of several deaths in this community. The letter is telling in its reiteration of key words that characterise the relationship with powerful *criollos* mediated by meetings with state officials: 'commitment'; 'concern'; 'wait.' In contrast with their local experience of effectively managing doctors and students, the structural inequity of Yanomamɨ, indigenous peoples and a large sector of the Venezuelan population comes as Yanomamɨ's decreased capacity to manage those who have the power to make large scale changes. 'Commitment,' 'concern,' and 'wait' encapsulate a cycle of powerlessness perpetuating the deceitful and unconcerned nature of *criollos*.

Concluding remarks

This cycle of 'commitment,' 'concern' and 'wait' must lead to reflection. Efforts to foster 'community participation,' grasping 'indigenous perspectives' by state officials

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[178] This was the case a year afterwards.

addressing Yanomamɨ health and other problems are, in principle, necessary steps towards the design and implementation of policy. However, these efforts, inasmuch as they perpetuate a pattern of raising and frustrating expectations, defeat their own purpose. The short time state officials allocate to their visits precludes true dialogue promoting the 'commoditisation' of solutions rather than the joint search for long-term policies with a general impact. This is significantly absent in state-Yanomamɨ encounters. In the Yanomamɨ Health Plan meeting in Puerto Ayacucho, Yanomamɨ were more talked about than talked with. In the Mavaca conference doctors were more talked about than talked with. What is needed is longer-termed dialogue.

On the other hand, state officials, laws, international agencies, anthropologists and indigenous organisations all agree on the necessity for 'community participation.' We would be misled, however, in thinking it will immediately ensure an improvement in the functioning of the health system. More Yanomamɨ and less *criollos* certainly eliminates a number of problems we have discussed throughout, but it emphasises others. The negotiated and contingent group considered 'us' that substitutes, in reality for our fixed notion of 'community' impinges on Yanomamɨ decisions and forms of action in ways that may fall short of planners' expectations of 'community service' (cf. Conklin, 1994:183). Again, a constant dialogue sensitive to the evolution of operational policies must be a necessary companion to the occasional state-Yanomamɨ encounter if 'community participation' and 'indigenous perspectives' are to yield successful policies.

Let me tie up some of the insights of this chapter with others thus far discussed. First, consistent with our discussion of the 'fit' of bio-medicine and shamanism, the requests from the Mavaca conference indicate the correspondence between *shawara* and bio-medicine. Yanomamɨ seem little concerned about the imposition of bio-medicine or the need to strengthen traditional medical practices; a justified preoccupation of state officials and other institutions (e.g. Direction of Indigenous Affairs, Ministry of Health, Pan American Health Organisation).[180] Yanomamɨ have a

[179] The letter is in Spanish I have slightly corrected the grammar of the original for comprehension.
[180] For example during the discussion of the Yanomamɨ Health Plan, the Direction of Indigenous Affairs was critical of a draft document for being too medically oriented not sufficiently considering Yanomamɨ perspectives, in particular 'traditional medicine.' Pan American Health Organisation's Health Initiative for Indigenous Peoples launched in 1993 counts among its principles 'respect and

place for bio-medicine and its practice and demand that place be filled appropriately given the spread of *shawara*.

Second, the *criollo* interpretation of Yanomamɨ performances that strategically obviate elements of their dual being as false theatricality reveals a difficulty with Yanomamɨ 'dual features' we have already come across. In this Chapter II we discussed the image of the naturalised Indian whose change is seen as degradation, a 'loss of culture' rather than a progression-transformation closer to Yanomamɨ's own self-evaluation. In chapter VII we saw the difficulties with 'believing' in both shamanism and bio-medicine. All these run counter to a *criollo* emphasis on essence: either one is or is not, to be both is either inauthentic or irresponsible or simply bewildering. But as Brown has noted 'the most successful new leaders master arts of persuasion appropriate both to native society and to the nation-states in which they reside, taking up one and dropping the other like a change of clothing' (1993:312). The metaphor of 'changing clothes' is an apt one indeed. It is this double constraint of the inter-ethnic situation that goes hand in hand with the necessity of constant differentiation against 'real Yanomamɨ' and 'real *napë*' which both makes *napëprou* significant and can achieve *criollo* planners' aspirations of a successful integration of medical systems.

In this chapter we have examined direct state-Yanomamɨ relations through the meetings they sustain, illuminating how, when regional and national processes are taken into account, Yanomamɨ lose their control over *criollos*. At this point Yanomamɨ's political management of *criollos* becomes intertwined with the politics of state institutions and, within that, is confronted with the structural position of indigenous people within the nation-state. Our next chapter will continue in this direction examining important limitations of the health system that fall beyond the power of both Yanomamɨ and rural doctors. In focusing once again on the health system itself we return to an ethnography of the system, and through it, a picture of Yanomamɨ's and indigenous people's structural place within the nation-state.

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revitalisation of indigenous cultures' (PAHO, 1998:12). The Ministry of Health is working on the defining an inter-cultural health policy sensitive to the existence and integration of indigenous healing practices (Rivero, *et al* 2002).

Chapter IX: The health system: internal organisation and regional context

Our closing chapter complements our analysis embedding the local health system within the wider structure of the regional administration and other institutions supporting the delivery of healthcare. I will focus on the Health District's lack of technical-administrative autonomy and how strong dependency on higher regional levels curtails its resolutive capacity. This contributes to the system's inefficiency and the fostering of rifts between a) Yanomamɨ health personnel and *criollo* doctors and b) between the operative level and the regional administration. Addressing some of the causes of these limitations, the centralised nature of the Amazonas health administration, together with its regional point of view, are explored. Beyond centralisation, some connections with regional and national economic and political processes are discussed as factors hindering appropriate responses to the critical Yanomamɨ health situation. Finally, a brief discussion of the draft of the new health law and the Yanomamɨ Health Plan closes the chapter, offering insight into the reform of the Venezuelan health sector as well as the state's new indigenist policies as reflected in the relation with the Yanomamɨ.

Lack of space poses an important limitation on a more in-depth analysis of the network of people and information linking the operative level of the health system with regional and national processes. High sensitivity in a politically volatile area has also dissuaded me from a more thorough analysis of inter-institutional relations. A critical analysis of the Venezuelan health sector and its historical relation to economic and social policies of the state and global economic forces, whilst enriching, falls beyond the scope of the thesis.

This chapter has, however, a practical orientation focusing on organisational issues that need be revised to address the Yanomamɨ health situation. In doing so we depart from Yanomamɨ's political management of *criollos*, entering the field of *criollo* institutional management of Yanomamɨ healthcare, substituting the politics of the Yanomamɨ for the policies and politics of the state.

IX. 1. *Health Districts and their lack of autonomy*[181]

Underlying many of the problems doctors and Yanomamɨ face within the health system is the strong administrative dependency of the local operational level on the regional and national levels within the Ministry of Health. Considering the local health system as a process of delivering healthcare personnel and resources, strong dependency entails a lack of control over key components of this process, resulting in doctors, nurses, microscopists and HD limitation to run the system as ideally envisaged (see Chapter I). In this context, then, it is not only Yanomamɨ who want more control over the local health system, but the *criollo* component of the system too. The one cannot be achieved without the other. Let me break down the multiple problems that stem from this dependency.

IX. 1. 1. Chronic infrastructure and resource limitations

In October 1996 rural doctors and the then HD drafted a letter aimed to make public the severe limitations they were encountering trying to do their jobs and the frustration with the Regional Health Direction's (RHD) unresponsiveness. They spoke of acute gasoline shortages; several months without motors – all broken down waiting to be replaced or repaired – some medicines supplied didn't match the existing needs and other indispensable medicines were lacking; clinics and doctors' houses were too deteriorated; missing electric plants, water pumps, fridges and radios curtailed the proper tending of communities; vaccination campaigns in 'distant' communities had been incomplete.

In October 1999 the then HD directed a letter to the RHD detailing a situation I resume: insufficient fuel for all the rural clinics; insufficient motors and bad state of those being used; no fixed contracts for microscopists, motorists, and workers (cleaning, cutting grass); no food for patients kept in the clinics for treatment; inadequate supply of vaccines and medicines. The HD also noted RHD's lack of response.

[181] Many of the problems discussed in this chapter affect not only the Upper Orinoco but all the health districts in Amazonas.

In May 2002-3 a rural doctor and the HD spoke in similar terms, in fact, things appeared 'worse than ever,' shortage of medicine, gasoline, inoperable radios and fridges for vaccines, a newly constructed rural clinic lacked running water…

Shortage and inadequacy of resources remains an unresolved and chronic problem (see Rodríguez Ochoa, 1992: 419 who notes this is characteristic of Amazonas as a whole). Even when, during my stay, I witnessed little in terms of lack of medicines,[182] and there are new gasoline tanks in each health posts and a new boat to transport fuel from Puerto Ayacucho, different posts were temporarily 'immobilised' lacking fuel. Even though substantial amounts of vaccines were flown in to the area they were insufficient to cover even the 'intermediate' communities assigned to each post, not to speak of those beyond. Recently installed solar powered systems for vaccine storage were inoperable, salaries for microscopists, motorists and other workers were unstable.

Beyond the gravity of an alarming health situation being met by a continuously under-resourced system, there are other implications. One set affects rural doctors in the field. Poor infrastructure makes living and working conditions overly harsh. Doctors quickly feel 'abandoned' and frustrated, unable to do their jobs properly and sensing no apparent concern from the RHD. Rural doctors are often critical of the RHD, speaking of it in terms of incompetence and neglect, not feeling themselves part of a system they begin to despise. Some fend for themselves besides frustration, some quit, and others fall into complacency citing these limitations as excuses for a poor service. Under-resourced and 'abandoned' students who could return as rural doctors are put off by their experience. Other doctors who enjoy working with Yanomamɨ are dissuaded, feeling 'alone against the world,' powerless to change things.

[182] I remember periods when antibiotics were scarce but never totally lacking, or situations where adults had to be treated with paediatric formulae. If specific medicines were lacking in one post, another would send the required amount by river. Occasionally I would hear doctors arriving and commenting on the completeness of the pharmacy in comparison with other rural clinics they had seen in other parts of the country. It is also important to mention that, given that he was a paediatrician, the HD had particularly pushed in the RHD for the supply of highest quality 'third generation' antibiotics and other medical supplies (e.g. special rehydration solutions) specifically oriented for diarrhoea and respiratory infections. Some students were surprised to find such sophisticated medicines in these rural clinics. Shortages of important though not essential medicines like pain killers or products for skin diseases were also infrequent.

For the HD the situation is no better. Dependency on Puerto Ayacucho means s/he spends valuable time and effort battling his/her way with the 'regional level' to secure the resources for the health district. Consider this HD's description of making medical supplies reach the Upper Orinoco:

> '…in general terms, all that I think I need to request I multiply by a factor of 5 or 10 so they send something reasonable…we have tried to change this…but it has been impossible…on the other hand, if you are not there personally moving things in Ayacucho, going to the medicine deposit, write the request, oversee that the RHD signs it then go back to the deposit…give a little tip to the men in charge there…and then beg for a car [to haul the medicine to the airport]…then go to the air support office [in the airport] if the GN are doing the transport and fight with the GN in charge, explain that this is medicine for the poor Yanomamɨ…[all this] because there is no linking office or unit of logistics in Puerto Ayacucho. What does that mean? That no one fully assumes, not even superficially assumes, the role of sending supplies for the health districts of the interior…it's the same for [other health districts]…Another issue…is that I have 6 AR II and 11 AR I rural clinics: Rio Negro is one AR II, Maroa is one AR II, Atabapo is one AR II, Manapiare is one AR II and a few AR Is. Here we have 17 rural clinics, so when my request reaches them, and they compare it with the rest, they say 'gee! These guys ask for too much medicine' so then they cut it down to the demands of the other districts...This is one of the things that has most affected me, supplies. Because they don't understand that my request has to be different [in size]…'

This is just one of the processes that takes up a HD's time because the health district also needs fuels, vaccines and continuous spare parts and reparations, etc. The HD must balance his/her act between pressing the upper levels to perform, but not being too critical or forceful lest the relationship breakdown and processes become insurmountably cumbersome. An HD spends most of his/her time and effort keeping the districts' head just above water line, if not occasionally drowning, having less time to oversee the work of rural doctors and maintain feedback with Yanomamɨ, for which s/he will be criticised by rural doctors, missionaries and Yanomamɨ. The HD post offers a fast track to frustration.

IX. 1. 2. Administrative dependency

The health district's dependency is also administrative. One of the most relevant implications is the inability to secure salaries. Elder Yanomamɨ nurses (4) are in the Ministry's or regional government's payroll, their salary is unproblematically deposited in Ayacucho bank accounts. Microscopists and motorists on the contrary have for several years had no stable income. No single institution – local government, Malaria Office, Ministry of Health – has assumed the responsibility for this personnel for more than months or a year at a time. Newly trained nurses had no contracts when they graduated.[183] An important limitation in this respect is the Ministry's reluctance to enlarge its already vast payroll. According to an RHD ex-administrator, new fixed posts require the retirement or payment of severance debts to existing personnel to make space for new people whilst retaining the payroll size.

Yanomamɨ health personnel is then constantly working in uncertain circumstances. The HD was constantly trying to secure their salaries from different entities whilst promising payments that were constantly delayed. A cycle of persuasion and unfulfilled promises left the HD with little credibility among Yanomamɨ health personnel. Correspondingly their morale is often low; *huyas* are put off from working for the health system; *criollos* deceitful nature is ratified. It was also easy to cast doubt on the HD's concern and some influential Yanomamɨ would criticise him for 'stealing personnel's money' or 'being money-driven.' Relations with rural doctors are also affected because these – variably sympathetic to microscopists' circumstances – normally expected microscopists to work even if not paid, feeling it was 'in their own community's interest,' compounding notions of Yanomamɨ as irresponsible.

In these circumstances rifts of distrust are widened between doctors and the HD and between the latter and Yanomamɨ personnel. Working negotiations are continuous, generating cycles of harmonious work, reluctant work, criticism and lack of interest on the Yanomamɨ side. All this constitutes a local version of the 'commitment,'

[183] At least until March 2002 (8 months after completion of their course), there was no contract for these two *huya* from Mavaca and Platanal who then had to spend time and money travelling to Puerto Ayacucho pressing different institutions – RHD, regional government (G*obernación*) – begging for a contract.

‘concern’ and ‘wait’ pattern of state officials’ relation to the Yanomamɨ (Chapter VIII).

Looking at the wider picture of the health system’s operation, its ever-changing front end (Chapter II), its inability to secure regular flows of resources, a pattern of persuasion and frustration, it is now the health system’s structural inconstancy – rather than Yanomamɨ’s – that feeds into Yanomamɨ perceptions of *criollos* as non-trustworthy and unconcerned enemies.

It is noticeable that several established Yanomamɨ nurses and microscopists have taken to party politics. Three of the four elder nurses and one of the three working microscopists along the Orinoco had been heavily involved in party politics for different lengths of time.[184] There are several factors I cannot explore here leading to this shift of attention. What we can highlight is how this reflects what we have described throughout the thesis, that healthcare is highly politicised, combining Yanomamɨ interest in the management of *criollos*, and inter-institutional rivalries in their interests over, or obligations to, the Yanomamɨ. Through healthcare Yanomamɨ representatives can advance community demands with the legitimacy of both Yanomamɨ and *criollo* institutions. Through healthcare, institutions such as missionaries or the municipality have historically legitimised some of their interventions among the Yanomamɨ (cf. Alès & Chiappino, 1985). In the context of ‘becoming *napë*’ and ‘civilising’ or ‘making society’ among the Yanomamɨ, healthcare has been a privileged articulating hinge.

Administrative dependency also translates into a lack of control over the training of nurses posing constraints in meeting Yanomamɨ demand for this personnel. First, training involves a six-month course held once or twice a year in Puerto Ayacucho with a limited student intake that must satisfy the nurse demand throughout Amazonas. Second, the course is held in Spanish and requires a minimum of 6th grade education meaning that the majority of Yanomamɨ, who live beyond permanent mission schooling, are automatically excluded. The demand for Yanomamɨ health

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[184] At least two of these, however, were already prominent in indigenous fora before the advent of party politics.

personnel requires the parallel expansion of some sort of education service, an adaptation of training courses.

Summarising, administrative dependency, on its financial side, is detrimental to more harmonic relations between Yanomamɨ and *criollo* personnel. In terms of increasing Yanomamɨ participation in the system, its limited capacity to train health personnel leaves the HD and RHD and the Yanomamɨ themselves with little ability to meet the recognised demand (again Rodríguez Ochoa, 1992:419 highlights this as an Amazonas-wide issue).

IX. 1. 3. Diagnostic and treatment resolution capacity

The Health District also has important diagnostic limitations. Although infrastructure planned to contain a clinical laboratory exists in La Esmeralda, it has never been operational, particularly lacking specialised personnel.[185] Blood, stool, sputum, and other para-clinical tests that aid correct diagnosis and treatment of infectious diseases, are all but impossible without sending samples to Puerto Ayacucho. In the absence of an operational 'cold chain,' vaccines must be sent in coolers from Puerto Ayacucho, constraining coverage in the area to the time vaccines remain effective in melting ice. Finally, patients requiring oxygen and blood transfusions require referral to Puerto Ayacucho in the absence of oxygen canisters in the AR IIs and transfusion facilities in La Esmeralda. The local capacity to diagnose malaria is perhaps the greatest improvement in this respect. There have been periods during the late 70's early 80's when Upper Orinoco blood samples needed to be sent to Maracay (north Venezuela) for diagnosis, a response arriving weeks later if it ever did (Fuentes, 1983:68). Nowadays Yanomamɨ microscopists are essential in early diagnosis and treatment of malaria and may be counted as co-responsible for the reduction malaria incidence along the Orinoco since 1995 (Dr. Magris pers. comm.).

[185] This centre was to have three lines of action: a) collection, processing and storage of samples for applied bio-medical research; b) training of local health personnel; and c) assistance through an indigenous Centre of Health that would have higher resolution capacity than an AR II rural clinic. The

Thus far we have explored the health districts' constraints within the health system, we will now comment on inter-institutional dependencies between the health system and other institutions with a supporting role in the delivery of healthcare.

IX. 1. 4. Inter-institutional dependency

The armed forces, normally through the National Guard provide important air support (helicopters) needed to visit Yanomamɨ communities classified as 'of hard access,' in the event of epidemics and occasionally in vaccination campaigns. Throughout the years this support has been variably reliable. I witnessed calls for response to news of deaths or presence of gold miners tended quickly. I also remember waiting for several weeks in response to another emergency call. I vividly recall a high-ranking military official committing the GN helicopter for a sizeable post-Mavaca conference and vaccination operation. The helicopter never came, the visits were never made. In short, to visit 'distant' communities, the health system relies on the military and is subject to its priorities which are not solely determined by Upper Orinoco's health requirements – or those of anywhere else for that matter. Ideally, the municipality could collaborate with the health system, providing salaries for Yanomamɨ microscopists and motorists. It should also invest in the maintenance of waterworks and garbage disposal in places like La Esmeralda. However, as mentioned in Chapter I, the municipality has fallen short on these agreed commitments.[186]

A third, more informal co-operation is with the Salesian missionaries. Ever since doctors began to take over provision of primary care (1985), Salesians have served as logistical backup. Salesians have more stable gasoline supplies and maintenance capabilities on which doctors often rely for responding to upriver calls for help. The mission's radio is also used daily by students to communicate with relatives and is a backup when the clinic radio is disabled. Occasionally the mission provides short-term roof for health-related personnel. Finally, missionaries, the only permanent non-

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implementation of this plan has suffered from the characteristic policy discontinuities of the region, the Centre of Health was finally inaugurated in 2001 but runs as a rural clinic.

[186] These were obligations contracted through an agreement with the RHD signed in April 2000. The involvement of local governments in implementation of health measures is also consistent with the general decentralisation strategy of the health sector as outlined in the draft of the new health law (see below).

indigenous presence, often become important company for doctors, sharing their concerns and criticisms and providing emotional support.

This is far from an ideal circumstance for missionaries always critical of the health system's inability to set up a logistically independent operation. Missionaries are generally sympathetic to rural doctors' problems but consider their ongoing support allows the RHD to leave logistical problems unjustifiably unattended. In general solidarity in the field is fostered by the recognition of rural doctor's powerlessness and the often pressing health circumstances. But this itself fosters criticism of, and accusations towards, higher levels whose actions and diligence are invisible to those in the Upper Orinoco.

Chronic shortages, recurrent dramatic episodes and the invisibility of higher level efforts foster the bypassing of the system's internal mechanisms of communication, creating tension between levels within the health system. A situation in late 2000, as described by a rural doctor, is exemplary. By late November she had run out of pain killers and anti-inflammatory remedies. She was also close to running out of antibiotics for the treatment of respiratory infections that had already brought two babies to the clinic, both dying in the midst of treatment.

> '…we went one day to the mission…we tell them [missionaries] / I was already angry / ah! we had radioed the HD who was in Puerto Ayacucho 'Look…we don't have one Acetaminophen, we only have three Ampicillin ampules' we had three ampules of Ampicillin and one hospitalised girl with pneumonia…then [HD speaking] 'there is no medicine because the request [for medicine to local distributors of medicine] / – it was already December – 'the pharmacies are closed' – you know the deposits that distribute medicine in Ayacucho – 'they are closed. I think they didn't make the request [on time]. We have to wait for January.'

Missionaries encouraged them to continue radioing or write a formal letter to prompt a response. She continues with reference to her call to Puerto Ayacucho:

> '…its very easy to say [that pharmacies are closed] because he is not here. The Yanomamɨ are not telling him every day 'give me medicine, give me medicine.' So then [HD] in Ayacucho, in Ayacucho, in Ayacucho doing I don't know what; in the end I didn't know what he was doing in Ayacucho…'

Recall the HD needed to personally overlook the sending of supplies to the Upper Orinoco. But from the perspective of a doctor with a hospitalised child, the HD's time in the capital becomes a waste of time and disregard for her and Yanomamɨ's plight. Her drama and his invisibility create the condition for the conspiracy theory: he is doing nothing – and neither is the RHD.

Throughout our thesis we emphasised Yanomamɨ's intrinsic distrust of *criollos*. But the system's inconstancy also fosters distrust and disregard within itself, contributing to sustain images of incompetence and backwardness in the minds of urban middle class doctors and students regarding Amazonas' administrative structure.

IX. 2. *Causes and responses*

An exhaustive analysis of root causes for health districts' dependency goes beyond the scope of this thesis; we can instead shed light on some of the issues people within the health system refer to themselves.

IX. 2. 1. Centralisation

In administrative terms Amazonas is one of the few remaining 'centralised' states from Health Ministry's perspective. Since 1988 Venezuela has been undergoing a decentralisation process of its politico-administrative structure. Most states have since 'decentralised' their health sector, meaning that regional governments assume the running of their health system, the Ministry retaining a regulatory role. Amazonas, however, still depends from the 'central level' for its budget as well as normative and programmatic guidelines (Sanchez, ms.:16). If health districts lack administrative and decision-taking autonomy, the same can be said at another level for the RHD.

Let me exemplify how centralisation impairs the functioning of the local health system. Ministry officials in Caracas, for example, required photocopies of national ID cards of all Upper Orinoco motorists and microscopists in order to pay them a year's contract. An RHD administrator had to go to each of the health posts in the Upper Orinoco with the contracts to have them signed and next go to Caracas to deliver the documents and have them counter-signed.

From the administrator's perspective the RHD was constrained by the inefficiency of 'central level.' Just as the HD needed to personally pursue the allocation of resources in Puerto Ayacucho, she needed to pressure Caracas for resources. Just as the HD requested a special treatment for the Upper Orinoco health district because of its multiple clinics, the administrator requested 'special treatment' for Amazonas because of the extra expenses required for providing services in a state with poor transport and communications networks. Just as the HD felt unduly criticised, so did the administrator complain no one recognised the work behind making financial resources appear.

Centralisation is also programmatic, limiting the development of responses in correspondence to specific local health situations. An example is afforded by the malaria control programme that traditionally includes the quarterly fumigation of houses with insecticide in the Upper Orinoco and elsewhere in Venezuela. It has been proven that the main malaria-transmitting mosquito in the area does not rest on walls. Beyond that, many Yanomamɨ residences (*shaponos*) have only one roof/wall and remain very open. In light of these peculiarities the standard vector-control measure is inadequate. A better epidemiological surveillance (early detection, diagnosis and treatment) provided by microscopists and use of mosquito nets for hammocks – the mosquito's biting pattern is nocturnal, when most people are in their hammocks – are more attuned means of curbing the incidence of malaria.

Summing up, centralisation fosters a network of dependency curtailing efficiency throughout the system. Health districts need more autonomy enabling a tighter feedback between ground-level reality – epidemiological and concerted needs of communities – and allocated resources and programmatic guidelines. In its inefficiency, from Yanomamɨ health personnel through rural doctors, HDs and RHD

administrators, all feel the problem is beyond them, perpetuating relations of upward criticism and blame and downward persuasion and promise. In these circumstances upward blame also becomes a credible and normally unverifiable excuse that can preclude accountability and conceal negligence.[187]

IX. 2. 2. The regional perspective

From the RHD's perspective 'the Yanomamɨ' are one of many health problems in Amazonas whose attention is divided throughout the whole state. A Regional Epidemiologist once commented on a visit to Ocamo, how Amazonas was 'always in a state of disaster.' Talking about the Yanomamɨ Health Plan, a Regional Health Director, among other comments, reflected on 'why Yanomamɨ and not the other ethnic groups?' Recall that no personnel within RHD is specifically assigned to any health district, its internal divisions correspond with the programmes they run throughout the state (malaria, immunisations, maternal-infant, etc.) and other state-wide functions like the title 'Regional Epidemiologist' suggests. The health problem of the RHD is 'Amazonas,' and attention directed towards the Yanomamɨ varies from one administration to another.

According to Signi (1996:39-41) and to others with long-term involvement with the regional health sector, during the early to mid 90's two Regional Health Directors were instrumental in reforming the health system. Signi praises their efforts: management of health programmes based on criteria of equity, efficiency, universality and solidarity and 'cleansing in terms of resource management.' During this period the Yanomamɨ Health District was created, Yanomamɨ microscopists trained, the Health Centre in La Esmeralda was planned and partially built, etc. All these measures were increasing community participation and augmenting of health districts resolutive capacity. The HD of the time recalled full support from the RHD. In contrast, the period that followed was characterised by a regional 'step backwards.'

On the other hand, the Health Director I interviewed felt that, in essence, RHD's problems had to do with people. People within the regional health sector nowadays

[187] As I left Amazonas, the regional government was working closely with the RHD to progressively take over the payroll as a step towards the decentralisation of Amazonas from the Ministry of Health. I

were driven by 'economic objectives.' A lot of time and effort was spent dealing with employees' conflicts in Puerto Ayacucho meaning administrative issues competed with health issues *per se* in a disproportionate manner. Old timers in Amazonas also considered that a working ethos of earlier days had been lost with the politicisation of health. Prior to the penetration of party politics (presumably intensified since statehood in 1992) things were better organised.

'Economic objectives' and 'politicisation' reflect the intermingling of political and health objectives. Many in Puerto Ayacucho spoke of the RHD as a politically run entity. Support from the regional AD government was conditional on political affiliation (Signi, 1996:40) and financial resources were often diverted in the AD governors' direction.[188] Armada (1997:301), an ex-Regional Director, himself summarises this situation:

> 'The party-oriented and clientelistic policies very frequently pursued by the health sector authorities and guilds [Sp. *gremios*] are characterised by their lack of knowledge of the sanitary problems of the region. They don't foster in personnel an interest for the collective good nor community participation.'

IX. 2. 3. Continuity

The ups and downs of the regional health sector translate into discontinuity at all levels. This has been one of the most salient historical criticisms by missionaries, doctors and human rights advocates in Amazonas: the lack of a continuous concerted health policy towards the Yanomamɨ (Oficina de Derechos Humanos Vicariato Apostólico Puerto Ayacucho, 1997:74). Improvements in the delivery of healthcare in the area are mostly creditable to a handful of people with long-term dedication rather than to a structured, policy-defined framework of action. As particular people come and go, progress is often succeeded by retrogression.

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am unaware to what extent progress has been made in this regard.

[188] Kroeger & Barbira-Freedmann (1992:93) report a similar situation of politically assigned administrative posts and high turnover rates of officials in their analysis of healthcare provision in the High Amazon of Peru and Ecuador.

For example, a structure for a Centre of Health – very much with the Yanomamɨ in mind – was built in 2001 in La Esmeralda, an important step forward considering the traumatic experience of many indigenous people in the hospital in Puerto Ayacucho (Rodríguez Ochoa, 1992: 420). However, to this day (May 2003), it functions merely as a rural clinic. In recent years, a high turnover rate of higher health officials in Puerto Ayacucho hinders the maintenance of long term policies/projects and inter-institutional agreements. In a more short-term framework, it is common to visit a particular 'distant' community to never return, leaving vaccination schemes incomplete and expectations unfulfilled. Complementing the precarious health system are sporadic, knee-jerk reactions to particular crises and patchy measures epitomised by the '*operativo*' 'operation': a quick intervention in the interior of Amazonas, normally including vaccinations, dentistry and primary care. During my stay the GN, through *Plan Casiquiare*, were particularly prominent in this regard. These costly interventions have minimum long-term impact but are highly visible, producing the illusion – specially for the media – that problems are being tackled.

Recapitulating. First, both in the long and short term, fragmentary, non-cohesive interventions are poor substitutes for a concerted policy, less sensitive to the high rate of personnel rotation at all levels within the heath system. Second, at regional level the Yanomamɨ health issue is indirectly immersed and affected by the politics surrounding the administration of Amazonas as a state. On the one hand, it is one of many problems in a 'constant state of disaster,' on the other, health issues compete with political ones shifting attention, efforts and resources away from Amazonas' population at large.

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Regardless of the political character of the health sector in Amazonas the historical evolution of the health sector in the region and some important economic constraints of Amazonas make the task of healthcare provision a formidable one. The health sector administration in Amazonas reveals a historical neglect of indigenous people symptomatic of a general assimilationist indigenist policy that forced Indians' adaptation to a health system rather than the contrary. On the other hand, Amazonas' thin contribution to the national GDP makes it overly economically dependent on the

local state apparatus as source of employment, facilitating the confounding of political and health objectives.

IX. 3. *Entrenched trends*

Most of the indigenous rural interior of the state has been historically neglected in comparison with the *criollo* component of the population (mostly urban) living in Puerto Ayacucho and its municipality. According to the 1992 indigenous census, 88.8% of indigenous communities lacked a health post. The other side of this picture reveals that 'more than 60% of centres of medical attention…are concentrated in the more populated areas, with road access and other facilities of land communication, and in the city of Puerto Ayacucho' (Toro, 1997: 319). Currently (2000) 34% of health posts (hospital included) are in the Capital and its municipality (Sanchez, ms.17). In this context the alternative for the indigenous population in Amazonas has been to reorient their settlement patterns towards the sources of goods and services that remained near the *criollo* population (Mansutti-Rodriguez, 1997 and Zent, 1997 for the Piaroa case). For the most, Indians actively approached the health service rather than the reverse.

Related to the indigenous-*criollo* divide is the concentration on urban and hospital-based investment at the expense of the rural primary care network. A preliminary study of health expenditure in Amazonas reveals that from 1984 to 1996, on average, the rural clinic sector has received 20 % of the investment (infrastructure, equipment, personnel and supplies). The hospital in Puerto Ayacucho absorbed, on average, 74 % of investment (data from Toro, 1997: 330-2). This fiscal abandonment of the rural network is symptomatic of a predominant emphasis on hospital-curative based activities that long ago took over the originally sanitary-preventative focus of the Health Ministry created in 1936 (Armada, 1997: 294).

So in terms of coverage and investment, Amazonas' health sector has traditionally favoured the needs of the *criollo* population which coalesced with the hospital-curativist emphasis of the Health Ministry (cf. Kroeger & Barbira-Freedmann, 1992:88 for the Ecuadorian and Peruvian cases).

Let us now consider some structural political-economic features of Amazonas. According to Toro, the cost of financial resources for the health sector has grown due to the internal increase of prices, the devaluation of the national currency and the effect of a substantial foreign and internal debt on national health budgets. On the other hand, Amazonas' economic backbone is the local bureaucracy of the public sector; as Oldham (1995:93) notes 'the *criollo* economy in Amazonas is not self-sustainable. One can consider Puerto Ayacucho and other *criollo* populated centres as 'enclaves' of the national society directly maintained by the state.' This means Amazonas depends heavily on assigned budgets from a central public administration which traditionally favours the states of the north of the country because of their economic importance. In the face of rising costs, northern states will receive larger slices of the budget at the expense of states like Amazonas where budgetary savings will not affect generated national incomes (Toro, Ibid.:327). Confirming this analysis PAHO's 'Health of the Americas' reveals that Amazonas, among the states with the highest indices of poverty and rurality, is not favoured in budgetary distributions (PAHO, 1998b:543) when principles of equity and accessibility of healthcare suggest the contrary. Finally, reflecting views expressed above, Toro (Ibid.:330) notes that in Amazonas health objectives compete with employment ones in the allocation of resources. Raising standards of health personnel in Puerto Ayacucho, thus avoiding and responding to social conflict, becomes an important budgetary drive.

In short, Amazonas' dependency on state bureaucracy together with its peripheral economic importance impinges on healthcare provision by a) Amazonas being disadvantaged in national resource allocation and b) Amazonas becoming a fertile ground for party political motivations to override those of healthcare.

Let me wrap up this section with a speech of the Health Minister in 1999 addressing the Constituent Assembly in charge of drafting a new constitution. He echoes several of the above points in his characterisation of the national health sector.

> '…it is false that we privilege preventative action and the rural clinic network, when our education and daily practice is strongly curativist, the organisation of work is fragmentary and our services most of the time only offer difficulties.…[referring to the lack of co-ordination he lists a number of bodies

composing the Ministry. These are] mostly impregnated with clientelism, party-ism [Sp. *partidismo*], where unions [Sp. *colegios y sindicatos*] are the protagonists in a world of complicity. To this we may add the severe under-financing of the health sector…[of which] almost 80% is destined to the payment of unmotivated human resources immersed in a severe ethical crisis.' (MSDSb, 1999:1)

IX. 4. *Changing tides*

We have explored the constraints on the resolutive capability of health districts, the historical neglect of Amazonas' indigenous population reflected in the health sector's organisation and investment, the influence of Amazonas' structural position within the political-economic structure of the state, and some aspects of the general profile of the Venezuelan health sector. All these elements must be considered in accounting for the state of Yanomamɨ health and the system that serves them. We shall now discuss some important counter-currents to this panorama. Two important changes are currently underway.

The draft of the new health law, apart from giving indigenous peoples a special status throughout, specifically addresses issues of decentralisation, local resolutive capabilities, community participation, and a sanitary-preventative emphasis. Among its declared principles is 'participation': 'Organised communities will participate in the design of health policies, plans, projects, programmes, norms and regulations…' (Art. 6). Preventative measures and 'anticipatory medicine' are privileged within a wider 'integral approach' (Sp. *integralidad*) to healthcare provision. In general terms the Ministry assumes a regulatory role, leaving ample space for regional and local government and other institutions and communities to formulate and administer adequate health plans. Article 27 states that 'Maximum resolutive capacity for rural clinics will be fostered…' Article 28 that hospitals and other health establishments will be able to obtain administrative autonomy to manage human and financial resources.

In the particular case of the Upper Orinoco the Yanomamɨ Health Plan also addresses the current shortcomings of the system. Its emphasis includes:

a. The need to expand the system's area of coverage.
b. The need to prioritise preventive and community control approaches.
c. The need to make of the Health District an autonomous technical-operative-administrative unit capable of defining and executing decisions locally, with a specifically assigned budget dependant on the Regional Health Direction in normative and accountability terms.
d. The need for a higher local resolutive capacity incorporating clinical biochemistry, dentistry and other health as well as social sciences professionals.
e. The need for increased Yanomamɨ participation in terms of a) more training of Yanomamɨ health personnel; and b) more integral feedback between system and community, suggesting the creation of local community-level health entities with decision-taking and monitoring capacities, fostering local fora for the discussion of health issues.

In the key aspects of participation, coverage, and autonomy at the local level we can see a significant overlap between Yanomamɨ and doctors' ground level demands and the general direction the state is promoting through the Ministry and its plans.

Concluding remarks

This chapter has shifted our attention from the Yanomamɨ politics of managing *criollos* and their resources to the politics and policies of healthcare at regional and, to a lesser degree, national level. This is also a passage from a strong Yanomamɨ localised control to a sphere of no control determined by the structural inequity of indigenous people within Amazonas and Venezuela in general. In Chapter II we saw, in the absence of indigenous peoples in rural doctors' motivation statements, a reflection of the invisibility of Indians in Venezuelan imaginary. Here another invisibility, the historical neglect of indigenous people, is apparent in the health sector's development in Amazonas.

So long as the Upper Orinoco health district runs as an undifferentiated part of a national health system, its improvements will be constrained by the progress of the national system at large. Slow and cumbersome bureaucratic processes proper to the

public sector will hinder the necessary agility for the proper running of field operations. Rifts within the health system, between on-the-ground personnel and higher officials, on the one hand, and *criollos* and Yanomamɨ on the other, are all the more likely so long as chronic under-resourcing and lack of district autonomy prevail. The urgency of the Yanomamɨ health situation demands a more rapid solution, less bureaucratised and less sensitive to the politics within and beyond the regional and national health system.

The Yanomamɨ Health Plan has the potential to overcome the problems associated with an inefficient state-run health system without the state actually turning its back from its constitutional obligations. This brief presentation of ‘changing tides’ is an apt closing for our thesis. If one must be reluctant to be too optimistic, it is undeniable that the current historical juncture looks better than before.

Conclusions

This thesis has sought to understand inter-ethnic relations through the prism of the health system and *vice versa*, to understand how the political character of Yanomamɨ-*criollo* relations impinges on the functioning of the health system. We have touched on a range of issues covering a lot of ground. Reflections could be drawn from each topic but I must necessarily be selective in these closing lines. What I will do is enumerate some of the contributions this kind of analysis can make in both academic and practical terms interesting anthropologists, on the one hand, and doctors and others concerned within the health system or Yanomamɨ, on the other. I shall treat these – not always separate – audiences in turn.

Method and theory

The first point I want to highlight is the propriety of our method and theoretical approach. We began with Turner's (1987) shrewd observation regarding the division of anthropological labour between those who emphasise indigenous traditional social and cultural forms and those who focus on relations with the encompassing national society and its institutions. In order to analyse both these aspects of most indigenous peoples' lives, we have analysed a state-run public service within an indigenous group.

A public service is an alternative to cosmology, mythology or identity politics as a site for the analysis of relations with Whites or the state. This alternative draws on and complements these more typical subjects of analysis, integrating them into the practical contexts of everyday social relations. This has illuminated 'the political' in everyday relations between *criollo* doctors and Yanomamɨ. Inasmuch as 'Yanomamɨ' and '*napë*' positions are constantly defined in moral and body/knowledge terms, a 'politics of identity and alterity,' of 'becoming *napë*' and simultaneously 'domesticating *criollos*' pervades the health system, in requesting medicine, upriver medical trips, sharing food, exchanging *criollo* items, translating doctors' instructions, managing clinic resources, etc. These quotidian events contribute much more than

political rhetoric, deployed in important, yet occasional meetings, to characterise Yanomamɨ's relation with the Venezuelan state.

By looking at a public service we have also gone beyond the White-Indian interface, seeing how the health system is integrated into, and contributes to define the extent and character of, a historical and synchronic '*napë* transformational axis' that links Yanomamɨ upriver communities to *criollo* towns and cities. This geographical network sustains a traffic of objects, people and meanings that, when described, dissolves notions of 'White' and 'Indian' as fixed categories of people implicit in common understandings of 'inter-ethnic relations' or 'relations with the state.' Instead, we have a graded and performative field of relations, where 'Indian' and 'White' are attributes, contexts and meanings detached from, and available to, Indians and Whites.

Our theoretical approach is also fitting for this task. The interplay between convention and invention has elicited the '*napë* transformational axis' as a context of relations and meanings resulting from the innovation of the 'Yanomamɨ conventional space.' It has allowed us to see historical change within the constancy of a relation to exteriority and a 'morality of being human,' yielding change as transformation and novel roles and forms of organisation as 'transformative substitutes' of previous forms. Finally, it has allowed us to contrast doctors' and Yanomamɨ perspectives in medical and non-medical relations within a single theoretical framework.

This combination of method and theory yielded important connections. It has shown the complementarity of dissimilar spaces, like upriver relations with *waikasi* and down-river public events with state officials, and dissimilar events, like doctors treating gravely-ill patients and Yanomamɨ requesting food from doctors, in the constitution of the '*napë* transformational axis,' providing the significance of 'being Yanomamɨ' and 'being *napë*.' Our choices have permitted an analysis of medical and non-medical relations, individual and collective events, without having to draw on a medical anthropology first and a political anthropology next, overcoming another compartmentalisation. Finally, by focusing on daily doctor-Yanomamɨ relations we integrated 'the symbolic' with practical engagements in a variety of contexts like healing, exchange, and politics.

For all these reasons we may suggest the analysis of public services (e.g. health – this thesis; education – see Rival, 2002; Hugh-Jones, 1997) as a profitable avenue to complement our understanding of indigenous people's relations with their respective states.

Regarding Amazonian anthropology

Let us suggest how this type of analysis can be of use in the wider context of Amazonian anthropology. Several authors have described the transformation of Indian identity into a White and/or dual Indian/White identity. This is the case of Gow's (1993; 2001) Piro, Vivieros de Castro's (2002) Tupinamba, Vilaça's (1999) Wari', Rival's (2002) Huaorani, all in their relations with Whites and with their specific inflections. A recent edited volume (Albert & Ramos, 2000) is also centred on '*pacificando o branco*,' 'pacifying Whites,' that is, 'contact' and its consequences, seen through the eyes of Indians. Our analysis suggests some principles to begin discussing a theory of '*virando branco*,' 'becoming White,' the necessary complement of the domestication of White people, still from the indigenous vantage point.

First, the coexistence of, and interplay between, a 'conventional' and a '*napë* transformational' context.

Following Albert (1988) we saw how Whites, manufactured objects and epidemic diseases traversed in tandem the Yanomamɨ conventional space. We then saw how such a trajectory necessarily implied the extension of meanings and relations producing a '*napë* transformational' context. This is a matter of expansion rather than substitution which is why current relations exhibit elements of both the conventional 'morality of being human' and the innovated (and now conventionalised) '*napë* transformational' context.

Every relation between *criollos* and Yanomamɨ, or between Yanomamɨ themselves with distinct degrees of 'civilisation,' implies a moral component defining a degree of identity (Yanomamɨ) or alterity (*napë*) and a body/knowledge component defining a

'*napë*' or 'Yanomamɨ' position in terms of a cumulative degree of *criollo* habitus and knowledge. The former refers to the 'Yanomamɨ conventional,' the latter to the '*napë* transformational,' context. Each occasion also separates/differentiates in one way, and collectivises/connects in another depending on the actor and his/her intentions. So it is that a doctor's successful performance in tending a gravely-ill patient may hinge on a Yanomamɨ moral display and a *napë* knowledge display. So it is that interface Yanomamɨ mediation in a protest or in an upriver medical visit hinges on the same combination.

Let me suggest that this sequence: 'conventional context'⟶'White transformational context'⟶'co-existence of contexts,' on the one hand, and the interplay between 'the moral' and 'the body/knowledge' component of relations, on the other, is applicable to many an inter-ethnic scenario. Consider Hugh-Jones on the debt-bondage chain of relations in North West Amazonia:

> '…this chain does not suddenly stop at an ill-defined ethnic frontier. It stretches on to bind Indian to Indian, so that the morality of the market penetrates that of kinship and the morality of kinship may be extended to dealings with White people.' (1992:51)

The blending of kinship and market morality seems like an inflection of the combination I have described. The transformation involved in 'becoming civilised' or 'becoming White,' which seems to be a shared indigenous phrasing, is a matter of progressively obviating innate Indian-ness. As such, it is a process that never completes itself just like 'making kin out of Others' never reaches complete identity: 'White' is a limit in the mathematical sense. 'Becoming White' and the 'construction of kinship' are similar in this regard, but they are inverse processes in that the former has similarity (Indian) as the given condition, whilst the latter's given is difference (affinity) (Viveiros de Castro, 2001). As a historical transformation, 'becoming White' has created Indian/White composite persons ('civilised' Indians) which is the condition allowing for current 'White' and 'Indian' performative action. The Indian/White duality may be a new 'contact' construct, but in its character and dynamic, it is another guise of the Self/Other internal duality that has been described for the Amerindian person (Viveiros de Castro, 2001; Kelly, 2001).

Its character is that of being White *and* Indian, just like people are relationally consanguine to some people *and* affine to others, or perspectivally 'body' to some *and* 'soul' to others (Viveiros de Castro, 1998). The 'given' conventional (Indian) does not fuse indistinguishably with the 'made' inventional (White), these components co-exist but, in essence, do not mix. Its dynamic is expressed in 'Yanomamɨ' and '*napë*' performative action where internal dualities are obviated and externalised (Strathern, 1988:15).

Second, the coexistence of Yanomamɨ and *criollo* perspectives, the role of 'homonymous disagreements' and 'inter-ethnic relations' as disputes over the nature of convention.

Our approach has illuminated the duality inherent in a network of relations that includes *criollos*, 'civilised' Yanomamɨ and *waikasi*. Because both doctors and Yanomamɨ extend their conventions in their mutual interpretation, they constantly 'miss each other.' An encompassing misunderstanding is that between 'becoming *napë*' as deliberate differentiation of body/knowledge and 'civilising' as deliberate collectivisation. This meta-misunderstanding is evident in the cycles of disharmony-conflict-meeting-harmony between doctors and Yanomamɨ; between being a *napë* potential affine and being a doctor. Conventional extensions also produce a dual medical context for doctors and Yanomamɨ who inversely assign the roles of curing and caring; who sustain different ideas of diagnosis and therapy; about what *shaporis* and doctors are. Mutually interested in each other but as part of different projects, these relations are endlessly negotiated, tending to reproduce the conventional images Yanomamɨ and doctors have of each other as the form of the innate ('potential affine' and 'nature' respectively), resisting each other's intentions.

Now within this meta-misunderstanding we have come across a number of selective affinities or mutual attentions. We mentioned Amerindian and Western mutual interest in the body as site of differentiation and marker of authenticity respectively. We developed two other points of what we can call (following Vivieros de Castro's, 2002b analysis) 'homonymous disagreements.' One was the focus on language, on how speaking Yanomamɨ or Spanish are both 'moral statements' and communicative

acts. A Yanomamɨ reprimands an official in Yanomamɨ making clear a relation of enmity; a *criollo* doctor fails to make patients 'collaborate' by speaking in Spanish. Doctors and some anthropologists emphasise language as purely communicative acts, hence the need to explain things in native language to ensure understanding, missing the moral connotations.

The other was the discourse of suffering, the convergence between the Yanomamɨ moral emphasis on ameliorating another's suffering, and *criollo* images of Indians as 'helpless' or 'poor' – also appealing to an obligation to assist. The homonymic aspect here are images of suffering which Yanomamɨ and *criollos* may reinforce agreeing on the formers' disadvantage. The disagreement comes when Yanomamɨ use this as a ploy to press others into moral action (share your food, return our ambulances), *criollos* seeing this as false theatricality or political manipulation. Another example is the affinity between *shawara*, tiny demons predating on your flesh/blood, and germs, tiny infecting invaders of the body. The disagreement here is the divergence between the agency and origin Yanomamɨ ascribe to *shawara*, which doctors don't to germs. But in their site (body) and form of action (predate-infect) and insofar as they can be killed with medicine and/or seen under a microscope, germs and *shawara* are homonymous. This contributes to doctors becoming *napë shaporis* and to the constitution of '*salud*' as the realm of *shawara*, doctors, their practices and concepts. 'Community participation,' now a state principle of engaging with indigenous people, resonates with indigenous valuation of community autonomy.

'Homonymous disagreements' are privileged lines of articulation between Indians and Whites, formed precisely out of the inter-ethnic context and the constraints of White and Indian perspectives. Some appear clearly in the analysis of inter-ethnic discourse at the White-Indian interface. Albert describes Davi Kopenawa's blending of cosmological and White categories, exemplifying the need to articulate inter-ethnic mutual interests (environment-*urihi*) for political effect. This is an aspect of a wider transformation in Yanomamɨ political discourse on Whites:

> 'from 'speculative resistance' (discourse about an other for oneself) to 'resistant adaptation' (discourse about oneself for another): from a cosmological discourse about alterity to a political discourse about ethnicity; from categories of

Yanomae t^{h}ë pë 'human beings,' and *urihi t^{h}eripë*, 'habitants of the land-forest' to 'Yanomami Indians,' 'people of the land,' 'people of the forest'.' (2000:242)

Our analysis suggests, however, some qualifications. We must stress that, beyond political discourse, the management of *criollos* requires a skill of greater scope. Because, from 'cosmological alterity' to 'political ethnicity' is not an *en masse* change in political consciousness, we cannot dismiss how *criollos* as innate potential affines, more akin to 'cosmological alterity,' pervade the politics of everyday life with doctors in the health system. Leaders, in their mediating role, are constrained by Yanomamɨ and *criollo* expectations for both satisfying opposed demands and making their careers. The terms of these constraints akin to, but more inclusive than, alterity and ethnicity are 'innate' and 'artificial.'

We may suggest, then, that the key variable in the analysis of White-Indian relations, equally relevant in extraordinary/political (e.g. meetings) and quotidian/political (e.g. treating patients; managing clinic resources) contexts, is the dialectic between 'innate conventions' and 'artificial conventions.' It is this that pits Yanomamɨ and *criollo* orientations against each other, yielding the cycles of conflict and harmony in doctor-community relations, doctors are now enemies and now friends, etc. What propels this dynamic is the dispute over the nature of convention. Consequently, balancing indigenous innate conventions and *criollos*' artificial conventions are the constraints on community leaders' action. The relevant shifts are not of political or historical consciousness, a leader may stand anywhere in this regard, his efficacy depends rather on balancing, for example, *huya's* 'bothering' of doctors with reaching agreements in meetings as to the usage of clinic resources, balancing 'becoming *napë*' with 'domesticating *criollos*.' In this sense, instead of 'inter-ethnic relations,' we could speak of a 'dialectics of convention' because, most of the time, neither of the parties to this relation are figuring themselves in ethnic terms.

In explicitly political events like the Mavaca conference, from their privileged vantage point, Orinoco Yanomamɨ leaders indeed consider 'the Yanomamɨ' as an object of a negotiable future. They attempt to 'make conventions' of engagement with *criollos* accommodating to the latter's constraints: supra-local organisation, keeping

long term agreements, requesting but also contributing to solutions, etc. In meetings like these, mediators, simultaneously constrained by opposed expectations deploy 'homonymic disagreements' such as images of suffering or notions like 'culture,' with effects on both Whites and Indians.

At some point along a particular group's trajectory of integration into the nation-state (i.e. as exchange with agents like missionaries, doctors and politicians intensifies, travel beyond indigenous territories becomes more frequent, etc.) collective historical consciousness may become increasingly 'political ethnic.' Convention ceases to be 'innate' and becomes a field of deliberate action, but there will be significant resonance between 'new, made' conventions and the 'old, innate' ones, provided by 'homonymic disagreements' as avenues of continuity. This is perhaps why anthropologists debate the place of the body in White-Indian relations – from a perspectivist emphasis that stresses indigenous aesthetics (Vilaça, 1999), to a representational one that stresses Western aesthetics (Conklin, 1997). The central point here is homonymy, both concealing fundamental differences, and being the line to dissolve these same differences.

Third, the role of meetings in the invention of 'civilised' Indians.

If *criollos* and their world are 'added' to the Yanomamɨ lived world as an existing form of alterity (cf. Viveiros de Castro, 2002:206), we must stress that this is not just a matter of symbolic incorporation or mythical readjustments. In everyday practical engagements *criollos*, as the necessary outsiders for 'becoming *napë*,' are transformative substitutes of affines as the necessary outsiders to make kin. The practices and efforts involved in the 'domestication of *criollos*' and the 'construction of kinship' are the same: a matter of progressive obviation of innate alterity. The whole morphology of doctor-community relations is an ecology of difference and similarity akin to that sustaining Self/Other dualities in all their guises throughout Amazonia. As Wagner (1981: chap. 3) has shown, the innate component of the cosmos is as much created as that of deliberate human action, but this former creation is 'masked.' Just as Yanomamɨ mask their creation of *pore* spirits of the dead, they mask the creation of the innate enemy-ness of strangers. Every illness diagnosed as a form of human sorcery does just this: unintentionally create the innate danger of

outsiders. But this difference is created as innate only to be carved into similarity in the production of kin. Similarly every instance of *shawara* inadvertently makes the innate enemy-ness of *criollos*. The need for fearless speech towards *criollos*, the presentation of *criollos* as non-trustworthy and unconcerned in public meetings, coupled with requests for solutions (healthcare, education, objects) all add to the creation of an innate potential affine that can be then domesticated, harnessed and controlled.

Meetings, in this regard, are transformative substitutes of the rituals of 'social reproduction' that typically play out difference (guests or opposed moieties as affines or enemies) in the local setting only to then obviate it, keeping real difference beyond 'the local.' These rituals 'domesticate' Others and ensure the 'outside' remains a source of difference. This dialect is portrayed, for example, in Fausto's (2000) analysis of the Pakaranã *opetymo* ritual, McCallum's (2001) description of the Cashinahua *kachanahua* ritual and Albert's (1985) analysis of the Yanomam *reahu*. Through this dialectic many Amerindians 'invent' their societies as self/other complements. A meeting such as the Mavaca conference clearly differentiates Yanomamɨ from *criollos* at some points, presenting the latter as enemies, at others, it obviates this difference, *criollos* become allies, and 'civilised' Yanomamɨ, as Yanomamɨ/*napë* complements, are 'invented' in the process.

Meetings as sites of political discourse have yielded fruitful analysis of White-Indian relations (Hugh-Jones, 1997; Gallois, 2000). Our analysis invites us to place further emphasis on the role of meetings in the dialectic of inventing 'civilised' Indians. First, as part of the cycles of disharmony-conflict-meeting-harmony in community-White relations. Second, in playing out fundamental Indian-White differences only to obviate them, reaching agreements or mutual compromises. This necessarily requires the contemplation of their structural-processual place, putting meetings into context with the everyday.

Regarding the health system and its articulation with indigenous medicine

The first point here is to underscore that an analysis of the articulation of bio-medicine with an indigenous medical system must traverse the frontiers of 'the

medical.' The analysis benefits from considering the extent to which the bio-medicine, as part of a service, is embedded in a wider socio-cosmological framework of managing relations with Whites, and how it is contributing to the constitution of Indians' lived world.

Second, analysis of doctor-patient relations are well complemented by a careful inspection of indigenous sociality. Anthropologists, planners with indigenist inclinations and doctors themselves often note that, whilst doctors are oblivious to indigenous culture in general, they tend to give particular attention to indigenous conceptions of illness and healing. In what way does a doctor benefit from knowing about *pores* or what Yanomamɨ may think about oral rehydration? Beyond adapting interventions or explanations to make them more effective, we have shown that a good reason to display awareness of this conventional knowledge is as a means to evoke a moral relationship: 'performing Yanomamɨ' a doctor helps a patient remain Yanomamɨ too. In this sense, to learn the language not only improves communication; as part of the innate form of humanity/morality, it is part of the morality of a performance that may make the difference between 'collaboration' and 'sabotage.' It is noticeable that Yanomamɨ don't seem to be bothered if doctors think differently from them in medical terms. This is not their problem. They do seem concerned about doctors' not 'letting people suffer' and sticking to conventional procedures. It is doctors themselves (and anthropologists) who tend to explain indigenous reactions overly in terms of 'the medical.' For all these reasons doctors would be well advised to consider the moral aspects of their relations in all the contexts of indigenous sociality.

It is also important for doctors to abandon the idea that Yanomamɨ 'believe' more in shamanism than in bio-medicine. Doctors and bio-medicine have an important role in both curing and caring. Both aspects of healing – eliminating causes and reducing suffering – are valued by Yanomamɨ. Doctors' 'utility' may change from case to case but they are rarely considered useless. The opposite concern of some *criollos* interested in indigenous affairs, that bio-medicine will overrun shamanism, can also draw from the conceptual and practical 'fit' between the two. Doctors' competency in dealing with *shawara* hasn't substituted that of *shaporis* who often operate together 'to see who can save the patient,' 'to see who is more powerful,' as Yanomamɨ often

say. *Shaporis*, far from being displaced, have incorporated *criollo* technology to their arsenal and occupied *criollo* spaces (rural clinic, hospital) 'behind doctors' backs.' Though they may not realise it, doctors too, have become *napë shaporis*. The articulation favours a commerce of attributes between *shapori* and doctor who should be kept separate for their values to be realised.

Shamanism's 'transformative substitute' comes less in the form of *criollo* doctors and more in that of interface Yanomamɨ. The necessity of *criollo* knowledge to manage relations with *criollos* as sources of what propels a 'becoming *napë*' trajectory is the force that makes education and political participation, rather than bio-medicine, a cultural adjustment to contemporary problems. It is this that is 'competing' with shamanism as a 'career choice' for youngsters.

This leads us to another subject illuminated in different chapters. Orinoco Yanomamɨ are today in a better position to negotiate their future with *criollos*. Some leaders have become masters of articulating the two worlds. The state is also more concerned with grass-root participation. So long as this future can be negotiated rather than imposed, a *criollo* emphasis – sometimes also anthropological – on essence must make way for an understanding of Yanomamɨ's own appraisal of their historical trajectory.

Doctors and other *criollos* must consider change not as a 'loss of culture.' Acquisition of a *criollo* habitus is part of the differentiating component of indigenous life, as a form of becoming, it is a 'very indigenous' way of being. In this same vein, *criollos* must begin to see Yanomamɨ performances as legitimate forms of action, not as inauthentic theatricality sometimes 'performing *napë*,' other times 'performing Yanomamɨ.' Here ideas of some smart leaders manipulating the child-like mass must give way to a more nuanced interpretation that can discern the legitimacy of forms of action notwithstanding the undeniable influence of institutional agendas (political parties, missionaries, etc.) and the personal careers of Yanomamɨ leaders. Finally, doctors should not demand from Yanomamɨ an ideological allegiance to a bio-medical reasoning of illness and therapy – which underlies reflections like 'they believe more in the *shapori* than us.'

All these situations that produce the image of inconstancy in the *criollo* appreciation of Yanomamɨ must be rethought for it is precisely this inconstancy – transformation, leaders' 'changing of clothes', switching from doctor to *shapori* – that is the expression of an inter-ethnic scenario where accommodation is possible. In medical terms this is the realisation of the ideal of the complementarity of indigenous and Western medical systems.

This doesn't mean *criollos* should surrender to every Yanomamɨ agenda. Constant dialogue with *criollo* perspectives is the most profitable avenue because *criollos* and their knowledge have important things to add to the possibilities afforded by even the most experienced Yanomamɨ leaders – this Yanomamɨ know well. Fora for this dialogue to take the form of long-term partnership must be fostered because, thus far, several of the official sites of this 'debate of the future' have been an alternation of monologues. For example, inasmuch as objectives such as 'community participation,' are aligned with Yanomamɨ expectations of greater control over the health system, these are potential 'homonymic misunderstandings' which will most likely require constant negotiation. We have discussed *criollos*' presumption of a (relatively enduring) 'community' in the face of the constant (re-)negotiation of Yanomamɨ categories of 'us.' We must remember how the health system is a site of Yanomamɨ and institutional politics, often becoming intertwined. For all these reasons a constant dialogue with Yanomamɨ, able to circulate Yanomamɨ and *criollo* concerns about the health system and its future, is necessary.

This brings us to our last reflections regarding the health system itself. It is clear that the rural year scheme is incompatible with the Yanomamɨ conditions for creating trust and affect, so necessary for the sustenance of less conflictive and more convivial relations with *criollos*. Efforts to make the Upper Orinoco a more attractive long-term option for doctors must be coupled with the preparation of more Yanomamɨ personnel. High level professionals could be substituted by technical level health workers, leaving the former in a more co-ordinating planning level, which should itself progressively incorporate Yanomamɨ.

In terms of preparing doctors to work in the field this thesis has interesting material for discussion. The whole process of 'getting to the Upper Orinoco' presented in

Chapter II can be used to reflect on the structural position of indigenous peoples in Venezuela and the power imbalances in the production and circulation of representations of Yanomamɨ. Yanomamɨ themselves could play a more central role in this phase of training doctors. Specific medical cases we have discussed can also illustrate the complementarity between doctors and *shaporis*, the moral aspect of relations, the role of the health system in 'becoming *napë*,' etc. Material and insights drawn from this thesis could complement an instructive document such as a 'doctor's manual.'

It is hardly worth restating the necessity to overcome the health system's own inconstancy. Greater autonomy at the health district level, increasing the ability to adjust field realities within the framework of a cohesive health policy is of the essence. The expansion of the area of coverage in a sustainable way is also a pre-eminent urgency. The Yanomamɨ Health Plan offers an opportunity to begin to implement a cohesive health policy responsive to the limitations of today's health system and Yanomamɨ demands. An interdisciplinary group of people with long term dedication to implement the plan should be constituted to develop a partnership with Yanomamɨ that can serve as a counterpart to the state in this regard. Such a counterpart is necessary to both manage allocated resources and monitor the efficacy of interventions, on the one hand, and to pressure for the state to fulfil its obligations, on the other.

Appendix A: Ocamo demographics/Upper Orinoco epidemiological profile

Given the lack of continuous and credible demographic and epidemiological information, important health ratios (e.g. birth/death) for the Venezuelan Yanomamɨ cannot be properly calculated. However some data can be presented to shed light on the epidemiological profile of the population. The following comparison of Venezuelan, Amazonas and Ocamo ratios gives us an indication of the health condition of the Yanomamɨ near the Orinoco today. **The calculations for Ocamo are estimates that give us an idea of the order of the problem but cannot be interpreted as precise data.[189]**

Table A.1: Crude birth rate (Births x 1000).

	1998	**1999**	**2000**	**2001**
Venezuela	24.72	24.3	23.89	23.53
Amazonas	34.04	33.34	32.65	32
Ocamo	44.57	72.39	66.12	35.04

Table A.2: Crude death rate (Deaths x 1000).

	1998	**1999**	**2000**	**2001**
Venezuela	4.65	4.64	4.63	4.62
Amazonas	7.1	7.08	7.06	7.04
Ocamo	33.43	26.81	13.77	18.87

[189] Available census data for Ocamo of March 1999 and November 2000 were used to cover for the limited data of 1998 and 2001. Apart from one large migration of the community of Kashora from the Ocamo area to the Platanal area in late 1999 early 2000, which has been considered in these calculations, it has been assumed that population changes due to migration from 1998 to 1999 and from 2000 to 2001 were minimal. We must recall that, in all Yanomami communities, there is a small 'floating population' which tends to move a lot between two or more communities. Birth and mortality rates for Ocamo 2001 are up to 31.10.2001. Data on national and regional ratios are from INE, *Instituto Nacional de Estadistica* (www. ine.gov.ve). Recent inspection of the Ministry of Health and Social Development website yields different yet similar regional and national ratios. To maintain consistency with a paper presented at the AAA 2002 conference I retain the data from INE. Again these figures are for expressing an order of the problem.

Table A.3: Infant mortality rate ((deaths < 1 year olds/ total births) x 1000).

	1998	**1999**	**2000**	**2001**
Venezuela	20.45	20.01	19.58	19.25
Amazonas	34.55	33.8	33.06	32.4
Ocamo	250	111.11	166.67	76.92

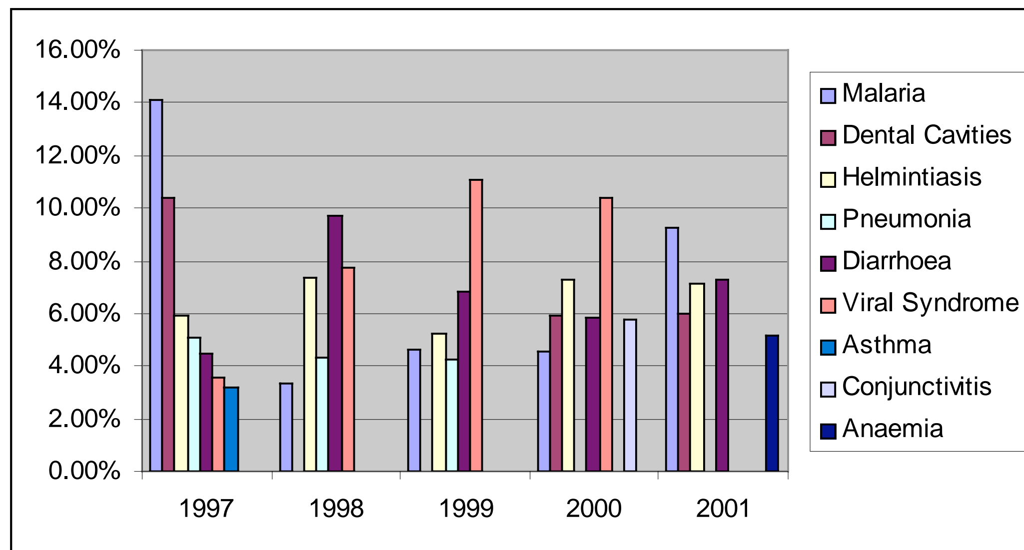
The above ratios speak for themselves: Ocamo's mortality ratio is from 3 to 7 times higher than those for the whole country and consistently higher than the rest of Amazonas. Infant mortality is between 4 and 12 times the national rate and 2 to 7 times the regional rate.

Table A.4: First five reported causes of mortality in the Upper Orinoco for the 1996 –1998 period (source: Regional Epidemiology Office).

Cause	**Percentage of Mortality**
Unknown	30.61%
Malaria	23.81%
Diarrhoea	10.88%
Viral Hepatitis	4.76%
Sepsis	4.76%
Acute Respiratory Infections (ARI)	3.40%

Table A.4 reflects the high percentage of deaths that occur without medical assistance ('unknown') as well as of the endurance of the main causes of mortality throughout the years in the Upper Orinoco – the relative importance of each cause changing from year to year. For example, in 2001 the top mortality causes were diarrhoea and malaria (26% each of reported deaths) followed by ARI (19%). Mission records reported by Cardozo and Caballero (1994:112-113) for the period between 1984-1990 also count ARI, malaria, diarrhoea, hepatitis and 'unknown' among the main mortal diseases of children under three years of age in Ocamo and Mavaca.

Figure A.1: Main causes of morbidity reported between 1997-2001 in the Upper Orinoco (Regional Epidemiology, 2002).

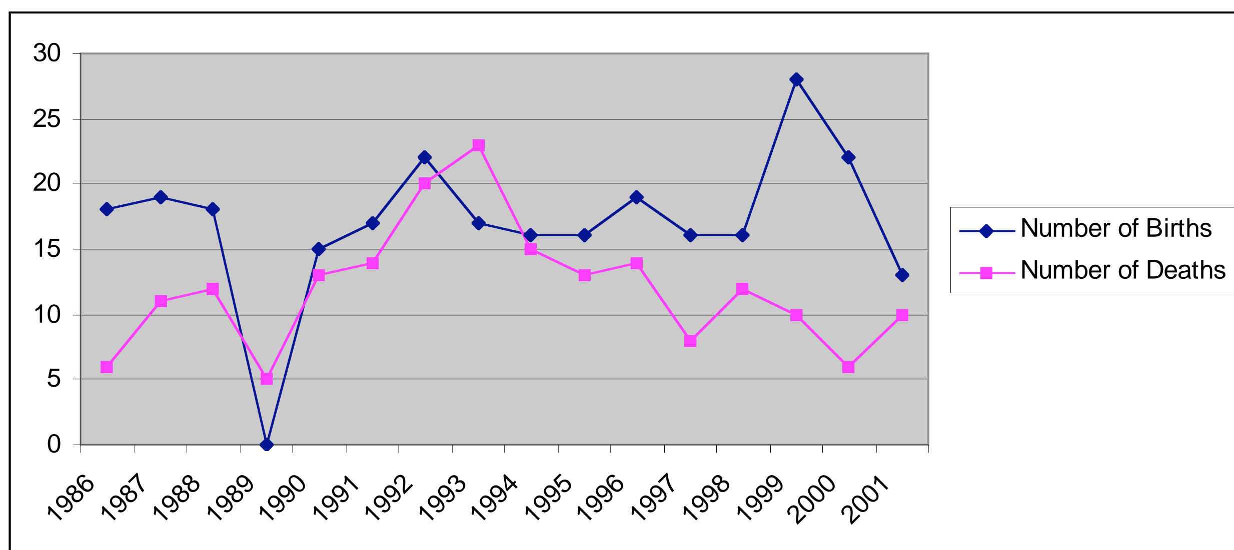


Examining the main causes of morbidity through the 1997-2001 period we find as most important: malaria, helminthiasis, pneumonia, viral syndrome, diarrhoea, dental cavities, skin diseases and anaemia, their relative importance varying, again, from one year to the other[190]

In terms of the impact of the health system, fluctuating rates of birth, death and of mortality and morbidity of particular diseases do not exhibit steady trends but rather better or worse years. Data from different periods of different areas reveal no trend in terms of general mortality (see Cardozo & Caballero, 1994:104-117 for Mavaca and Ocamo between 1980-1990 based on mission records). My data for Ocamo from 1986-2001, based on the health post's records, again present no definite long term trend:

[190] In explaining these variabilities in causes of morbidity we must include variables such as climate change and the different emphasis placed by changing rural doctors in registering, as well as the presence or absence of a dentistry team in the area (which will report dental cavities more rigorously).

Figure A.2: Numbers of births and deaths recorded for the Ocamo 'close' communities in the 1986-2001 period (source: Ocamo health post records).[191]



So whereas we can say the health system has a positive impact in general, we cannot say it has been enough to foster a general trend of improvement. Having said so, in those areas where specific programmes have been more continuously applied and registering has been more rigorous, we can see improvements in certain health standards. For example, malaria incidence in Ocamo and Mavaca has decreased from 1994 to 2001. In Ocamo this has been from 111% in 1994 to 10% in 2000. This trend seems to be related to, first, the introduction of malaria microscopists in these areas since 1995 enabling more efficient early case detection and treatment, and second, due to the use of mosquito nets since 1999 as an alternative vector control measure. Tied to this, mortality, haemoglobin levels and splenomegaly indicators have improved significantly in the same areas (Dr. Magris, pers. comm.). The onchocerciasis programme also reports decreases in parasite charge as a result of Ivermectine treatment. However, more long-term data and continued rigorousness in the application of these measures are necessary to confirm these trends.

Other public health concerns are:

HIV: Apart from an HIV screening done along the Padamo river in 1992 which yielded no positive cases, there has been no further analysis that can afford us an

[191] The data for 2001 end on 31/10/01. There were no data for 1989 births. Given the lack of precise

image of the HIV infection profile in Yanomamɨ population. There are however reports of increasing HIV infection rates in Puerto Ayacucho which is commonly visited by a sector of Yanomamɨ society. Positive HIV cases among other ethnic groups of Amazonas have also been found. Sexually transmitted diseases are not uncommon in military personnel, some of whom work in frontier posts (two within Yanomamɨ land). The potential for HIV infection among Yanomamɨ is evident. This being so, a strategy to face this situation must be addressed promptly by the health authorities.

Tuberculosis: Among the Yanomamɨ in Brazil, Sousa *et al* (1997) have reported epidemic levels of tuberculosis (an estimated prevalence of 6.4%) and a high susceptibility of Yanomamɨ to the disease even among those that have been vaccinated. These levels of tuberculosis seem not to be the case in Venezuela where just a few cases have been reported since 1996 (Casiquiare, Platanal and Parima); most of them have been treated and the respective communities are under surveillance. However, it is clear that a larger problem could lie beyond the reach of today's health system.

Hepatitis: Very high rates of HBV have reported among the Yanomamɨ. Even in areas classified as 'very remote' from the current health system, rates are uncommonly high. There is evidence of the transmission of hepatitis C, D and E although the magnitude still remains to be addressed (see MSDS, 2000; Pujol *et al*, 1994).

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census data birth and death ratios for all this period cannot be properly calculated.

Appendix B: Comparing the Venezuelan and Brazilian approaches

The structure of the health system that serves the Yanomami in Brazil differs in several respects from that in Venezuela. This appendix aims to contrast the two systems, bringing out the most salient features without attempting a thorough analysis.

The first important difference is that the Brazilian service has been provided since 1999 in the context of a partnership agreement between the Ministry of Health through the National Health Foundation (FUNASA) and several NGOs. FUNASA has been charged with the development of a 'Subsystem of Attention to Indigenous Health' (P. *Subsistema de Atenção à Saúde Indígena*) in articulation with Brazil's 'Single Health System' (P. *Sistema Único de Saúde*). This subsystem is made up of 34 Special Indigenous Sanitary Districts (DSEI), one of which is the Yanomami District.

The Yanomami health district covers a wide area straddling the Brazilian states of Roraima and Amazonas. Its area of coverage includes an indigenous population of 12,795 most of which are Yanomami (a small fraction of Yekuana are also covered). There are number of NGOs working in different areas within the health district which counts with 24 bases (P. *Polo base*), each with an assigned area of coverage. These bases are comparable with the Venezuelan AR I and AR II rural clinics (depending on their complexity and staffing) as entry points into the healthcare network proximate to indigenous communities.[192]

As an example of NGOs working in the area we have URIHI, a Brazilian NGO born out of another NGO with a long history of work alongside the Yanomami (CCPY).[193] URIHI operates in 9 regions, covering 96 communities with a population of 5,364 Yanomami, equivalent to 50% of the Yanomami population in Brazil. As is the case in Venezuela health teams of *polos base* execute a number of disease control programmes (maternal-infant, vaccinations, malaria, onchocerciasis, etc.) requiring a monthly minimum visiting frequency. There are a couple of salient organisational differences.

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[192] This information comes from the FUNASA web site, www.funasa.gov.br (accessed 25/7/03).

First, URIHI's health personnel counts with 71 health professionals: 44 'intermediate level' nurses (perhaps equivalent to the Simplified Medicine Auxiliaries normally called 'nurses' in the Upper Orinoco); 19 microscopists; 1 lab technician; 4 nurses; 1 dentist and 2 doctors.[194] This contrasts with the personnel available in the Upper Orinoco that counts in normal circumstances with 5 rural doctors (including the La Esmeralda post), 6 official Yanomamɨ Simplified Medicine Auxiliaries and 4 relatively active Yanomamɨ microscopists. There is a post for a district dentist in La Esmeralda that is irregularly occupied. So in simple terms of personnel numbers, URIHI counts with roughly four times more dedicated personnel than the Venezuelan system. On the other hand, URIHI's personnel profile is less doctor-intensive than the Venezuelan one, consisting mostly of technical health professionals.

Second, URIHI counts with a central co-ordinating unit in Boa Vista, capital of the state of Roraima (equivalent in many respects to Puerto Ayacucho: 2 hours flight to the Yanomamɨ area, site of a hospital for patient referral, etc.) As explained in Chapter IX, there is no such unit in Venezuela. A specifically dedicated group of people in Puerto Ayacucho, securing medical and non-medical resources and logistics for the running of the rural clinics is absent.

In terms of health ratios a swift comparison can be made. We can compare the data of all the URIHI attended areas (pop. 5,364) and the data I have obtained for greater Ocamo within the permanent range of the health post (pop. 370).[195] Taking into account that the populations here considered are of a different order or magnitude and that a substantial part of URIHI's area of coverage is not permanently assisted, as is the case of greater Ocamo, it is clear from this data that URIHI's activities are being significantly more efficient in driving down general and infant mortality rates.

[193] Information about URIHI has been drawn from its web site, www.urihi.org.br (accessed 25/7/03).
[194] URIHI lists 71 health personnel yet mentions 77 health professionals elsewhere on their web page.
[195] Data for greater Ocamo during the year 2001 only reach 31/10/2001 so there are two missing months. It should also be recalled that Ocamo was without a resident doctor although with a Yanomamɨ nurse from April 2001 onwards.

Table B.1: Crude death rate (Deaths x 1000).

	1998	1999	2000	2001
URIHI	22.5	16.6	8.3	-
Ocamo	33.43	26.81	13.77	18.87

Table B.2: Infant mortality rate ((deaths < 1 year olds/ total births) x 1000).

	1998	1999	2000	2001
URIHI	172.1	160.4	63.2	-
Ocamo	250	111.11	166.67	76.92

A summary of this short comparative presentation is made in Table B.3.

Table B.3: Salient differences between health systems tending the Yanomami.

	General strategy	Personnel Profile	Health posts / coverage	Relation to national health system
Venezuela	State-run system with no NGO participation	• Doctor-intensive • Under-resourced in terms of dedicated personnel	• 8 (AR II + AR I) • Low population coverage	Non-differentiated: part of the regional/ national system
Brazil	Partnership between state and NGOs	• Technical health professional-intensive • Significantly more resourced in terms of dedicated personnel	• 24 *polos base*[196] • Higher population coverage	Differentiated: indigenous health district, part of a nation-wide special subsystem of indigenous health

[196] According to FUNASA (www.funasa.gov.br), apparently for the year 2000. The same document mentions a target of construction of several more *polos base* for 2002.

Glossary

The following is a list of 'quick reference' definitions to aid the reader through the thesis. More detailed definitions are provided within the text with the first appearance of each term. Definitions of Yanomamɨ terms are mainly based on Lizot (Unp.) and Albert (1985).

Yanomamɨ terms:

Amahiri: Supernatural beings that live in the level of the cosmos below where ordinary Yanomamɨ live. When shamans expel the *shawara* demons of disease from ill people they cast them to this underworld of the *amahiri*.

Hekura: Supernatural spirits of the forest; shamans' helper spirits. Together with the Yanomamɨ (humans) and the *yai* 'demons' they constitute one of the three major categories of beings of the Yanomamɨ cosmos. *Hekuras* 'descend' on shamans and enable them to cure people or attack enemies by mystical means.

Hërɨ: Series of magical substances of diverse origin (plants, insects) prepared to cause harm (illness or death) or benefit. When used for benefit, it can be considered 'plant medicine,' complementing shamanic cure in the sphere of reduction of disease symptoms.

Huya: Young male person. It broadly distinguishes youngsters from male elders (*pata*) and children (*ihiru*).

Kiri: Fear/shame.

Napë: Enemy; White.

Napëprou: Literary 'becoming White'; to be living like Whites (eating their food, using clothes, speaking Spanish, living close to Whites, etc.).

Napëramɨ: Class of *hekuras* of White people.

Napë yai: Real Whites. Given that '*napë*' can contextually refer to Yanomamɨ with White habits, to other more 'acculturated' Indians or non-indigenous people in general, the addition of the term '*yai*,' 'real, true, essential' is used to contextually distinguish non-indigenous people.

Nɨ wari: See *shawara*.

No patapɨ: The ancients; the first people of mythical times.

Pei hushomi: The 'inside' of a person. It distinguishes a series of invisible vital aspects of the Yanomamɨ person, in opposition to the 'outer envelop' or biological body *pei sikɨ*.

Pei ɨyë: Blood.

Pei mɨ amo: The ‘centre’ of a person. Vital aspect of the person only visible to shamans, it is subject to be abducted by supernatural agents causing illness and death.

Pei mɨshia: Breath, in shamanic contexts, associated with life.

Pei no porepɨ: Component of the person associated with unconscious activity. Upon death, the person releases a *pore* ‘ghost.’ It can then be considered a ‘dormant ghost.’

Pei noreshi: Animal alter-ego of every person. Animal and person share destinies, if one is injured or dies, so does the other.

Pei no uhutɨpɨ: Component of the person, a ‘vital image’ subject to abduction by supernatural agents. Invisible double or ‘image’ of humans, animals and objects.

Pei puhi: The term ‘*puhi*’ enters all Yanomamɨ concepts that refer to intellectual or emotional activity. It can be considered as ‘consciousness.’

Pei sikɨ: The skin or ‘envelop’ of the person. The ‘biological body.’ It forms an opposition with the *pei hushomi* ‘the inside’ or *pei mɨ amo* ‘the centre’ of the person.

Pore: Ghost of the dead.

Reahu: Funerary feasts, involving the preparation, distribution and consumption of the ashes of the dead.

Shapono: Village. The traditional *shapono* is one large circular house. Nowadays, particularly close to the Orinoco, the *shapono* is formed by several closed houses normally, but not necessarily, in a circular layout. The *shapono* also defines the category of co-residents.

Shapori: Shaman. It also designates the shaman’s helper spirits.

Shawara: Demons of disease. Tiny supernatural beings that eat people’s blood/flesh, they are mainly associated with infecto-contagious diseases.

Waikasi: Term used by Orinoco Yanomamɨ to designate ‘real Yanomamɨ,’ normally referring to upriver Yanomamɨ who, because of their lack of White habits and knowledge, are said to live more ‘like the ancients.’

Wayu: The term designates any substance with powerful effects on the body like *curare*, *hërɨ*, *yopo*, tobacco; it also means ‘pathogenic substance/power’ causing illness or death. It can have connotations of danger and may also be used to refer to enemy warriors.

Yai: Major class of supernatural beings. The *yai* are evil demons often responsible for the abduction and/or devouring of vital aspects of people causing illness and death.

Spanish terms (as used in the Upper Orinoco):

Aparato: Technological device. *Aparatos* are associated with White's creativity.

Casabe: Manioc cake.

Civilizado: Strictly meaning 'civilised,' it is a term used by Orinoco Yanomamɨ to differentiate themselves from upriver 'real Yanomamɨ' who have less White habits and knowledge. It stands in opposition to *waikasi* (see above).

Colaboración: Strictly meaning 'collaboration,' in Yanomamɨ-White relations it often refers explicitly to 'doing something without expectation of return' or 'helping.' The term may also particularly connote 'to make life easy on someone,' or attitudes favouring convivial relations. For example, a docile patient is 'collaborating'; if Yanomamɨ help out in the clinic and are not constantly tricking the doctor, they are 'collaborating.'

Criollo: Non-indigenous people. In Yanomamɨ usage it corresponds with '*napë*,' hence its usage also exhibits the graded character of that term.

Malandro: The term refers to different levels of criminality, from petty thieves to murderous thugs. It is strongly associated with urban shantytowns.

Malcriado: Person (normally a child or youngster) who doesn't know how to behave him/herself due to bad upbringing.

Mañoco: Grated manioc.

Mesquino: Stingy.

Propio: Spanish equivalent of the Yanomamɨ term '*yai*' meaning 'real, true, essential.'

Vivo: Smart; to be quick to take advantage of a situation.

Yopo: Generic term designating hallucinogenic drugs.

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