


The sound of maracas (tribute to Ailton Krenak): indigenous medical practices and public health¹

O som dos maracás (homenagem a Ailton Krenak): medicinas indígenas e saúde pública

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Abstract

Over the past decade, we have seen the gradual setback of public policies for indigenous health care in Brazil, especially with regard to the basic pillars of its formulation, developed from the 1980s onwards: specific and differentiated attention, participation, and social control. This paper, despite mentioning some critical moments in this process, offers an opportunity for some reflections on how policies and practices, essentially biomedical, can be understood in the more general context of indigenous societies in the country.

Keywords: Indigenous Health; Health Policies; Indigenous Medicines.

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¹ I must say that I like beautiful titles, even though I have rarely done them, due to the academicism of the time. But it is really a tribute. I was invited to participate in Nayara Scalco's doctoral examination board and Ailton was also in it. He arrived with the maraca and played it to acquiesce to the reigning noise and be able to start his speech. For me, this is more than a mere request for silence to those present: it is a sign that something solemn and sacred is about to happen, a sound that invokes good spirits so that speech can be a "good speech," one that brings knowledge and wisdom. Thanks to Nayara, Marília Louvison (her supervisor) and, of course, Ailton. Any references to the data I have collected and cited in this text (or in reference to other texts already published by me) originate primarily from my postdoctoral project funded by the Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq) - Process 15.1548/2004- 8 - and, subsequently, from the indigenous health research project coordinated by me, also funded by CNPq (Process 401240/2005-3; Registro Conep 12.545) and which was authorized to enter indigenous lands by the Fundação Nacional do Índio, term of consent authorized by the local chief and collaboration of the Instituto de Pesquisa Etno-Ambiental do Xingu and the then students of the Graduate Program in Social Anthropology at the Universidade Federal de São Carlos, Marina Pereira Novo, Antonio Guerreiro and Reginaldo Silva de Araújo.

Resumo

Durante a última década assistimos ao retrocesso paulatino das políticas públicas de atenção à saúde indígena no Brasil, principalmente no que concerne aos pilares básicos da sua formulação, construídos a partir da década de 1980: atenção específica e diferenciada, participação e controle social. Este texto, apesar de citar alguns momentos críticos desse processo, dá ensejo a algumas reflexões sobre os modos como as políticas e as práticas, essencialmente biomédicas, podem ser compreendidas no contexto mais geral das sociedades indígenas no país.

Palavras-chave: Saúde Indígena; Políticas de Saúde; Medicinas Indígenas.

In the Greater Antilles, some years after the discovery of America, whilst the Spanish were dispatching inquisitional commissions to investigate whether the natives had a soul or not, these very natives were busy drowning the white people they had captured in order to find out, after lengthy observation, whether or not the corpses were subject to putrefaction. (Lévi-Strauss, 1980, p. 22)

Who actually does “science”? This essay did not start like this, but in the face of the pandemic we are experiencing, the original text has been changed, as it is no longer possible to be unaware of the events or to refuse to understand socio-anthropological factors that may possibly contribute, however small that contribution may be, for the understanding of what we are going through. Thus, written almost in the first person, it references anthropologists and ethnologists who listened to, investigated and recorded the indigenous speeches and narratives, even though “they may have not got it right” (there are versions and “verzions”), to carry out some effort of analytical comparison whose basis is not “the Indian,” but what we still insist on calling “humanity,” in all its diversity and difference.

The problem is already there, for what notion of “humanity” are we referring to? People who have a soul or not (Christian, or Christianizable, preferably)? Ordinary people, whose bodies, similar to ours but “others,” putrefy and are not or do not seem to be spirits wearing different “clothes” to deceive us? The world is inhabited by many different “beings” and we need to be careful.

The last ten years, at least, have enabled, through political, social, academic, artistic and digital inclusion, “the Indians” to take the floor and acquire oral and written linguistic competence in Portuguese (in addition to that in their native languages) and continue to teach us, and it is to that teaching that this article is dedicated, with all its limitations of text, information and training. There are indigenous theories, in all their linguistic, mythical and contextual variations, which point to a world inhabited by countless beings, among them the “humans,” “ours” and “others,” but whose precarious balance is maintained by the delicate relationships they establish among themselves and with one another. According to

recent news about the current pandemic, biologists, environmentalists, epidemiologists and other experts tend to claim the same. Thus, the purpose of this essay is to bring some elements to this discussion, and, if possible, in the already troubled (to say the least) political period that we are going through, to endorse public health policies that take into account not only indigenous medical practices, but, and mainly, the precepts on which they are formulated, as this not only involves native therapeutic techniques and practices, directed and performed by and for its practitioners, but the necessary adjustments to a socio-political economy that includes sanitary, agroecological and environmental aspects that also presuppose “our” joint existence as “humanity.”

During 2011 and 2012, I was the representative of the Brazilian Association of Anthropology (ABA) in the Ministry of Health’s Intersectoral Commission for Indigenous Health (Cisi). I quote this because it was precisely during this period that the Special Secretariat for Indigenous Health (Sesai) began to be implemented, created in 2010 by Decree No. 7336 as an integral part of that Ministry (Brasil, 2010). Previously, the planning, resources and actions for the area were linked to the National Health Foundation (Funasa), which had already created the model, still in effect, of attention to indigenous health through the Special Indigenous Health Districts (Dsei) and the decentralized and hierarchical service network that was subordinate to it: health posts in the villages, health care centers, multidisciplinary indigenous health teams (EMSI) and Indigenous Health Houses (Casai), located in cities surrounding indigenous lands

and in reference hospital centers.² The creation of Sesai then met the requests of the indigenous communities and movements themselves for the centralization and coordination of health actions for indigenous peoples, maintaining the specificities of the National Policy for Attention to the Health of Indigenous Peoples and the process of management of the Indigenous Health Care Subsystem (Sasi) in the Brazilian National Health System (SUS). Among Sesai’s main duties are the promotion of differentiated attention, participation and social control of the indigenous people over the formulation and management (including budgetary) of health resources and actions directed at them.

It was as a witness of what happened then that I start writing here, perhaps even as a way to dispel the malaise that I still feel about my experience.³ More academic analyses on the topic of public health policies for indigenous populations in Brazil can be found in other articles by researchers in the field – for example, in some of the chapters of the collection organized by me and Esther Jean Langdon (Langdon; Cardoso, 2015). Changes in institutional responsibility for service provision always cause disruption. In relation to indigenous health, this had already happened when assistance was transferred, in 1999, from the Fundação Nacional do Índio to Funasa. Services were interrupted and, even with the implementation of the indigenous health care model, there were numerous reported problems, ranging from the repeated delays in budget transfers to the difficulties of indigenous associations in following a bureaucratic and managerial protocol that was foreign to them.⁴

Even though there is already a service network for care, although precarious, the problems occurred again with the transfer of health actions from Funasa to Sesai: activities stopped for

2 Anyone who wants to view the model, as well as consult the past history of indigenous health policies in Brazil from an analytical perspective, can refer to Cardoso (2015).

3 The “malaise” here refers to the expectations of finally acting directly with my knowledge in the area, arising from research conducted by me and other diverse researchers, towards public policies on indigenous health. What I watched, then, even though I was aware that Cisi is merely a consultative rather than a deliberative body, was the deepest indifference of the managers in relation to the proposals of the various representatives of the academic, scientific, legal, social and indigenous areas who composed or were invited to be in the Commission. Since 2016, ABA is no longer part of Cisi.

4 The thesis of Reginaldo Araújo (2019), already published as a book, reports this process when analyzing how this action was carried out with regard to the Xingu Dsei, the first to be created, still in 1999. Luiza Garnelo and Aldemir Maquiné (2015) also address the complexities of the management and bureaucratic system in view of the demands for more agile and effective assistance for indigenous health services.

months, delay in meeting emergency measures and the beginning of new measures that came into force for the management of resources, among them (and what seems to me to be the most relevant one) the non-renewal of contracts with indigenous associations and the various indigenist organizations that had taken on the task of managing resources and health actions in the different indigenous lands, in favor of hiring organizations that presented the Social Assistance Charity Entity Certificate. Thus, indigenous and indigenist entities whose contracts had expired were excluded in advance from the public call notice issued by the Ministry of Health in October 2011, which aimed to hire institutions to work in the area of indigenous health. At the time, only three private non-profit entities (considered philanthropic) were contracted: Missão Evangélica Caiuá, Associação Paulista para o Desenvolvimento da Medicina, and Instituto de Medicina Integral Professor Fernando Figueira.⁵

I highlight this measure because it had a huge impact on “self-management control,” as it prevents the indigenous people from acting more directly in resource management, budget control and health actions, in addition to a series of centralizing measures that, at first, would not meet the different demands of the various Dsei and their distinct areas of ethnic and territorial activity. The local and district councils and their national forum apparently continue to operate, but at the expense of intense participation in all decision-making spheres that had been observed until then, in addition to the loss of the political control that self-management allowed and which is now subsumed to the neoliberal policies of dismantling SUS and, of course, Sasi. In this case, since the early 2019, we have witnessed attempts to terminate Sesai, which were reversed by the marked indigenous mobilization; however, critical problems still remain, if not aggravated, already extensively reported by researchers in the field: low effectiveness of health actions in the districts, marked by the lack of qualified professionals to serve the population and their high

turnover (which was, for a certain time, supplied by the Cuban doctors of the Mais Médicos Program, who no longer participate in the Program), and lack of infrastructure resources and equipment for certain procedures operated by Dsei, as well as integration and a more effective communication system with that of reference in SUS, which has also been suffering damage in these times of dismantling public service structures (Cardoso, 2015).

However, in the face of ostensibly anti-indigenous public policies (in all sectors), the indigenous movements (in the plural, because they are several, coming from the various indigenous associations and some with a partisan political character, but which have the same common agenda, i.e., the defense of the territorial and constitutional rights already ensured, among them differentiated access to health services) “reflourished” (if it is correct to say so), and in a very peculiar way: in addition to public face-to-face demonstrations (as was the case of the I Meeting of Indigenous Women in 2019 and the holding of the Terra Livre Camps, for example), today there is an extensive presence of indigenous people online, in university, academic-cultural networks, disseminating their knowledge and, of course, their medical practices and their healing spaces.

All of this is moved by them asserting themselves as participants in the world, and no longer as tutored subjects as they were seen until then. This extensive presence in networks allows not only rapid communication between the various relatives to disseminate common agendas, complaints and mobilizations (as is the case with current actions to curb the entry of covid-19 in the villages), but also the realization and dissemination of works in spaces that used to exclude them, such as photographic, cinematographic and artistic exhibitions, literary and musical festivals, whose languages (films, photographs, books, paintings, installations, songs, radio programs, among others) they can use to perform the critical exercise of the non-indigenous world, but maintaining one (or several) indigenous point of view.

5 It was not possible to identify on the Sesai website how many there are currently, or even what their duties are.

This was probably only possible due to access to digital technologies, indigenous schooling (even if still precarious) and the entry of indigenous people into universities and extension and training centers during the last decade. But, of course, the intensive search for these trainings and this access has always been an indigenous prerogative, because, contrary to what common sense may think, the search for knowledge and mastery of different technologies has always been actively undertaken by them; not at the expense of their own knowledge and technologies, but as a mechanism of the very exercise of human thinking of “bricolage”:⁶ after all, everything is “a present” (for better or worse) from the “creators,” from the “owners”⁷ of the things in the world, which are other beings, non-human and not visible to us, only to shamans. The assumption of the sacred nature of the world demands respect, sharing and is a form of ethics in relation to all others, human and non-human, visible or not, even if this distinction is fallacious, but still necessary for our deaf white ears.

From this assumption, which is exposed here in a very general way, all relations established with the land, which is not “ours,” are derived too, just like the waters and what we call, in general, “nature” are not “ours”: Animals, plants, trees and everything else that inhabits the world. To hunt, fish, harvest or plant it is necessary to ask permission from the “owners,” follow some precepts and rituals and do it moderately, just to ensure physical reproduction (which is also moral; in fact, greed is one of the “mortal sins” of this cosmophilosophy) of the group. Luck or bad luck in hunting and fishing, good or bad harvest will depend on these factors, which, if

not respected, may even bring diseases. Let’s recall here Davi Kopenawa’s work,⁸ which masterfully illustrates this perspective, mainly from the point of view of the whites’ entry into the Yanomami lands, generating destruction and, consequently, diseases and deaths.

The same movement is reflected in the preservation and dissemination of indigenous healing rituals and their different techniques, whether shamanic, herbal medicines, or women’s health care, for example, with regard to childbirth. Several “indigenous and/or traditional medicine centers” have been created, both in indigenous areas and in cities – such as Bahserikowi’i, located in Manaus, AM –, and they also serve non-indigenous people and are managed by their own practitioners. Nuclei for the production and dissemination of indigenous knowledge were also created, such as the Nucleus for Studies on the Indigenous Amazon, from the Universidade Federal do Amazonas, or the Education through Work Programs (PET)⁹ of Indigenous Health, such as that of the Universidade Federal de São Carlos or that of the Universidade de Brasília, which promote debates on the topic. Thus, the occupation of spaces, including academic ones, is actively sought in order to give greater visibility to indigenous issues (mainly territorial and environmental) and disseminate their practices and knowledge.

The case of indigenous health is exemplary. Since it was formulated, Sasi has adopted “differentiated attention” as one of its pillars, which means respecting traditional indigenous medical practices, their precepts and agents in health actions and even incorporating them into the subsystem. On the one hand, there were programs and incentives to promote

6 Lévi-Strauss (1976) coined the French term “bricolage” to refer to one of the ways in which (human) scientific thinking operates: mythopoetics, an intellectual form that works through continuous sensitive approaches, heteroclitical combinations of diverse, pre-existing, fragmented and finite materials, such as myths. For the author, this form differs from that of science not because it is less “scientific,” but because it creates its own methodologies and results through the continuous generation of its conceptual, hypothetical and theoretical structures, always raising new events and new intelligibilities.

7 Owner” (or “master”) is a broad ethno-Amerindian category, that is, it is a way of translating indigenous terms into Portuguese (or English) that refer to someone (human or not) who is assigned the role of owning or controlling something or someone, as well as the mastery of certain knowledge, the promotion of care, protection, or even the collective representation, for example, of the group, as the chiefs.

8 This is about the book *A queda do céu: palavras de um xamã yanomami* (Kopenawa; Albert, 2010), written in partnership with anthropologist Bruce Albert. For a more complete discussion on the topic, one can also consult the book organized by Bruce Albert and Alcida Ramos, *Pacificando o branco* (2002).

9 According to its precepts, PET, which has been operating since 2009, integrates education, service and community, and is a partnership between the Secretaria de Gestão do Trabalho e da Educação na Saúde, the Secretaria de Atenção à Saúde, from the Ministry of Health, and Secretaria de Educação Superior, from the Ministry of Education. There are more specific PETs, among them those aimed at indigenous health.

this integration, but this was always occasional, with “differentiated attention” remaining in the rhetorical sphere of official speeches. On the other hand, this took place (and still does) in the trajectory and in the indigenous therapeutic praxis, due to the simultaneous resort to health posts and units, as well as to local shamans and healers. I have pointed out in other texts that indigenous medical practices do not exclude “other” medical practices or their resources and techniques (on the contrary, they even demand them as a right), but they encompass them because, in the *bricoleur* way, the meaning (absent in science) is outside of the precepts, here biomedical, and builds on their own cosmologies and ontological compositions (Cardoso, 2004, 2015).

Therefore, for me, it makes little sense to name this process as “pluricultural,” “intercultural” or “transcultural”:¹⁰ it is a human phenomenon of the order of the intellect (and, of course, of its multiple therapeutic and symbolic efficacies) that produces new forms that can be combined in different ways; nothing that we have not already seen in these lands, such as spiritist hospitals, *candomblé* or *umbanda* centers, Chinese medicine clinics and many others. There are dividing lines, but possibilities for convergences (phytotherapy, obstetrics techniques, for example) and others that follow alongside.

Indigenous care with the “making of bodies” (Viveiros de Castro, 1979) is not dissociated from control over relations with other beings, humans and non-humans; on the contrary, they suppose it. Thus, diseases and therapeutic processes are rarely restricted to a technical determination: they necessarily refer to representations about the body and the construction of the “person” (Mauss, 1974a, 1974b; Seeger; Da Matta; Viveiros de Castro, 1979), which are formulated in logical systems of symbolic character that relate nature and society in a cosmological and transcendental order. For this very reason, “medical pluralism” or “intermediality,” as the way in which biomedical practice is being incorporated into indigenous therapeutic strategies has been characterized, has not implied a substantial change in its underlying fundamentals and

principles, but its instrumental and prophylactic addition to native practices (Cardoso, 2004, 2015). Thus, the precious logical, technical and symbolic resources that humanity, with all its differences, still preserves have been maintained.

According to the news spread in newspapers and information sites of various communication vehicles of research institutions or indigenous and indigenist associations, the advancement of covid-19 in indigenous areas is already a reality. The rate of contamination and mortality, according to several researchers, depends on the degree of isolation in which the communities find themselves: whether in urban areas and/or peripheries, camps, rural areas or villages and more remote indigenous lands (Codeço et al., 2020). The increasingly uncontrolled intrusion in indigenous areas, demarcated or not, by mining and criminal agricultural activities (unconstitutional today), coupled with the precariousness and collapse of health care services, makes indigenous groups increasingly vulnerable to the current pandemic. But, in addition to the eminently technical aspects of epidemiological projection and control, other factors must be considered in order to have the real dimension of the tragedy already foretold.

Historical, epidemiological and demographic records establish a close relationship between epidemics (mainly those of smallpox, measles and influenza) and the Amerindian depopulation since the beginning of the contact and the European and national expansion and colonization fronts (Santos; Coimbra Junior, 2003). Massacres, slave labor and epidemics led to occupations in devastated territories and, according to various ethno-historical reports, also other population, demographic and cultural rearrangements, such as, for example, the case of the current Xingu Indigenous Land, which oscillated between displacements, fragmentations and regroupings due to the high degree of mortality that some villages and/or groups have suffered from epidemics over the past centuries, and even over a few decades (Heckenberger, 2001).

What appears to be “new” in relation to the current pandemic is perhaps its global dimension, which

10 For a strong criticism of the concept of interculturality and its political use by neoliberal public health policies, consult the text by Boccara (2015).

also falls on whites and which indigenous leaders such as Raoni, Kopenawa and Krenak “warned”: the delicate and complex socio-environmental balance is not altered without serious consequences for all, assumption defended also by the different sciences of the modern world, aside from the fallacy, supposedly laughable, of the “revenge of mother nature,”¹¹ which is the way in which it is intended to obliterate the refined knowledge that comes from the “peoples of the forests,” founded on the meticulous observation and sensitive experimentation of the world (Lévi-Strauss, 1976).

Dominique Buchillet’s (2002) analysis of the Desana’s representations of the upper Rio Negro on epidemics, in particular on malaria, is exemplary. The Desana recognize that malaria was not brought by whites, as was smallpox, measles or influenza, but it is a “disease of the universe,” known to them for a long time and associated with pools of water between stones of river waterfalls, “hot spots of malaria,” home to numerous mosquitoes that proliferate around these puddles and are also related to paludal outbreaks. It is the shamans who see and learn to close and control these “spots” and mosquitoes, which can be opened, broken or damaged during flood periods (or even by the shamans’ deliberate action), but also by whites’ predatory activities while dynamiting rocks and river stones for the construction of buildings, hydroelectric plants or mining, thus releasing paludism into the waters (Buchillet, 2002).

Whites seem, therefore, “inexhaustible sources of goods” (Franchetto, 1992, p. 353), but also of contagions, diseases and deaths. However, a parenthesis must be added here. In this understanding of diseases as contagions of whites, native exegeses often overlap shamanism and sorcery. I have heard, for example, that the measles epidemic that devastated the Xingu and decimated almost a third of the local population around 1954 was indeed a shamanic attack by rival groups. The two explanations are not mutually exclusive, but

they complement each other in a hierarchical order of multiple causalities that are linked. Even because “disease” is almost always the result of a spell or “theft of the soul by some spirit,”¹² and often from the combination of both.

Ethnological records from different peoples, whether from the lowlands of South America, or from other lands and continents, almost always make this correlation, even if the techniques of sorcery and/or shamanic practices are different or have another ontological assumptions (which will not be possible to elaborate here). For this reason, medicines and biomedical practices are only specific resources for symptoms relief; healing requires other operations, of a spiritual character, in the shamanic sense of the term. For the Kalapalo, whom I know best, all diseases, even those of the whites, are ultimately spells (*kugihe*, in Karib Kalapalo), and the sorcerer is the *hugihe oto*, or the “owner of the spell,” the one who, for envy, jealousy, greed, discord or even malice, shoots the “spell arrows” at his human targets and who can, for greater precision of the “arrow-shooting,” carry something that belongs to them - remains of nails or cut hair, pieces of used ornaments, and so on. In times of great tension and conflict in the villages, one tries to be extremely careful not to leave anything in sight that could be caught or used by possible sorcerers. The sorcerer acts alone or in groups, but he can, and often does, ally himself with the spirits (*itseke*) that inhabit the world.

The Kalapalo describe the *itseke* as anthropomorphic beings that inhabit forests and the bottoms of rivers and ponds. Present at the origin of the world, they became invisible to human people, who were created by Taügi (“Sun,” one of the twins that created current humanity) during an epic conflict that is reported in the myths of origin (Cardoso; Guerreiro; Novo, 2012; Guerreiro, 2015). The diseases caused by the *itseke* result from the successive approaches they make to humans through the “theft of souls” (*akuã*),

11 Els Lagrou (2020) made a timely analysis of the Huni Kuin ecosophy and its relationship with the recent discoveries of epidemiologists and biologists about the viral epidemics that have happened today.

12 The term “spirit” here does not refer to the common meaning of “dead,” but to beings that already existed in the beginning of the world and continue to exist in it, but that, in the time of human people, are only visible to shamans.

generally because they violated some relational norm, such as killing without need or justification any animal, whose “double” starts to chase the transgressors, making them ill. The true Shamans (in Kalapalo, *hüati heku*)¹³ are people who have gone through this illness, and through prolonged imprisonment, various abstinences and training, in the case carried out by other shamans through mainly tobacco use, go into a trance and thus acquire the ability to see and to relate to the *itseke* that generated the original illness episode, which will now be his “guiding spirit” and will help him in the negotiation of “stolen souls” by other spirits, revealing even if there is or who is (are) the sorcerer(s) involved. That was the story of Nümü Kalapalo, who gave me his testimony and also made me a revelation: the spirits act like this to provoke the exchange, because they need “things” (cloths, necklaces, *tukanapes*) that will be obtained through the “payment” made to the shaman so that the “stolen soul” is returned and the cure comes to anyone who has been affected by some evil (Cardoso, 2007).

The healing rituals, as well as other rituals and the most diverse ceremonials, not only offer an opportunity for the exchanges, form and realization of societies (Mauss, 1974c), but seek, by these means, to reestablish and strengthen the delicate relationships between the different beings that inhabit the world and that affect bodies due to their multiple possibilities of transformation, as illustrated by the anecdote mentioned by Lévi-Strauss (1980) and quoted in the epigraph of this text. The most recent analyses on the theme have emphasized a discussion more focused on the ontological dimensions that would be underlying these ceremonial and/or shamanic practices. Thus, it is no longer a question of

attributing categories of human relations to the relations between humans and non-humans, but the very possibility of dissolving the natural and cultural series with which the Western cognitive model operates.

For Viveiros de Castro (2008, p. 92), for example, it is not about just supposing a “nature thought as culture - a supernature,” but a “culture” shared by different types of “people/bodies,” which denotes continuous approaches that create relationships, possibilities of communication between beings and their eventual final transformation to a world that is no longer here. Perhaps it is possible to think, by these means, of the recovered ancestry as an “eschatological becoming”: “Just as animals were human at the beginning of everything, humans will be animals at the end of each one: the eschatology of (de)individuation reencounters the mythology of (pre)speciation” (Viveiros de Castro, 2008, p. 100). The emphasis on spirit (*itseke*, not the animal, *ngene angolo*)¹⁴ and its anthropomorphic form suggest much more the widening and deepening of the notion of ancestry instituted essentially in a common background (perhaps that of the “creator spirit”), although differentiated in and by bodies (Viveiros de Castro, 2008), but that is always necessary to recreate through exchange.

The problem, however, remains open. The same can be said of human relationships, which require their continuous making and remaking through the control of bodies, their mutations and the bundles of relations (spiritual, ancestral, social and those derived from kinship and household) that cross and constitute them, and that must be updated by specific communication ritual, ceremonial and shamanic codes. For this reason, indigenous medical practices escape the

13 There are other shamans (*hüati*) who also heal through the use of tobacco smoke, prayers, plants and herbs, but do not go into a trance like the *Hüati heku*.

14 According to some versions of the Kalapalo myths, “animals” were like “people.” They died in the war waged by Taügi to retaliate against the near death by poisoning of his real mother by the jaguar-mother-in-law, and the concealment of the fact. Taügi, later, would have “prayed” about them: they came back as “animals,” but with “souls.” The “animal spirits” would be the same ones that Taügi killed. For this reason too, they would bring disease to the Indians (who would have been created by Taügi to help him), which would be an interesting way of thinking about war/death/illness through this mechanism. The Kalapalo, however, place much more emphasis on sorcery as the main disease agency, perhaps the same that poisoned and ended up killing the mother of the creator twins (Cardoso; Guerreiro; Novo, 2012).

narrow limits of health management, even if they also require it: they are other “managements” of diseases, conflicts, and relationships that, as I tried to outline here, occur in multiple plans of therapeutic exegesis, and whose socio-environmental dimensions demand due attention from us to “postpone the end of the world,” as Ailton Krenak (2019) recalls.

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