

Diseases and therapeutic practices among the Teréna in Mato Grosso do Sul, Brazil¹

Doenças e práticas terapêuticas entre os Teréna de Mato Grosso do Sul

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Abstract

This article aims to describe the views of health and disease held by the Teréna people of the Buriti Indigenous Land, in the state of Mato Grosso do Sul, Brazil, devoting closer attention to the identification and diagnostic interpretation of chronic disease and related therapeutic practices. Conducted from March to August 2010, this qualitative study employed semi-structured interviews with 24 Teréna members and was complemented with field notes (participant observation). The understanding of health and disease held by the Teréna are integral to daily life issues such as diminishing land availability, climate change, influences of urban life, and rule-breaking. Observations regarding therapeutic processes revealed an interest in counseling, as well as in family and religious care, concurrently with the biomedical care obtained at the local health center - resources that are seen as complementary. The interpretive schemes reported by the participants for the causality of hypertension bear relation with living conditions, environmental contamination, dietary changes, spell-casting, and disobedience to older adults. Understanding disease and seeking cure are experienced by the Teréna as processes stemming from local knowledge, involvement of various participants, and available resources and technologies, each of them part of a dynamic cultural and social context.

Keywords: Health of Indigenous Peoples; South American Indians; Therapeutic Itineraries.

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Resumo

Este artigo propõe-se a descrever as visões sobre saúde e doença, enfatizando a identificação, as interpretações diagnósticas e as práticas terapêuticas relacionadas à doença crônica entre os Teréna da Terra Indígena Buriti de Mato Grosso do Sul. Realizou-se um estudo qualitativo por meio de entrevista semiestruturada com 24 indígenas e de observação participante, com registro em diário de campo, entre março e agosto de 2010. Para os Teréna, o entendimento de saúde e doença compõe questões de sua vida cotidiana: redução na disponibilidade de terra, mudanças climáticas, influências do meio urbano e quebra de regras. Quanto aos processos terapêuticos, observou-se a busca pelo aconselhamento e pelo cuidado familiar e religioso, e o atendimento biomédico obtido no posto de saúde, sendo estes vistos como complementares. Os esquemas interpretativos mencionados pelos Teréna para a causalidade da hipertensão arterial indicam relação com as condições de vida, contaminações do meio ambiente, mudanças na dieta alimentar, feitiços e desobediência aos mais velhos. As experiências vivenciadas pelos Teréna no entendimento de suas doenças e na busca pela cura são processos resultantes dos saberes locais, da participação de diversos atores envolvidos e dos recursos e tecnologias disponíveis, todos inscritos em um contexto cultural e social dinâmico.

Palavras-chave: Saúde dos Povos Indígenas; Índios Sul-Americanos; Itinerários Terapêuticos.

Introduction

From the contact with the non-indigenous society and between interethnic relations, indigenous peoples go through changes in their ways of life, social, and economic transformations that invariably affect, over time, their livelihood and way of understanding health and dealing with diseases.

According to Concone (2003), to deal with the disease, all cultures (any culture) produce health knowledge. Thus, the disease is part of symbolic processes and is not considered an entity that is universally perceived and experienced in the same way (Langdon, 1994). In addition, the disease is perceived not as a static state, but as a process that requires interpretation and action in the sociocultural environment, which implies negotiation of meanings in the search for a cure (Staiano, 1981).

Reinforcing this idea, Souza (1998) points out that defining and explaining an experience of distress and endowing it with meaning involves acts of interpretation, which are not reducible to a mere projection of subjective meanings, or a reproduction of the already given meanings in culture, in which trying to put some order to the threat of disorder that accompanies the illness is a process that develops in a world shared with other people, composed of a plurality of voices with which you dialogue, negotiate, and debate to produce definitions and ways to manage the disease.

From these considerations, and aiming to score the theoretical positioning in this study, the culture follows the concept presented by Geertz (1989), which conceives it as a symbol system providing a *model from* and a *model to* reality, in which culture means human action, people's everyday life experience, different interpretations formulating, day after day, the ways in which they are reproduced, according to the meanings of life, death, and the universe.

Thus, the reflections in this article aim to describe the visions on health and disease, emphasizing the identification, the diagnostic interpretations, and therapeutic practices related to chronic disease among Teréna Indians living on Buriti indigenous lands, Mato Grosso do Sul, Brazil.

Methodology

The study was a qualitative approach developed in the Teréna villages belonging to Buriti Indigenous Land (TI), with 2613 people (IBGE, 2010). Buriti TI has 2,090 ha and is divided into nine villages - Buriti, Água Azul, Recanto, Oliveiras, Olho D'Água, Barreirinho, and Nova Buriti belonging to the municipality of Dois Irmãos do Buriti, and Córrego do Meio e Lagoinha belonging to the municipality of Sidrolândia.

Data collection was carried out between March and August 2010, when semi-structured interviews were conducted with twenty-four people (i.e., adults who received the diagnosis of having a chronic illness and with families who experienced the illness, in order to get to know the individual and collective experiences of the illness, regardless of whether or not going through treatment) and religious leaders with significant presence in situations of illness - combined with the participant observation method and record in field logbook. Interviews were conducted in households to search for proximity and privacy of information, being recorded when allowed; the participants of the study were introduced by Arabic numerals, and the logbook records and transcripts were written in italics.

The research project was submitted to the Research Ethics Committee of the Federal University of Mato Grosso do Sul, receiving favorable opinion and forwarded to the National Commission on Ethics in Research, with the request for approval and authorization of the Regional and National Executive Board of the National Indian Foundation (Funai) to initiate contact with the leaders of local councils and family leaders when the goals, methods, and study procedures were presented.

Teréna People: social, political, and economic organization

The Teréna people are identified as members of the Arawakan linguistic branch, living in small areas in the states of Mato Grosso do Sul, Mato Grosso, Sao Paulo, and Parana, with a long history of contact with the non-indigenous society.

It is the second indigenous group of Mato Grosso do Sul, divided into ten indigenous lands and in two other areas, together with Kadiweu people, in the municipality of Porto Murtinho, and among the Guarani/Kaiowa in Dourados, in addition to Teréna people who migrated to urban areas, especially to Campo Grande, the state capital.

When describing elements of the Teréna culture, Azanha (2005) highlights the patrilineal social structure, in which the male and female roles are well defined. Each village is formed by a group of family branches establishing a network of marital, economic, political, and religious alliances. For each village there is a leader (cacique) and a board (council of men), which work directly in the community's political and economic issues.

In general, the cacique (chief) is expected to follow up the various events of the community, the ability to fundraise, exert positive influence on conflict mediation, the distribution of strategic information and material goods, especially those obtained in negotiations with external institutions. His performance is constantly evaluated under socially valued behavior parameters in the Teréna culture such as serenity, reciprocity, and balance in the exercise of power. For this reason, nowadays, the choice of the cacique is performed by the community of each village, which chooses their leaders by voting, unlike the imposition or influence of the Government agency in previous years.

In addition to these political representatives, Funai has the chief of Indian Station in Buriti Village (Buriti PNI), who is currently an indigenous representative. There are still the family leaderships (branch leaders), religious leaderships (Protestant, Pentecostal-Evangelical, Catholic, Spiritualist Churches, and Shamanism), professional leaderships (groups of indigenous workers in the areas of education and health), and associations (indigenous organizations) within each village.

Regarding productive activities, most are farmers, enhancing the traditional way of life that connects them directly to the land and production of the family farms of permanent crop intended for household consumption and in case of surplus, for commercialization, in addition to providing seeds

for the next harvest, food for pets, and enabling intra- and interfamily exchanges. They use mechanization (tractor) and traditional techniques of preparation and land use (slash and burn farming, planting, and harvesting according to the moon's phases and nature signs) (Ribas, 2011).

The life of these families is subject to the possibility of its set productive capacity in the available area (family farms), satisfying the subsistence needs of its members, the renewal of the means of production and consumer goods, and the exercise of social and political activities.

Thus, the availability of food to share always had great importance and strengthens the principle of reciprocity, therefore, it is intrinsically related to Teréna social identity.

Besides the cultivation of plantations, some families raise cattle on a small scale, in the extensive system in grazing regime, with low productivity in light of the few viable resources and the limited availability of fields and pastures for raising cattle. They also work as cowboys, string trimmer men, sugarcane cutters in the sugar mills of the region, tractor drivers, tractor mechanics, horse tamers, pole pullers, fence makers, lasso knot and implement makers, butchers, and other occupations in rural areas.

In the TI, there are still occupations in public services in the education (school principal, teachers, and secretary) and health (nursing technician, dental hygiene technician, nursing assistant, Indigenous health agent, and Indigenous sanitation agent) fields requiring schooling and that are very valued and disputed.

According to Teréna leaderships, the territorial extension of Buriti TI is insufficient to meet the need of reproduction of the existing population due to the reduced territorial extension allocated to family farms (0.87 hectare/per capita), the impoverishment of the soil, the few forest reserves, and the population growth of Teréna.

Analyzing the situation of indigenous lands in the State of Mato Grosso do Sul, due to the population growth, degradation, and impoverishment of areas, the average size of family farms has decreased with a tendency to downgrade the

territorial standards originally established by the Indian Protection Service (SPI), which are far from the standards of the National Indian Foundation (Funai) to the northern region of the country (Ferreira, 2007).

Explanations for diseases

In every society, interpretative models of health and disease are daily built, theorized, and rewritten by different cultures (Kleinman, 1980; Menéndez, 2003).

In general terms, an episode of the disease is characterized by the recognition of symptoms, diagnosis, treatment, and evaluation. In severe or prolonged cases, episodes often become crises threatening lives and defying the meaning of existence (Langdon, 1994).

According to the collected narratives, in the design of the health-disease process, biological, sociocultural, and psychological aspects are present in the context in which they are inserted.

Although unique for those expressing them, the meanings of health and illness for Teréna indicated possibility of combination of different recurring factors that, somehow, compose questions of their everyday life and which, at other times, did not exist in the community: reduction in the availability of land, climate change, changes in lifestyle, breach of rules, influences of the urban environment, and the presence of processed foods.

The people care much about children and young people, due to the spaces, we no longer have enough spaces to work and extract, or dwellings [...]. Suddenly, it contributes with the possibility to turn into disease. The high pressure is because of the heat [...] and the things we eat [...] all of it has contributed. About the disease, it can be for breach of rules on eating habits. With the increase in population, now it has a better relationship with the city, we often go to town, and have acquired habits of white people (Interviewee 7).

Now this generation that is coming, the more inserted in the purutuy habits (not Indian), the

more it looks like it's good. However, it causes unpreparedness for the body to fight the disease. If you could preserve those foods that are unique, our body would be able to fight diseases more easily (Interviewee 8).

Our tea was of ground cane, heated up; this current sugar didn't exist. We made beiju, grated the cassava, twisted, squeezed the broth out, strained the dough and put it in the pan, baked it a little bit [...] only the cassava dough [...] and flipped it; ate it with sugar cane juice early in the morning. At lunch, it was cassava with animal meat, [...] armadillo, white-lipped peccary [...] We didn't eat salt. We used cattle and pork grease. The meat was well roast and we had cowpea. Rice came later. It was a novelty [...] then, the pasta came [...]. The guys called chicken gut... purutuy food (Interviewee 1).

I believe that is because the use of oil, since before we didn't eat, it was only grease. I think that it started rising blood pressure [...]. With that, this problem has arisen. We didn't have hypertension, it began recently. I think these frozen chickens we eat, it is accumulating, I think it was accumulating this disease. This oil comes from soybeans. From poisonous soybeans and the chickens that we don't know what they eat (Interviewee 7).

The understanding of health and disease and its causality described in the aforementioned accounts suggest a complex interaction between the elements of territorial, environmental, and social order that are experienced on a daily basis from the perspective of culture itself and its own individuality. According to Geertz (1989), understanding the culture of a people exposes their normality without reducing their particularity. Thus, suffering and becoming ill, although afflicting people in a similar way, are not always perceived in the same way by people of the same culture or people of the same gender, age, and social role they occupy.

It should be emphasized also that these meanings depend on the time dimension, because the knowledge of a person is continuously reworked and reshaped due to specific interactive processes (Alves, 1993).

There was no such thing. I always comment that in the Indian village those types of diseases, such as stroke, high blood pressure, diabetes, didn't happen [...]. These things were not discussed in our community, it has never been existed. And nowadays we have them in our community. Most people suffer from high blood pressure, something that didn't exist in the past here (Interviewee 8).

In this account, we observe the past/present dichotomy when highlighting the diseases that they did not know, but now they are frequent because of changes in life with which they have to deal and seek to understand, from their own understanding of the world.

Therapeutic itinerary

The idea of therapeutic itinerary involves the recognition of the disease, its stages - generally composed initially by evaluation in the family or in the community, during which the focus is directed to the relief of symptoms and subsequently, if applicable, the search for the last cause of disturbance -, and the different interpretations that emerged during the process (Buchillet, 1991).

Under this logic, the therapeutic itinerary must be understood as a result of negotiations between various persons and groups with interpretations that diverge or not about the identification of the disease and the choice of appropriate therapy (Langdon, 1994). These negotiations guide the decisions to be taken by these people and their groups.

You can use the drugs purchased, right? But, if we realize that it's not working, you have to remember the ancient medicine. First, we'll use the medicine remedies, but if we see that people are taking, taking, and they aren't recovering, you have to change, right? Return to the herb. And the herb solves it. If the medicine drug does not solve it, the herb does. Why does it solve? Because plants are a God's creation. So, that is the reason. It's not artificial (Interviewee 12).

Such accounts lead us to the existence of concomitant practices of their cultural health care system and their biomedical system. The use of medicine has always been present and with great importance, but accompanied by other resources.

It is noteworthy that the understanding of the cure of the disease has been linked to the preparation of the root medicine, i.e., the use of the plant as a medicinal remedy can be explained not only by therapeutic properties assigned to it, but also by an order of elements more complex and inherent in the health system that incorporates it (Laplantine, 2004).

In many narratives, we observe the search for counseling, family and religious care coupled with the biomedical service obtained from the health center, seen as a complementary practice.

They take the doctors' medicines, but accompanied by much prayer, in addition to the roots (Interviewee 3).

[...] if it is necessary I go to the health center, I take some medicine, some syrup, but the prayer [...] improves a lot. Sometimes, I make homemade tea for them too, some leaf I know that is very good to cure fever, cough too [...]. To cure fever, the orange leaf. I take nine orange leaves, scorch them a lot in fire, boil and strain them, and give them with child pill. [...] it's the medicine from pharmacy, since I take care of my children when they were all little babies, now I'm making it to my grandchildren [...] there is another child pill, ah, those sweet ones they like best. It's very good (Interviewee 4).

The reinterpretation of religious practices, as well as its application in the life of the Teréna, is a result of the interethnic contact, which opens changes in shamanic practices. The traditional shaman, known as *koixomuneti*, ceases to exist and the incorporation of new religious practices is recognized, as in the case of Catholicism, Evangelical churches, and Spiritism.

If, on one hand, we see the absence of a *koixomuneti*, on the other hand it is recognized that the shamanism is present in different practices. We

observe a reinterpretation of these practices, such as the adoption of shamanic activities, which are widely referred to by women (such as blessings, chants, baths, and herbal preparation, both in the taking of infusions and in baths or massage), being recommended according to the initial diagnosis of the disease and modified throughout the treatment in view of the responses obtained.

In general, such practices are transmitted within the family circle, especially among women in the family who directly take care of the choice of the therapeutic resource that will be used for themselves and their relatives.

Well, his disease was very difficult, you know? At night, the disease attacked him. He couldn't urinate, he went to the bathroom and couldn't urinate, he kept moaning all night long. I took the anointed oil and anointed his belly where he felt pain [...]. Then, after a while he would sleep, woke up, and could urinate a little. The time was passing, passing [...]. Then, he received a call, you know? He was afraid of doctors, he said that I am afraid of doctors, but he is worse. I said to him: You know what? You will undergo surgery for this illness. You will have to go through doctor's operation! You have to lose the fear, you have to accept the invitation which is made to you! Then, he accepted it because he couldn't take it anymore. Then, I talked to the nurse at the health center: Transfer my old man to the hospital to undergo surgery because he can't take it anymore. And this problem is not a problem of praying for him. He has to see the doctor. So, he went to see a doctor (Interviewee 11).

We have to take our children, for example, grandchildren, and we have to guide them. I inherited a lot from my grandmother and I have to pass on to my grandchildren, who are growing up, we have to counsel them [...]. (Interviewee 17).

In addition to women, the indigenous pastors of Evangelical churches are important figures in the recommendations for appropriate treatment. According to the informants, they know they will be supported at the

Evangelical churches, since there are groups with links set out in search for the cause of the disease and its cure.

I'm going to see the pastor. Then, I'm going to find a doctor. As that day that I had a stomachache. I was on the mountain, we went to pray there on the mountain. There we tell the problems, thirteen people, we make a circle. Everyone goes together [...]. I had a stomachache [...] the pastor saw that I was sick, then he anointed oil and put in the water, and I drank it, at the same time I got better. Then, I went to his house and he gave me another dose [...]. I got home, slept, then I got better. I was cured and I don't feel anything anymore (Interviewee 2).

There are a lot of sick people coming here, with all kinds of problem. I pray, the spirits tell me the medication I have to take. And I always give advice. Advice is always necessary, because the patient is often disrespecting (Interviewee 3).

Next, the health experiences here described refer us to the importance of controlling feelings for a healthy mind and for the maintenance of a balanced body.

Being healthy is staying quiet [...] is having that joy, when we are concerned we have pain, headache, tachycardia (Interviewee 15).

Yes, we need to be quieter, right? To keep calm, I think you can't be so upset or angry. I have to live a quiet life, to be happy, smiling, chatting with my kids (Interviewee 16).

There is an explanation for the production of health and disease that qualifies, in a distinguished manner, the way by which the Teréna determines its therapeutic process. Therefore, the specific and peculiar way by which a health problem is explained and experienced by this people should not be neglected by health services.

On the other hand, it is important to note that the use of other practices, especially shamanic, is omitted in the areas of biomedicine. Long conversations with interviewees have enabled us to realize that such practices are mentioned only to indigenous health

agents, and not to other professionals of the team (doctors, dentists, and nurses), for fear of reprisals. Such behavior may be related to the process of increase and appreciation of biomedicine to the detriment of the knowledge and experience of this people, very common in the health services that serve them.

In the villages, there are health centers with multidisciplinary team of indigenous health. Services are offered by the spontaneous demand from patients, and the presence of health staff in each village varies from one to three days a week, depending on the village. This enables a constant high demand for consultations at the health facility, leading professionals to prioritize the service at curative model.

Dealing with high blood pressure

The interpretive schemes causing hypertension mentioned by the Teréna indicate different representations for its origin and may be related to living conditions, climate change, environmental contamination, changes in diet, breach of rules, spells, and disobedience to older adults, whose logic is grounded in collective knowledge and individual experiences.

I think it's because of the heat, because the sun is hotter now, right? Because often, the sun, in the old days, wasn't like this, now it's hotter, right? (Interviewee 18).

Ah, I think it's because of too much pollution, right? I think it's because of the heat, because the sun is hotter now, right? Because often, the sun, in the old days, wasn't like this, now it's hotter, right? Here comes the cold, often those who have hypertension can't handle it sometimes, right? They get suffocated (Interviewee 7).

In the explanations of the causes of hypertension described earlier, we realize that the person maintains a relationship of exteriority regarding the cause of the disease, that is, for reasons beyond its will. It is important to emphasize that individuals produce more than one kind of explanation for their disease, since their knowledge is procedural (Young, 1982).

Another explanation for the cause of the disease was correlated to spells and when people become the target of envy for accumulating goods and refusing to share them with others.

There are diseases that can come up due to a kind of envy or spell. There's also those when people just want things for themselves, they don't share, don't think of others and then they get sick (Interviewee 3).

Thus, each individual understands the disease in different and variable ways. To prepare their assumptions, they rely on a multiplicity of elements available in their sociocultural context, but which will be suitable differently due to the uneven distribution and singularities of the personal trajectory (Adam; Herzlich, 2001).

In the accounts of older people diagnosed with hypertension, we have identified another way of understanding the causal factors of the disease itself and aging. They refer to the children's imbalances and the non-compliance of rules by not "listening to older adults".

What makes us grow old and sick is the concern with the kids who drink; I wasn't going to get old fast if I didn't have to worry about the kids; nowadays, children don't seek to talk with the older one; the younger ones follow what they think, no longer listening to the older people's idea [...] I lived with my mother-in-law and she took us to work on the farm, clean, gather corn, and stack rice; it was a hard work, but it was good and I don't think that's what makes us grow old, but the concern with the kids (Interviewee 20).

The problem of old age is only high blood pressure, which is the concern. The high blood pressure only began when my children started drinking. When they are all together drinking tereré in an afternoon [...] You can control, right! The blood pressure remains good and getting old isn't a problem (Interviewee 21).

Nowadays there are many things [...] and the young ones do not listen to the old ones (Interviewee 22)

It is possible to recognize, in the reports, the dissonance between the behavior of older and younger people, especially because the younger do not give importance to the advice of their family members.

Regarding the restrictions on the use of salt and fat in the diet, they recognize the need for control, but claim to be impossible to comply with the medical recommendations received, for they contradict the very "nature", that is, their way of being. The fat is still considered as a food with symbolic value for what it represents when providing strength to the daily work in the plantations, essential in the economy of Teréna.

If in everyday life, with the usual food, the restrictive recommendations contradict what they understand as adequate and essential food to have strength in carrying out the work, at parties of the Teréna the recommendations jeopardize the participation and sociability, because the main shared food is the salted meat in the form of blankets with a thick layer of fat. While the guests wait for roast beef blankets and boiled cassava, they serve puchero bowls (broth with marrow, fat trimmings, cassava, and salt) that are prepared in large pots and shared through with all those present, a reason of great joy and prestige for the party organizer. Thus, those who are perhaps following some diet with salt and fat restriction would not have enough to eat during the festivities.

Women who received guidance on the need to restrict salt and fat in their diet, with foods that could not be consumed (coffee, fatty meat, and salted food) reported that, although understanding what was requested, they have difficulties to comply with it, because it is difficult to prepare two types of foods (foods with salt and no salt), even by the lack of utensils (pots) and because the food shown as banned were the most desired in the diet, citing the example of the meat, predominantly fatty and salty. In addition, the fact of having fatty meat and coffee at home means wealth and power, by the prestige given to families when consuming such foods.

The doctors say that I can't eat salt, grease [...] I understand, you have to go easy on them, but it's in our nature to eat fat (Interviewee 1).

In the accounts, the Teréna question the consumption of foods that have always represented health and strength and that today are presented as disease-causing. It is necessary to remember the importance of the empirical experience and the symbolic value of these foods to interviewees before new concepts and recommendations.

Formerly, the relatives ate fatty, salty, and fried meat and didn't have these current diseases. I don't understand how these foods are bad now (Interviewee 2).

In addition, the timing of meals is always reported as a meeting with all the family in the “circle” (circular balcony where they have meals) to eat the same food. Thus, having a different food was as if it was not part of that meal for being excluded from the family sharing. Getting things off their chest, they said that “it was better not to eat salt-free and fat-free food, because the food is no longer food”.

In this case, it is necessary to consider that the food prepared with salt and fat is inserted in a cultural context, in which the symbolic and social elements have a strong expression for the Teréna.

Another issue, which emerged in the stories of women having high blood pressure, refers to the medicalization of care in health centers, focusing on the measurement of blood pressure and prescription of anti-hypertensive drugs, and without reference to or interest in the living conditions of these same women and their interpretations about the disease.

I went to the health center, they measured my blood pressure and said it was too high. Then, the doctor only prescribed medicine. I was supposed to take it three times a day. Remembering to take it every day and still on time is difficult (Interviewee 13).

My father is hypertensive. He has a heart problem. He's that old man who lives there, he doesn't have diabetes [...] He is treating the disease. And sometimes his heart is accelerated, then they take us to see the doctor. It's like that, then he returns to normal. And when he feels bad, he goes to the health center, to measure the pressure [...]

sometimes it's the pressure, you know? Or they go there, when his blood pressure is too high [...] then, they give medicine or increase the dose of his medicine to normalize it (Interviewee 5).

The biomedical resources are widely and significantly used by interviewees, but without evidence that other practices and other agents are not triggered.

Another aspect to be highlighted refers to the way in which the healthcare professional makes its guidelines, most of the time, regardless of the context of a person's life.

The doctor told me to hike to lower the pressure. I don't stop, I walk all day long, I wake up, give corn to chickens, sweep the yard, pick up the dry leaves, make food, wash everyone's clothes, there is a lot of dirty laundry, farm clothes, you know. In the afternoon, I'm going to pick up firewood with the children, I step on the farm, pick up cassava, carry it on my back and head until I get home. I'm going to see my mother, who is sick. I do the dishes and bring her clothes to be washed. Then, it's time to water the plants, to heat the dinner, to clean the kitchen, to take a shower, and go to sleep. What time do I have to hike? (Interviewee 24).

In her speech, she claims especially the recognition by the healthcare professional that in her everyday activities she already carries out numerous activities that move her body, and even so she has high blood pressure. Thus, the recommendation of physical activity practice as a positive action in reducing the level of blood pressure may seem contradictory for those who believe to remain active in their daily routines.

On this subject, Rozemberg and Minayo (2001) highlight that in health services, medical recommendations for people's behavior changes are treated regardless of the environment in which they live. We perceive, therefore, that the ignorance of the everyday life of the people and the nonacceptance of their afflictions hinders the approach and the results of the treatment proposed.

In spite of the difficulties referred to on the understanding of the treatment received, most interviewees reported the regular use of medication and resources they judged important, and not contradictory, to the treatments offered by the doctor.

Therefore, it is possible to affirm that the Teréna perform numerous arrangements and negotiations between its health system and biomedical system in conducting the therapeutic process. In other words, they make a reading of the biomedical apparatus according to their perspective and use it for their own benefit.

As an example of this negotiation, we highlight the use by Teréna of yerba mate with certain roots and leaves added to the mate water (*chimarrão*) as a resource to lower the level of blood pressure. Although the medical recommendation was for the restriction of the consumption of yerba mate, its use is understood as a therapeutic representation similar to certain therapeutic drugs recommended in the blood pressure control.

I take root... that lime leaf... I put three leaves inside to drink the mate. Because then the pressure doesn't go up, right? I drink in the morning [the mate], then after lunch I take this medicine [of the health center] (Interviewee 13).

[...] together with mate, I take mulberry leaf, every day. I believe in both [remedies]. There is no difference, everything is remedy (Interviewee 14).

Early in the morning I pray for God. Then I get up and there're always roots in the kettle. I drink the mate early and there is root in the mate water. I hardly take pills (Interviewee 15).

Gallois (1991) defends the assumption that the disease should be analyzed placing it in a broader level, which is interrelated to the social and cultural reality of certain people.

Final remarks

Despite changes and new ideologies, the shamanism remains present and important in the

daily routine of the Teréna. The belief in the need for harmony between the environment, the spirits that inhabit it, and the people's body is identified in the narratives gathered.

We understand that the experiments experienced by the Teréna in understanding their diseases and in the search for the cure are proceedings resulting from local knowledge, the participation of the diverse actors involved, resources, and technologies available, all enrolled in a cultural and social dynamic context.

The guidelines received by health professionals are part of a parallel and hierarchical knowledge, for they reflect a recognition of the legitimacy of prescriptions of the doctors, who studied and have the authority due to their knowledge. However, the instructions are not always followed, because the doctors are often unaware of the daily life and do not take into account particularities and risks to those who live there, who are the only ones subjected to them. Somehow, this defines the gap between biomedical knowledge and local wisdom.

Approaches and reinterpretations of the recommendations received by the medical staff were observed, as in the case of restriction of the consumption of yerba mate (*chimarrão*), which continues to be used by Teréna with hypertension.

If, in the current configuration of the Indigenous health care system, the biomedical knowledge is imposed without considering the effective conditions for the implementation of the recommendations (restriction of food, physical activity, and use of medicines at fixed times), other actors constitute important alternatives in health care, based on each person's and each family's experiences, being used simultaneously without causing major conflicts. Thus, the use of various resources available is guided by the pursuit of the understanding and the solution of the suffering experienced, extrapolating the physical and showing a complex and broader view of the disease.

To recognize the ways in which the Teréna seek the balance of the body and to consider the non-passivity of reinterpretations before adverse conditions and recommendations that they experience is the challenge of those aiming to prevent and to treat diseases in different social groups.

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Authors' contribution

Ribas participated in the conception of the study, fieldwork, elaboration and approval of the final version of the manuscript. Concione guided the study and contributed for the drafting of the article. Pícoli participated in the drafting and critical revision of the article.

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