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ARTICLE

Healing in the Hospital: the Caring Sensorium and the Containment of Yanomami Bodies

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Abstract

This paper addresses the question of care in a hospital environment. Focusing on Yanomami people at a hospital in Venezuela, I show how Yanomami practices of re-making the body and restoring health are challenged by the material practices and sensorial qualities of the hospital. Being ill for the Yanomami is an uncontrolled bodily transformation, resulting from improper interactions with other beings. I examine the relation between different components of the Yanomami body, and focus especially on the reconstitution of the body envelope or skin as a fundamental aspect of healing. This reconstitution is accomplished through body techniques that notably involve the senses and which foreground the importance of containment. I argue that the hospital operates as another containing layer among a multiplicity of forms and practices of boundary-making in the healing of bodies. But for the Yanomami, this hospital-container is inappropriate for healing, in the sense that prescribed food is lacking, scents are disturbing, temperatures are either too cold or too hot, relatives and shamans are too far away. I show the significance of recursive practices and the materiality of containment in the processual making of Amazonian bodies, and end with a reflection on the articulation of different projects of healing in the hospital.

Introduction

For the Yanomami, hospitals are very ambiguous places for healing. They bring into tension the power and effectiveness of doctors' treatments, and their maximal social alterity. But most importantly, they condense the difficulties and dangers of healing far away from home.

The following scene happened at the hospital in Puerto Ayacucho in 2010, in the Amazonas state of Venezuela. I walked with one of the kitchen staff down the aisle connecting the wards as she pushed the trolley with metal trays filled with food for lunch. She handed trays to a couple of Yanomami women, and turning to me she said, "you see, we give them the trays, and they take them and eat it all, we receive them back empty." Immediately after her comment, we both saw against the backlight of a window at the far end of a corridor how the Yanomami women walked with their trays to the nearest rubbish bin, and there, stopping and taking the bread and fruit, threw the rest into the rubbish. The kitchen assistant looked at me with such an expression I could not tell if it was disbelief or fear of having been betrayed by these women tipping the greater content of their trays into the rubbish bin. I could not help but wonder, had the hospital staff really never noticed this before?

It is likely that people turned away from such incidents, which revealed that Yanomami and other indigenous people in the hospital do in fact really dislike the food and possibly go for days without eating much. This clearly goes against any biomedical understanding of how important nutrition is for healing, and even against common sense hospitality in Venezuela.

However, in a hospital in which there is a chronic and persistent situation of scarcity - of medicines, of personnel, of laboratory resources, of clean and comfortable rooms - in which caretakers are overwhelmed with different forms of crises, the nourishment of inpatients fell low on the list of priorities.¹ This is especially true since the hospital usually struggled to provide food for all their inpatients on a daily basis. Some months, the budget was not even

enough to buy food from regular suppliers.² Even if the hospital would have accepted the buying of indigenous food staples from the local market, the simple fact that receipts are not given in this market means that there is no choice but to buy industrialized food from the formal shops. Within these budgetary and administrative constraints, what would seem like a desirable situation - providing better or culturally appropriate food for indigenous peoples - turns into an impossibility for one or another reason.

I assume that caretakers such as the doctors, nutritionists and nurses, were ultimately genuinely interested in the recovery of their patients. But certain practices contributed to not realizing what the problems experienced by indigenous patients were. For example, there was no systematic way in which they could be made aware of what was going on with Yanomami people's nourishment in the hospital. For one part, the eating activities of indigenous patients were usually not registered in the medical records. In principle, nurses and doctors ask patients daily if they have defecated, urinated, or if they are feeling worse or better. They also ask if patients have eaten, but rarely how much and whether they liked it - unless of course the nutrition or digestion of the patient is considered part of the medical problem affecting a person. But the vast majority of medical and nursing personnel are unable to speak any Yanomami, and Yanomami people often have difficulties in fully communicating in Spanish. Even in cases when the health personnel do ask, interactions might be completely misleading, leading to important equivocations. For example, it is common to hear interactions that go like: "Did you eat?" "Yes" ("*Ya comió?*" "*Si*") in which the Yanomami is thinking the verb 'eat' is an invitation to eat, when they are indeed hungry. As in the preceding scene, it is most often just assumed that because patients receive food, they eat.

In this paper I explore the equivocal encounter of different ways of practicing sickness and healing in the hospital, and some elements of care that fail and increase suffering. Kelly (2011) has suggested that among the Yanomami this depends on the alterity of doctors. He shows the equivocal coexistence of partially overlapping processes of transformation in which doctors try to civilize the Yanomami people, and the Yanomami try to appropriate certain practices from doctors (as radical others). However, diverging projects of body-making are also central in the coordination of healing practices. Although biomedical and indigenous healing practices may each show considerable internal diversity, there is a significant ontological gap separating them (Bonelli 2015). We have then on the one hand a biomedical notion of bodies affected by biological pathogenic agents or physiological processes, which can be revealed through different technologies, and are healed by medicines, prescribed postures and movements, hygiene and biochemically defined nutrition. On the other hand, we have Yanomami people's perspectivist and processual practices of body-making (or of its remaking during sickness) in which spirit agents are part of an animistic ecology of living beings which may cause disease.

My position as a medical doctor and anthropologist in this encounter was frequently that of accompanying Yanomami patients and their relatives as a translator. This translation was not only linguistic. I helped them sort out the many practical difficulties they had in living and healing in the hospital, amidst equivocations surrounding bodies and personhood, food, and pathogenic agents, in an environment that the Yanomami perceived as powerful in terms of healing, but also filled with radically different people and dangerous spirits. I also intervened at times as a doctor, by interviewing and examining patients, writing down notes to speed up care activities inside the hospital, taking samples, helping patients move around or be more comfortable. It was this practical engagement in a process of care, what allowed for equivocations to become partially recognizable.

For Amazonian people, the body is the main centre of personhood, which shapes perception and agency (Seeger, da Mata and Viveiros de Castro 1979). There is wide consensus that bodies in Amazonia are in a permanent process of transformation by means of a range of relational practices involving the body (Taylor 1996; Vilaca 2002). Some of these transformations are positive and actively sought, but there are also uncontrolled transformations which result in illness or death. In sickness, the human body becomes more like that of other species of animals, or like the dead.³ Healing requires a controlled form of transforming the body back into that of a human being, a kin. The body has been conceived "a bundle of dispositions and affects" that is held by a kind of "cloak" (Viveiros de Castro 1998). However, a sort of multiple-layered envelope that contains the vital soul or essence of

all living beings and conforms what we call “body” (Barbira-Freedman n.d.) has been less studied. This envelope is usually translated as “skin”, but it may comprise other elements such as clothes and ornaments. Yvinec (2014) stresses that for the Suruí health is a temporal state that is related to the “skin” part of the body. Many pathologies in Amazonian are indeed related to surfaces of the body or its orifices. It follows that healing in Amazonia may be above all a matter of re-containing a body (as an essence, a self, a person) whose skin or envelope has become somehow disrupted.

Far away from home, the hospital was for the Yanomami a place which strongly challenged the most basic principles of body re-making. What I suggest in relation to the process of healing the body, is that a recursive configuration of containers or containing practices was important for the process of healing. Drawing an analogy with practices of transformation such as those of alchemy, I pay attention to the containers and the containing operations they allow, as elemental in a process of bodily transformation. Amazonian people, including the Yanomami, have different kinds of important containers - pottery, baskets, funerary gourds - which may also be significant in the life-long process of making people. I will not focus on those here, but these potentially would expand the relations I will here trace. I focus instead on two forms of containers that are fundamental for healing: the skin-envelope of the Yanomami patients that needs to be reconstituted into health, and the hospital itself as a form of container in which this reconstitution of the skin-envelope happens. In between these two layers, other containment practices will also be considered.

What I am examining in more detail here are the ways in which the hospital as a container challenged the sensual making of Yanomami bodies, as compared to healing in a Yanomami village. Many hospitalized Yanomami perceived dangers and obstacles that would normally forestall healing in their own villages, such as the inability to perform certain rituals or prescriptions, or the presence of dangerous beings or influences. The hospital environment crucially affected the ability of people to nourish others and to be nourished, and also their ability to rest, dream, urinate, defecate, bath, and be well and happy among their relatives. Furthermore, the sensorial landscape of the hospital itself - the warmth or cold, scents, lighting, sounds, a general sense of being contained in the hospital - created very particular conditions in which skin or envelope reconstitution happened. I follow in more detail the severe illness of a young boy. Other cases of severe illness in Yanomami villages also elicit similar affective states of anxiety, doubt, fear and anger, as healing practices may not always work. But the sensual landscape and structural limitations of the hospital made the healing process even more fraught, and hence the equivocations more evident for me, the anthropologist. The hospital setting, its sensorial qualities, and its ever failing care, provided an ideal though unfortunate setting for exploring what the Yanomami valued as important for healing.

Hospital Food Stinks

Thë ni bithāri, “it stinks,” many Yanomami people said when I asked them about the food they were given at the hospital in Puerto Ayacucho. Served on a metal tray, they usually received a piece of bread, some fruit, a portion of rice and one piece of meat or chicken. The meat was usually prepared with carrots, tomatoes, onions, garlic and several spices. *Thë nikerewë*, “it is mixed,” the Yanomami exclaimed with disgust, referring to how the *napëʔ* cook together different categories of food, adding ingredients that the Yanomami utterly dislike such as garlic and onion. While roasted chicken has somehow made it to be one of the favorite foods of Yanomami people who travel to Puerto Ayacucho, they still find beef repulsive. Furthermore, during illness some kinds of food are to be avoided all together, and meat especially can be quite dangerous to eat. With no money of their own, and few known people in the city who could help them, most Yanomami have no other options for accessing alternative forms of food that they find safe and tasty, and they spend days and weeks almost without eating.

I followed a Yanomami friend, whom I will call Simón, as he became progressively angrier about the food provided to his nephew during his stay in hospital. Simón, who was a

shaman and a school teacher and was able to speak strongly and without fear⁵ to the non-indigenous doctors and hospital authorities, wrote a letter to the main nutritionist in which he specified the kinds of food the Yanomami would like to eat when convalescing. His list included manioc flour, small fish and plantains, all foods which the Yanomami consider to be bland (*okëivë*) and therefore appropriate for illness. Also rice, oatmeal, and other *napë* foods that are also considered bland. This reveals a Yanomami and possibly pan-Amazonian theory of flavours, (salty, sweet, bitter) and thermal qualities (hot, cold) as they are known to effect the constitution of the body.⁶ Many of these restrictions have also to do with the vital properties of certain animals, such as large fish or large game whose 'soul' stuff (for the Yanomami, the *pei puhì*) is considered to be too strong. However, what I want to highlight is that when Simón was speaking about garlic and onion, or the mixed quality of the food, he was stressing their stench and how dangerous that was for an ill person.

The nutritionist saw the list and complained there were not enough proteins and vitamins in the meals proposed, and they would therefore not provide adequate nourishment for people whose bodies were already compromised by disease. Furthermore, most of the products on the list - such as fish and manioc - were only available in the fresh produce indigenous markets in Puerto Ayacucho, and could not be bought through the habitual networks of hospital food providers. Administrative hurdles - such as year-long defined catering contracts with the Ministry of Health, the need for official receipts, and also hygiene standards - favored the acquisition of prepackaged food from certain industrial suppliers rather than fresh food in the market, which the Yanomami and other indigenous peoples in the hospital would find much closer to their usual eating habits, and much more safe and beneficial to eat during illness.⁷ The disparaging explanation given by the nutritionist revealed an incontrovertible biological understanding of food as composed of different biochemical properties, in relation to a biochemical body. Additionally, it revealed the unavoidable constraints of a bureaucratic system of food provision in the hospital.

The kitchen staff were not much more open to discussion. While there are specific meal plans for different diseases - such as a cardiovascular diet low on salt and fats or a diabetic diet low on carbohydrates - when Simón and I tried to explain how an "indigenous diet" could be prepared simply by not adding garlic, onions, spices and salt, they immediately rejected the idea as involving much more work. One of the cooks replied, "such an insipid meal?" We had here reached a much more difficult hurdle to overcome, that of a different notion of what constitutes a proper meal, not anymore in terms of biochemical parameters - a particular ontology of the body - but in aesthetical and even ethical terms of food and eating - what Annemarie Mol (2013) has called the "ontonorms" of dieting, the "goods" and "bads" in relation to norms and practices of food and eating. What the Yanomami wanted to eat, sounded like a non-meal to them. Therefore, the kitchen staff simply refused to hear that the Yanomami did not like the food they prepared.

Providing appropriate food for indigenous peoples in this southern Venezuelan town of Puerto Ayacucho was a challenge to established biochemical norms, to mainstream cultural practices of feeding, to standard bureaucratic practices of food procurement and to established practices of care and paperwork in the hospital. For the Yanomami, eating according to the hospital menu did not only impair healing but placed them at risk of becoming even more ill. Many people even preferred not to eat at all, and for example, a couple of concerned Yanomami parents left the hospital against medical orders, when their child refused to eat the food for days in a row. This is not to say that biomedical technologies never bring positive results, or that the Yanomami did not appreciate them. However, in the case of nutrition one should be warned of the shortcomings and limitations of biomedical knowledge and practices.⁸ In the next section I will describe the health system that serves the Yanomami.

The Venezuelan Yanomami and Their Use of the Health Care System

There are about 30,000 Yanomami people living in a rainforest area which spans the international border between Venezuela and Brazil. I refer in this article to the approximately 15,000 Yanomami who live in Venezuela, in an area about the size of Ireland. Only a small

proportion of these Venezuelan Yanomami have easy access to any of the seven health posts set out first by Catholic and Evangelic missionaries in the 1960s and 1970s, or those later established by the Venezuelan state and its official health system since the 1980s. Some Yanomami people live in the vicinity of a mission and a health post, and only need to travel a few minutes to a couple of hours by foot or by boat, in order to see a doctor in the health post when they need one. However, many other Yanomami people remain outside of the confines of areas which are habitually visited by doctors, and the health posts remain too far away to walk when they are actually weakened by sickness.

Yanomami people have been observing medical doctors for several decades though, and consider that many medicines are effective for things such as malaria, headaches, stomach pains, diarrhea and pneumonia. Many people who live nearby the health posts go to the health post when ill. However, at the same time they continue to make use of their own shamanic healing resources. And for example, they incorporate doctors' colored pills and injections into their own shamanic understandings of illness and healing, a hybrid incorporation that Greene (1998) has called "intermedicinity".

Shamans are ultimately the ones able to really perceive the causing entity of the disease, and they do so by transforming themselves into their *bekura* helper spirits⁹ and following the tracks of agents responsible for the disease. As in other parts of Amazonia, illness is always the result of a malevolent being's agency. After tracking the agent of disease - which can be another *bekura*, *yai thë* strange beings, or transformative *hëri* substances blown by another Yanomami - shamans engage in a fight and simultaneously recover the missing parts of the ailing person's vital components, the *pei pubi*. Reuniting the ailing person with the lost parts of the *pei pubi*, and sometimes also extracting pathogenic *hëri* out of the body of a person, are the two main ways in which shamans are able to heal. However, the Yanomami people also draw from a variety of plants and *hëri* which they use to treat specific ailments or illnesses. The medicines of doctors are also called *hëri* - indicating that these substances all have in common their transformative potential over bodies. The Yanomami consider some doctors' *hëri* as particularly helpful in palliating the effects of certain pathogenic agents, or in treating diseases that seem to have a distant origin in the lands of the non-Yanomami doctors (Kelly 2011:161-162). These are usually acute and fast spreading epidemic diseases, which the Yanomami perceive as caused by tiny *shamara* spirits which travel through the air - for example in the fumes of metal tools (Albert 1988) and the smoke produced by motors and rubbish incineration.

The health posts usually have only one doctor and few diagnostic or therapeutic resources. Therefore, patients are often sent to the urban hospital in Puerto Ayacucho. Not all Yanomami people are keen to go to Puerto Ayacucho, and many strongly refuse. The journey is long, usually involving several hours of walking, boat travel, and finally a two or three hour flight on a small plane or helicopter. Many Yanomami have never been to the city nor travelled on an aircraft. The many stories of people dying in the hospital instill even more fear among the Yanomami. Even those patients who go to the hospital and return in better conditions can tell stories about the suffering they faced in the hospital: hunger, thirst, sadness and intense nostalgia, not understanding the language, and unfriendly doctors and nurses. But in cases of severe illness, for which procedures such as surgery are known to be effective, many Yanomami patients still demand to be taken there.

The hospital in Puerto Ayacucho is not very large, comprising only one single floor and about a hundred beds. It has doctors from the main specialties and more diagnostic resources than in the health posts. However, for several decades it has operated under a context of chronic scarcities, a pattern all too common in Latin American and other under-resourced countries. Furthermore, for health professionals it is often the first point of encounter with indigenous peoples. Not understanding the language, nor anything about indigenous peoples' contexts, many feel truly at loss, and they become frustrated by encounters which do not seem to provide them with the diagnostic and interpersonal clues they are used to. Caretakers in the hospital who only see severely sick and debilitated Yanomami, come to perceive them simply as a deteriorating, unruly and unhygienic people. They criticise their dirty, ragged clothes; their bare and blackened feet. Cleaners often complain that they soil and make a mess of their rooms. Doctors write in the medical charts that Yanomami patients "do not cooperate with the interview" when in fact the problem is that they don't understand the Yanomami language. It is challenging because most health

professionals receive no intercultural skills trainings. They seek to make the Yanomami adhere to what they deem is a good kind of care, to their own projects of hygiene and body making. But as in many other contexts they end up repeating neo-colonial relations of domination and control that ignore local healing practices (see Apffel Marglin 1990). Yanomami people clearly perceive these discriminating effects. “We are treated like animals,” some Yanomami have said to me, for example when health professionals openly say that they stink.¹⁰

To improve the care of indigenous peoples in hospitals, in 2010 the Ministry of Health and its Office of Indigenous People’s Health officially created the Service for Indigenous People’s Care and Orientation (SAOI, *Servicio de Atención y Orientación al Indígena*). Indigenous patients are guided and accompanied by indigenous “intercultural facilitators” who also speak their language. However, this service was immersed in the encompassing bureaucratic disorder of the hospital and was often insufficient. Beyond linguistic translation, it remains very difficult to translate ontologies of the body, health and illness. The local biomedical knowledge remains authoritative, setting the norms across the hospital, especially its food.

Touching and Warming the Body into Being

When I first saw Simón’s nephew (his sister’s son) in the hospital, the young boy was lying in a bed in the emergency ward, completely unconscious, with traces of blood on his mouth. Simón was sitting next to him, terribly worried he would soon die. His nephew, a boy of about 16-17 years of age, had been in the city of Puerto Ayacucho for about three months with a Baptist church, doing some menial jobs, when he suddenly fell very ill. The boy’s companions in the city - two other close relatives - had been scorned by Simón for not having taken proper care of his nephew in the city. From then on, it was Simón who was by his nephew, day and night in the hospital. Due to the severity of the boy’s condition, he was soon transferred to the intensive care unit.

This small room with three beds posed several problems for care. The intensive care unit was one of the few rooms in the hospital which was air conditioned, and in contrast to the 40°C outside, it was kept unusually cold (17-20°C). Worried that he would suffer from the cold, Simón managed to find several blankets and covered the boy from head to toe. In the rainforest, it may get quite cold during the night, but people always sleep next to the fire. The sick are especially protected from the cold by paying constant attention to and rekindling their fire. In the case of small children or newborns, the mothers sit down right next to the hearth and place their hand close to the fire; when the hand is hot, they transfer the heat to the child by rubbing the skin. There was no such source of warmth in the intensive care unit. So whereas other nearby patients seemed fine with one or two blankets, Simón was careful to keep his nephew under five or six very thick ones, lifting only certain sections for cleansing or for doctors’ examinations.

In the medical chart, every day the doctors wrote their evaluation of the boy’s progress, new findings from lab results and a list with the plan for therapy. Some of the items listed referred to supportive or therapeutic measures such as keeping the bed in an upright position so he could breathe better, a nasal cannula for oxygen at a certain concentration, parenteral hydration, and antibiotics or other medicines. Other measures written on the chart referred to the regular functions or activities of the body, which the unconscious boy was unable to do for himself and therefore needed to be done by the nurses and by the boys’ relatives - for example, moving his body every now and then to prevent pressure sores, and monitoring urination and defecation. A seemingly simple instruction such as “monitor evacuations and urination,” implied several time-consuming activities such as changing diapers, bath sponging, and when the boy became finally conscious, it required placing a basinet or walking him slowly to the nearby toilet. Most of the actual practices of care were thus minimized or made invisible by the surmised instructions of the medical charts. Nurses were often too busy to accomplish all the needed work of care, and the responsibility fell onto relatives such as Simón. These practices therefore fall on the border between medical and familial care (Brown 2012). As in the case of the Bangladeshi hospital that Brown describes, relatives in the Puerto Ayacucho hospital remain next to their ill relatives, often

sleeping underneath or next to the hospital beds and receiving the same meals that are given to the patients, and accomplish similar tasks as nurses.

However, Simón did even more than specified in the therapy care plan. His permanent presence allowed him to perform other aspects of care which are important for the Yanomami people during illness. His own practices of care revealed the limit between what biomedical caretakers consider as necessary for the supportive care for failing bodies, and what ‘support’ for a failing body could signify for the Yanomami. One important example was for the care of the mouth: the boy had bleeding gums, and because of the lack of salivation and the constant oxygen through the nasal cannula, his mouth became very dry when unconscious. For Simón this was a significant problem, and he constantly had a cotton swab to keep the boy’s mouth moist, also clearing out any blood which might have accumulated and leaked out through the corners of his mouth. Whereas for the biomedical caretakers the only reason to do this would be to prevent excessive drying of the mouth, which could lead to further damage of the mucosa and bleeding; for Simón it was more as if he was trying to awaken his immobile mouth, attempting to cause it to come back into functioning, as a mouth that eats. I have often seen Yanomami giving fluids to the unconscious, for example pouring water from special plant concoctions into the ill person’s mouth. Similarly, when small babies or newborns are ill, the mother puts her breast next to the baby’s mouth and squirts some milk into it, even when the baby is too weak to suck. This seems a form of bringing back the memory of what a mouth does - eating, sucking and chewing - of awakening the mouth, of reminding the person of the basic human mode of eating. In contrast, doctors avoid feeding unconscious people because it may result in bronchial aspiration of food - food going the “wrong way” into the lungs, because the swallowing mechanism is impaired.

The recovery of an “eating mouth” through the contact with food is analogous to other forms of touch that are done to the body of a sick person. During his nephew’s illness, Simón massaged his nephew’s extremities everyday. Being a shaman, his massage resembled what I had seen in many rituals of healing. With his both hands, he began a stroking movement from the top of the head, moving down towards the extremities. Finally, with a quick motion he propelled something from his hands towards the floor. He repeated similar movements from the proximal end of the boys’ extremities, working his hands outwards towards the hands or feet, and always ending by throwing an invisible thing contained in his hands onto the floor. Shamans explain that what they throw are the pathogenic elements or substances causing the disease, towards the underground spirits - the *amabiri* - to devour.

However, Simón also explained to me this was about making the person feel his skin again, just as when one has a leg or arm that becomes numb in a certain position, and movement or rubbing brings it back to life. In the Yanomami language, a numb part of the body is called *si moboti* or *si potete*, and the process of waking it up is to become again *moyavë*, awake or aware. *Moboti* and *moyavë* are also opposite words used in reference to children who are too small and do not know yet and subsequently become aware, or in general for a state of not knowing and learning. The implication of Simón’s comments seemed to be that the extremity had become un-knowing and needed to be brought back to knowing. If we consider that in Amazonia bodies hold agency in the form of knowledge (McCallum 1996), a leg that does not move or feel, or a mouth that does not eat anymore could be understood as a leg that does not know how to walk, or a mouth that does not know anymore how to eat. My interpretation is that touch or feeding a mouth, produced important sensorial experiences which were essential for bringing back the knowledge and agency to the affected body parts. We will go over a few other examples of the sensual making of bodies.

Scent as Marker and Maker of the Body Envelope

For the Yanomami, scent is an indicator of a person or body, and can also exert forces of attraction or repulsion over different forms of personhood in the cosmos. For example, mothers try to keep young babies in close contact with their own bodies, and do not let them wander away, as a baby’s smell is highly attractive to malevolent *hekura* spirits, who are hungry for the vital essence of humans and other beings. Babies are always inside their

slings, carried by their mothers. In permanent contact with their mother's skin, they are still perceived by the spirits as a single mother-baby human being, and protected at the time of life in which their bodies are considered to be more soft and permeable. Mothers never let their babies crawl around alone until they are older, so that spirits cannot smell or perceive them.¹¹ Next to visibility or sound, smell emerges here as a character of a body or person, which emanates unintentionally from bodies, and allows an intersubjective process of recognition.

While body scent is unintentional, it can be manipulated in order to disguise a person's bodily identity, and not be recognized by others. For example Lamista Quechua hunters use tobacco as a way of hiding their human scent from the forest animals (Barbira Freedman 2002). When Shipibo women want to become shamans, they must also cover their scent while menstruating, as the stench of blood is said to be repulsive for the spirits (Colpron 2006). Yanomami shamans may cover an ill person with the fetid excrements of their helper *hekura* spirits, for example the deer, in order to repel the attacking spirits. Yanomami women hang around the neck of their babies pieces of *hëri* (vegetal charms) the smell of which is also repugnant to the *hekura*, and this protects growing children. On the other side of the spectrum of scents, women adorn themselves with sweet scented leaves that attract men. Yanomami men who nowadays travel frequently to the city, buy for their trips deodorant, soap and cologne. They know that *napë* people smell different because of their toiletries, but scent is additionally understood as resulting from the kind of *napë* food they eat. These snippets of ethnography - as well as mythical accounts in which bad characters also have nauseating smells - point to scent as a quality of interpersonal recognition, a substantial quality involuntarily emanating from bodies and dispersing in the air, but which can be altered to facilitate particular forms of attractive or repelling relations.

Scents can also affect, to different degrees, the internal conditions of the inner vital principle *pei pubi*, and the external manifestation of a person-body. For example, a woman came once to the clinic to ask for sardines and onions, some of the most foul-smelling foods for the Yanomami. She explained that following the incorrect ingestion of the ashes of the dead in a funerary ritual, she was affected by the spirit of the dead, called *kamakari*. The only way she found relief was by eating sardines and onions, the stench of which kept the *kamakari* away. In a contrasting case, mothers avoid sardines when breastfeeding, as they can seep through the milk to their babies and make them ill. Sardines may have dangerous souls, but above all they are foul-smelling, salty food.

In the hospital, not only the food smelled bad. The corridors, the rooms and the emergency wards had that characteristic smell of hospitals: a mixture of strong cleansing products, bodily substances out of place, and bodies in different stages of failure. Furthermore, towards the back of the hospital, near the areas designated for indigenous people's companions, there was a barren area used as a dump, where young men sneaked in to smoke different drugs. When Simón's nephew was inside the intensive care unit, the scent was not a problem. But once he left the cold intensive care unit room and moved to the much warmer and less ventilated internal medicine ward, Simón expressed his worry about the stench and the air. One day, he called me early in the morning asking me to come and see him. He himself had fallen ill with what seemed to be asthma, but he denied ever having suffered something similar. His explanation was that the air of the hospital was bad and full of *shawara* sickness, which had made him ill (respiratory illnesses being typically caused by *shawara*). *Shawara* spirits can travel through the air, and it is their stench which reveals their presence, usually brought by the smoke of burning things. So even among the Yanomami caretakers, the integrity of their own envelopes were affected by a stinky hospital container.

Enveloping the Vital Principle of the Body

One day, when I arrived early in the morning for my daily visit to Simón and his nephew, Simón was holding a package of leaves in his hands, and together with a few other people from his village, they were binding it tightly with a string. My curiosity was stoked by what seemed to me as a novel element in a series of healing objects and practices that Simón tried out during his nephew's illness. Each day I followed Simón's reasoning about what was

being done to his nephew and what could be tried out next, as medical or Yanomami treatments continued to fail. One day, for example, he was holding on to the bible, even though I had never really seen him as a practicing Catholic in the missionary church in his own village. Simón also encouraged the visits of his nephew's Baptist friends in Puerto Ayacucho, who came to pray over him and brought him some homemade food. Sometimes, Simón returned to accusing his relatives of neglecting the boy when he fell ill; sometimes it was the doctors who were giving inappropriate treatments. The failure of treatment raised the issue of hope, and continuously tested out understandings about the social causation of affliction and the effect of therapies, a conjuncture that is not exclusive to the Yanomami (see Lewis 2000).

The package itself seemed quite ordinary, just like any other package that the Yanomami prepare when they go hunting or gathering different foodstuffs in the forest, packages in which they bring their food back to the village, and which they also use for cooking. When I asked Simón what it was, he explained it contained the vital principle, the *pei pubi* or soul (*alma*, in Spanish) of his nephew. He had taken the *pei pubi* from his nephew's skin by rubbing it, and it was now held in the package he had carefully prepared. He was going to send it to his village, so that shamans could work on his nephew's *pei pubi* directly.¹²

I had never seen any Yanomami sending *pei pubi* in a package for healing before. However, it is indeed common that shamans may heal or protect people remotely, or also bring diseases and other afflictions. In their shamanic state - either in dreams, or with the aid of a mixture of powerful plants - Yanomami people are able to travel far away and have agency over otherwise distant beings. There are also situations in which a person may harm another one by taking something which has been in contact with that person - for example, the earth of a footprint - and then mixing it with pathogenic substances or having a "shamanic snake" bite into it. I have been told that the earth of a footprint used for such sorcery needs to be wrapped in a similar way as in the package I saw Simón hold. Though these interactions imply effects over body surfaces and the integrity of an envelope, the package hinted at a new set of relations.

The enveloping of the *pei pubi* in palm leaves seems to suggest precisely a container-contained relationship between the external layer of the body or *pei siki* (usually translated as skin) and the inner vital components such as the *pei pubi*, *pei ni amo*, *pei noreshi*. But the rubbing care of the skin and the transfer of the *pei pubi* to another container suggest that this relation may go beyond the dichotomy proposed initially by Albert (1985: 139-140) between a biological organic external body envelope, the *pei siki* or skin, and an immaterial psychical interior with the different internal components such as the *pei no ubutipë* and *pei pubi*.¹³ Chiappino (1995) has suggested that the *puji* is also material and can be transferred within bodies by either diffusing out or by incorporation, in which we may see the envelope operating in the mode of a semi-permeable membrane. This is an important consideration, but perhaps we also need the opposite challenge, in which the skin is no longer considered to be a mere a material component, but rather, more of an immaterial (spiritual, invisible) one.

Transcending an argument of the skin as boundary between the social and the individual, where techniques of ornamentation of the skin are mere symbolic mediums for the expression of the social (Turner 1980), several authors have stressed the interactive or intersubjective properties of the skin or outer envelope of the body. Lagrou (2012) describes the way in which different kinds of corporal paint designs make the skin more or less permeable to spirits and can act as a shield against disease. In the case of babies, they are entirely covered with annatto paint to seal their still weak bodies; in contrast, the bodies of young initiates are covered with rough designs so that they are open to these spirits. Kondo (this issue) also offers another example where drawing designs on the skin allows a person to avoid being recognized by evil spirits. We also saw among the Yanomami how mothers use *bëri* substances to mask the scent of the child, or shamans hide a person by using stinking deer shit.¹⁴ And again, in yet other situations it is desirable to make the skin more permeable to spirits, as Alès (2010) has described how anointing themselves with annatto, Yanomami shamans may enhance their perception of the voices of the spirits.

These forms of boundary-making are central to an Amazonian notion of affliction and practices of healing. Disease in Amazonia is considered to be a transformation of the self

that results from the inappropriate contact with other cosmic beings, who trespass or dissolve the boundaries of a person for example by inserting darts or other pathogenic substances, or stealing components of the soul. Barbira-Freedman explains that for the Lamista Quechua, healing an ill person requires the action of a shaman who first de-differentiates the boundaries of the afflicted person, in order to subsequently restore (or create) the patient's ordinary boundedness and the proper functioning of all body orifices (2002:144).

Coming back to the case of Simón's nephew, the packaging of his *pei pubi* is a reference to the multiplicity and partibility of soul-like components among Amazonian people: a part of the *pei pubi* was fragmented from the rest, and then used to heal the whole body. More composite notions of bodily envelopes may also help us perceive what the care by his uncle and other relatives - stroking, warming, cleaning, and covering him with blankets - was trying to get at. Fausto (2011) shows that what we might perceive as a single layer - the body and its ornamentations - is actually composed of a series of superimposed layers, which recursively hold different forms of subjectivities. He uses as an example a series of masks with designs on their internal and external sides, which must be used by people whose skin has also been painted, each layer unfolding different forms of subjectivity. These recursively enveloping layers add further complexity to the idea of the composition of the body through the skin. Furthermore, Yvinec's (2014) proposes that among the Suruí, there are different temporal modalities in corporal and soul-like parts of the self, which may be dissimilarly affected by the action of close relatives or more distant people. This may further help explain, in the case of Simón's nephew, the spatial and temporal separation of the *pei pubi*, and of healing care by doctors and shamans.

Yvinec also sustains that the skin is a crucial site for transformational processes during affliction and healing as it constitutes an important interface between the human and non human, and therefore it is subject to friction and injury. Rather than superficial or unimportant, skin diseases among many Amazonian Indians, including the Yanomami, are usually seen as very severe or entailing important transformations. It is widely recognized that other processes of personhood formation and transformation in Amazonia are also accomplished by the use of techniques of the body's surface. Among the Yanomami, becoming *napë* notably includes wearing *napë* clothes (Kelly 2011:75-76). Bonilla (2009) shows how the conversion process of the Paumari included the healing by the missionary of a depigmenting skin disorder. Kondo also explains (in this issue) how for the Emberá, the human skin is a surface that relates to others and composes the body itself, for example by applying animal and plants substances to it. The use of perfume by Yanomami men in the city should also be seen in this light.

A final reference to an episode that occurred in a Yanomami village may further show how the senses affect an envelope, which then brings about a new form of embodied agency. Once I was replaying for some women a few *hëri* songs¹⁵ I had in my recorder from other distant villages. Suddenly, a couple of the women left the circle and ran to get fresh annatto fruits. They opened them as to expose the red seeds, and returning towards us, they placed them right next to my recorder. When the recording ended, they took the annatto seeds and painted their body. Later on, I was told this was a way of "taking" (*tëai*) the songs better, by capturing them on the annatto paint and covering their bodies with it. That the songs are "taken" suggests indeed there is a form of incorporation into the body. Nonetheless, this example also strongly suggests that for the Yanomami this is not a purely cognitive process, but a matter of making a body-envelope,¹⁶ a *pei siki* that constitutes the body. That hospital sounds were not brought up in my ethnography does not mean that the Yanomami were not affected by the sounds in a foreign world, during their efforts in re-containing the body, nor that these soundscapes are not significantly different.¹⁷ In the next section, missing the village - which is notably recognizable from afar by its distinct sounds - sadly becomes a determining factor in Simon's nephew's illness course.

Healing Away from Home

A few days after the boy was finally improving and was transferred to the internal medicine ward, Simón developed an urgency to bring him back to his village. For all the doctors, including myself, he was showing great improvement. Even though he was visibly still distended in his abdomen, he was looking better and his lab tests seemed to show he was under relative control. But Simón vehemently expressed his worry that his nephew was beginning to miss his family and life at the village. He explained this desire was very dangerous for his nephew. In his own village the shamans could work properly, or he could find some plants to heal him. The sending of the *pei pubi* was no longer working, and the boy's own *pei pubi* was starting to fade away. But before the lengthy administrative process of leaving the hospital against medical orders and finding a plane to return home had even begun, Simón called to say that his nephew had died, against doctors' expectations, and my own hopes.

I have tried to make sense of this deeply saddening and angering moment, and what it tells us about care and different cosmologies of the body and of healing. How had we missed his imminent death, while Simón was so convinced about the dangers? Some answers came in reading Barcelos Neto's (2007) description of food desire.¹⁷ He explains that for the Waúja, having a desire for food occasions a salience of the person's soul, which attracts malevolent spirits who will either introduce pathogenic objects, or steal part of the vital principle of the person. This salience of the soul could also be seen as a weakness in the envelope protecting the person from other beings, allowing him or her to stay whole. Similarly, I often heard from Yanomami people that if you were angry, ill, or sad, you should better not go wandering around in the forest, as bad things could happen to you, spirits would attack you. Moreover, the *pei pubi* of young children leaks out of their bodies when they are afraid or cry too much.¹⁸

Lizot explains that hunger, fear and sexual desire are considered dangerous (*wayu*) by the Yanomami; hunger because it brings suffering, and fear and sexual desire because it changes people's behaviour (Lizot 2007: 276). However, desire may also be a productive force. Reig for example shows that Yanomami people's desire for tobacco is experienced as a sense of being unfulfilled; a lack, but one that actually incites to movement and expresses a craving for commensality and exchange, for society (2015:177-178). Perhaps it is extreme forms of desire - usually expressed by the form *ya pubi wayou* - that have the property of modifying the body or a kind of body-envelope which contains the soul. In a perspectivist mode, these result in altered forms of perception and action, and hence in transformations into illness or death.

What Simón had also foreseen was that a whole sensorial landscape of familiar foods, scents, views, sounds, and the convivial care and the presence of familiar others in the village was essential for the boy to recover. Furthermore, shamans' long distance treatment of fragmented portions of the *pei pubi* had failed. The doctors' medicines were no longer useful either. The hospital was overall, an inadequate container for healing him. As his disease progressed and nostalgia set in, his body-envelope became lethally weaker.

Conclusion

The ethnography I have presented here suggests how the hospital operates as another form of container, another layer that affects the capacities of Yanomami bodies-envelopes to be well and to heal, in a series of multiple layers that form the body. The hospital is an ambiguous place to heal not only because of the combination of powerful medical healing techniques and dangerous others; it is an inappropriate place for healing from a Yanomami perspective because its particular materiality makes impossible a synaesthetic form of care which is fundamental for re-containing the body-envelope.

I have shown in this paper how different kinds of containers affect the transformation of bodies during processes of becoming ill or restoring health. I presented a recursive set of containers which affected each other: the boy (himself a container) was suffering of a failing envelope, which his uncle attempted to make stronger through a stroking care, but which was ultimately impaired by the improper sensorium and food in the hospital. Finally, his

inner essence was split and transferred onto another (weaker, more permeable) package of leaves, in order to be re-bounded by shamans in his village. Even his uncle fell ill due to the hospital stench during the almost two months that he remained in the hospital.

Several forms are emerging here. First, there was a constant process of encompassment, of exteriorizing and interiorizing the material and immaterial, the human and non-human, and visible and invisible elements, in the constitution of something - a body and an envelope together. Second, the containers were not just external, but rather intrinsic elements to the transformations, in which these multiple enveloping materials or practices affected one another. These forms begin to delineate an important aesthetic of a recursive and encompassing multiplicity, which requires further elucidation. Anthropological theories of Amazonian bodies have benefitted from taking constructional approaches (Santos Granero 2009). What is suggested here is that perhaps other analogies with transformational processes such as alchemy - or more common processes in Amerindian societies such as fermentation, distillation, conservation and cooking - could expand our analytical vocabulary in relation to the making of the body.

Finally, as with all forms of action that aim towards making something work - in this case, healing a disease - there was an iterative process of formulating an expectation (or belief) about the effectiveness of a therapy, trying it out, formulating reasons why it did not work, and new expectations and treatments to be tried out. The Yanomami are clearly not alone in this. Gilbert Lewis's analysis of a failed treatment in Papua New Guinea (2000) suggests that especially in the worrisome and all-too-human circumstances of disease, this constant enquiry on the effects of healing care is quite common, if not universal.

An increasing number of ethnographies focusing on hospitals explore the practices by which multiple diseases or diverging logics are coordinated within a particular spatial configuration (Street and Coleman 2012; Mol 2002). Returning to Street's example of the Papua New Guinean hospital, diverging medical and aboriginal projects of disease, healing, and of body-making, become entangled within a hospital infrastructure that is inadequate for either (Street 2014). These spaces of intersection are often fraught with equivocations. We may heed to Mol's (2008) suggestion of adopting a 'logic of care' - that is, a constant 'tinkering' of options, of taking into practical account what medical evidence might show but also what patients are able and willing to accomplish. However, the ethnography presented in this paper still points to an asymmetrical agency in this tinkering with care in which biomedical opinions prevail, a situation common among indigenous populations. The Yanomami were trapped in a hospital, which in spite of providing technologies of healing they valued, proved to be an inadequate sensorial and material space for remaking an envelope and re-containing a person.

Equivocations are pervasive in the encounter between different people. Attempts to eliminate them run the risk of further erasing the differences at stake. However, strategically controlling the terms of the equivocations could lead towards finding productive compatibilities along these equivocations (Pina Cabral 1999), a process which seems to be at the heart of many situations of 'intercultural' tinkering with health care. Minimal changes such as including hammocks in the hospital could potentially improve Yanomami people's experience of care in the hospital.¹⁹ The ethnographical exercise here was thus one of expanding and inhabiting these equivocations, rather than attempting to erase them (Viveiros de Castro 2004) - that is, of embodying and affectively perceiving what is in the food, scents and soundscapes of the hospital.

Clearly, these are issues that do not exclusively concern the Yanomami. Several regimes of multiculturalism, interculturalism, super-diversity in care are being tinkered with, yet are still frequently unsuccessfully. A truly intercultural care requires a serious interest towards other people's ontologies and a committed effort in becoming aware of the sources of equivocation. It also demands an openness towards states of disconcertment (Verran 2001; see also Escobar 2007) which might reveal that after all, the care we provide in hospitals might not always be that good. Other people's practices may show us the blind spots in Western forms of medicine, pointing to better ways of caring collectively for the body.

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For the Yanomami the dead are not to be remembered, but this paper is dedicated to Simón's nephew, whose name I have concealed here, in the hope that others may not go through the same suffering while at the hospital. My fieldwork was done with the support of the Indigenous Health Office, and I specially thank Noly Fernández and Enrique Atencio. I am grateful to Elizabeth Rahman and Juan Álvaro Echeverri for organizing the panel 'The alchemical person' where this paper was presented, and for their invaluable comments. I also thank Françoise Barbira Freedman, Alejandro Reig, William Vega, and Tipití editors and reviewers for reading and commenting on previous versions of this article. Finally, to the Yanomami health workers and personnel at the Indigenous Health Office who made this work possible.

Notes

¹ Except in cases, for example, of children being admitted into the nutritional ward for malnutrition, in which food becomes the treatment itself. The kind of diet is also imposed in these cases by the nutritional service, and Yanomami people, especially children, do not like to eat it.

² Patients who lived in the city were asked to have their relative bring food. Indigenous patients rarely have networks of social relations who may bring food on a constant basis, so there were often extraordinary measures taken to assure that indigenous patients continued to be fed on a daily basis, such as asking governmental agencies or 'social missions' for support.

³ Illness and death are in fact seen as part of a continuum. A person who becomes unconscious is said to be dead already (*a nomaroyoma*), and we can see Yanomami funerary rituals as a means of assuring that the dead do not return to the world of the living (Albert 1985). Some of the words used to speak about gravely ill people also stress the lack of properly human functions, such as the inability to speak (*a wāyoimi*), to eat (*a iaimi*), or to recognize others (*a no ihīpiaimi*).

⁴ *Napë* refers to others, to alterity, and to distant and potentially dangerous people. It is the denomination usually given by the Yanomami to all non-Yanomami people including Venezuelan nationals, but also other indigenous peoples and foreigners.

⁵ To speak clearly, without fear (*wawētowë wayou*) is a much appreciated linguistic skill developed first in the context of ceremonial *wayamou* and *patamou* speeches, but which also comes into play when protesting or demanding something to doctors, politicians or other authorities.

⁶ For more on the body and different categories of food among the Yanomami, see Chiappino (1995). Food practices in relation to illness among other Amazonian people have been described by Butt Colson (1976) who on Guaianan notions of hot and cold, or for example Fausto (2007) or Arhem (1996) on the vital properties of different game animals or people.

⁷ When balancing tuna fish cans and all their chemical additives against fresh fish from the market, I am probably not alone in agreeing with the Yanomami that the latter is more desirable.

⁸ Biomedical nutritional sciences have lagged behind in the 20th century since the emergence of other medical technologies such as antibiotics, genetics and surgery.

⁹ *Hekura* can be freely translated as spirit, but is more precisely a class of supernatural beings, distinct from humans and from other kinds of supernatural and potentially harmful beings such as the *yai thë*. The *hekura* are associated to plants, animals or elements of the environment. They also constitute the forces of the shamans, who house them in their chest and transform into them during their healing or shamanic interventions.

¹⁰ Scent is an important element of the intercultural encounter, as we will see. When I asked a Yanomami health agent why he did not react to such highly discriminatory remarks by one doctor, he just said "*Siempre son así, así siempre dicen*" (They are always like that, that is how they say), showing how prevalent this kind of encounter with the *napë* still is.

- ¹¹ In Helena Valero's (1984) autobiographical ethnography, she was scolded by other women for leaving her baby alone on the ground, because the *hekuru* can smell the babies and come to steal their soul.
- ¹² Two weeks afterwards Simón told me the fragment was already “wearing off,” becoming weak, and the process had to be done again.
- ¹³ In the linguistic variant of Yanomami in Albert's fieldwork area, and according to his ethnography, the components of this interior body, the inside or *bei ôshi* are: *bei bubî*, *bei a nê borepî*, *bei a nê utubî*, *bei a nê reshîpî*. There are strong controversies around the internal components of the body, which as mentioned earlier, might reflect regional differences. Lizot (2007:290-293) distinguishes the following: *pei noreshî*, *pei mî âmo*, *pei no ubutîpî*, and argues that the *pei pubî* is just a person's conscious thought. Chiappino notes simply the existence of a *puî* (a dialectal variant from *pubî*), which is the inner vital principle and can be present in many other human or non human beings, and the *pei puî*, which is a sort of thought.
- ¹⁴ I often saw Yanomami women pray for their children or shamans praying over the group, and wondered if these were not ways of protecting the body from intrusions, by creating a layer around the body, in the same mode as these *hêri* do.
- ¹⁵ *Heri* are sung during the context of ritual feasts, or when men go on long hunting expeditions. They speak of different animals, plants, and sometimes elements of the landscape. They are intended to attract game for men who are hunting.
- ¹⁶ See Brabec de Mori (in this issue) for more on sounds and the processual making of bodies.
- ¹⁷ See Rice (2003) for an account of the soundscapes of hospitals in the UK, and how patients make sense of care by learning to interpret these strange sounds.
- ¹⁸ I do not touch here on the medical reasons, but it is becoming increasingly clear that environmental and sensorial elements may be involved in the physiological processes of healing.
- ¹⁹ Some hospitals in northern Venezuela—in Maracaibo, where many Wayúu, Barí and Yukpa patients arrive—already do provide culturally appropriate foods such as *chicha* and *mazamorra*, or tiny hammocks for newborns inside incubators.

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