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Variations Around Water

Bodies, encounters and translation processes

Pedro Paulo Gomes Pereira

Resumo

Este ensaio apresenta e analisa narrativas de profissionais que trabalham com saúde indígena no Brasil. Essas narrativas discorrem sobre intensos e dramáticos dilemas sobre água e corpos. As perguntas que nortearam a pesquisa foram: O que acontece com profissionais de saúde que se vêem diretamente relacionados a concepções diferenciadas de corpo, saúde e doença? O que sucede quando as práticas de saúde se dão num processo de tradução da própria conceituação do que seja saúde? Estariam esses profissionais de tal forma subsumidos no universo da biomedicina que nada os modificaria do início ao fim de encontros nos quais as práticas ocorrem em processos instáveis de tradução? Ocorreriam estabelecimentos de acordos que não os de dominação? Haveria uma diferença significativa entre os profissionais mais próximos dos contextos indígenas e os que não possuem essa experiência?
Palavras-chave: Corpo, profissionais de saúde, saúde indígena, antropologia simétrica

Abstract

This essay presents and analyses narratives of professionals who work with indigenous health in Brazil. These narratives discourse on intense and dramatic dilemmas concerning water and bodies. The questions that guided the research were: What happens to health professionals who are directly faced with different concepts of body, health and disease? What happens when health practices occur in the process of translating the very conceptualization of what health is? Are these professionals so subsumed in the world of biomedicine that nothing would modify them from the onset to the end of encounters in which the practices occur in unstable processes of translation? Are agreements established other than those of domination? Are there significant differences between the professionals closer to indigenous contexts and those who do not have this experience?

Keywords: Body, health professionals, indigenous health, symmetrical anthropology.

Variations Around Water

Bodies, encounters and translation processes

Pedro Paulo Gomes Pereira

Let us help the hydra expel its mist.
Mallarmé, *Divagations*.

This essay intends to follow narratives involving water and bodies. Beginning with Peter Gow's description of the meeting of a Piro woman and a female schoolteacher, and Eduardo Viveiros de Castro's (2002b) analysis of this event, the text will accompany the impact and effects of this scene on doctors and nurses. For almost two years, I distributed this story among healthcare professionals, particularly those who work with indigenous health. I systematically recorded the responses, always believing that this encounter in the Peruvian Amazon had something to say concerning indigenous health. The procedure sought to invite health professionals on an exercise of the imagination, putting themselves in that teacher's place – an *imaginative interpellation*.[1]

This initiative is due to a set of questions that I have been asking myself. During research into biomedical technologies that I have been developing since 2008, I was faced with insistent questioning by health professionals warning of the need for denser understanding of their specificities and recognition of their presence as actors and as integral parts of the context of indigenous health in Brazil.

The university that I belong to, the Federal University of São Paulo (UNIFESP), has collaborated in the healthcare of indigenous peoples of the

1 *Imaginative interpellation* in the sense of an interpellation *to* the imagination of health professionals and an interpellation *of* other imaginations. In reality, this procedure presented many limitations. The first was the ignorance of my interlocutors regarding the Piro universe and of the discussion concerning the Amerindian body. I tried, however, to support the discussions with information and materials that could widen the conversation. Anyway, the contours were extrapolating the context presented by Gow. That story emerged as an allegory of a kind of meeting that would interpellate the imagination of health professionals. I owe this endeavour to reading *L'eau et les rêves* [*Water and dreams*], a work in which Gaston Bachelard discusses symbols and images produced by the poetic imagination about water; and to Renato Sztutman, the first to perceive the relevance of this Gow narrative for health professionals. The charming book by Stelio Marras (2005), *A Propósito de Águas Virtuosas* [The Purpose of Virtuous Waters], was also a great incentive. I am also grateful to Patricia Rech and Juliana Rosalen for their reading and contributions.

Xingu Indigenous Park (*Parque Indígena do Xingu*, PIX) since 1965. Many of my interlocutors were (or have been) somehow linked to the project denominated "The Xingu Project," and began to seek me out in order to narrate their experiences.[2] The consistency and frequency of these meetings led me to think about Gow's short story *as a way of interpellation* and of encouraging discussions. I then proceeded to systematically record the narratives derived from these interpellations, many in extensive interviews, statements that transpired in various locations (the Indian Outpatient Clinic, inside the Xingu Project, in university departments, etc.).

This essay attempts to record the reactions of health professionals, principally those linked to indigenous health, the imaginative interpellations, and thus reflect a little concerning how these professionals understand their actuation, what their concerns, discomforts and questions are. The desire is always to *identify the questions of our interlocutors*, *rather than seeking answers to our own* (Viveiros de Castro, 2002b). Briefly, this text is an attempt to take the interpellations of my interlocutors *seriously* in a search to problematize, in the form of an essay[3], the complex relationships of health professionals in the face of radical alterity (Peirano, 1999). The questions that guided the research were: What happens to health professionals who are directly faced with different concepts of body, health and disease? What happens when health practices occur in the process of *translating* the very conceptualization of what health is? Are these professionals so subsumed in the world of biomedicine that nothing would modify them from the onset to the end of encounters in which the practices occur in unstable processes of translation? Are agreements established other than those of domination? Are there significant differences between the professionals closer to indigenous contexts and those who do not have this experience? With these questions in mind, without any intention of exhausting or addressing all the nuances of these questions, we can begin the *variations around water and bodies* by presenting Gow's story.

2 This text, however, is not an analysis of the Xingu project and its policies, nor does it seek to evaluate it, or narrate any comments on the development of their activities.

3 I deliberately assume the essay form, i.e. the reader will not encounter in this text a formal arrangement established by so-called scientific methodologies. The orientation is established by the questions and reflections raised by *imaginative interpellations*.

I

The scene is as follows:

> A mission schoolteacher in [the village of] Santa Clara was trying to convince a Piro woman to prepare food for her young child with boiled water. The woman replied, "if we drink boiled water we get diarrhoea." The schoolteacher scoffed, and said that the common infantile diarrhoea was caused by drinking unboiled water. Unmoved, the Piro woman replied, "Perhaps for people from Lima this is true. But for us native people from here, boiled water gives us diarrhoea. Our bodies are different from your bodies." (Viveiros de Castro, 2002b:137-138)

Gow concluded that the episode would performatize the "irreducible" divergence between multiculturalism and multinaturalism. This prosaic event expresses the common cultural background of Amerindians: perspectivism – the concept as conceived by Viveiros de Castro. *Perspectivism* is the notion that the world is populated by species of beings endowed with consciousness and culture. The manifest form of each species is an envelope that hides the internal human form. This internal human form is only apparent to the eyes of the species – or "transpecific" beings, such as shamans. And each of these species is endowed with (and constituted by) a unique *point of view*. The way humans see animals – and other agents that roam the universe, like spirits, gods, the dead, artefacts, objects – is distinct from the way animals perceive humans and themselves. Thus, each species of being, including humans, sees itself as human.

Amerindian myths tell us about an original state of intense communication between humans and animals. In the mythical narratives, beings emerge whose form, name and behaviour combine human and nonhuman properties. The communication between beings, between humans and animals, human and nonhuman, is similar to the relationships between humans of today. This state of intense communication demonstrates that the original condition shared by humans and animals is humanity and not animality. Amerindian myths persistently narrate how animals lost the attributes inherited or preserved by humans – animals are thus ex-humans; humans are not ex-animals. Indigenous thought concludes that, having once been human, animals and other beings of the cosmos continue to be so, albeit non-evidently.

The idea of a world composed of a multiplicity of subject positions seems to pertain to the notion of "cultural relativism" and the term

"multiculturalism". The reasoning is more or less as follows: indigenous peoples are cultural relativists, only they extend this relativism "animistically" to other species. However, referring again to Viveiros de Castro, there is an equivocation in this deduction. Cultural relativism implies equivalence between a multiplicity of representations of the world, but presupposes a single world behind this multiplicity. For Amerindians, all beings observe the world the same way, what transforms is the world they see, the things they observe are other. Thus perspectivism is not a "multiculturalism", rather a "multinaturalism". In the former, one nature and various cultures exist, or, as Viveiros de Castro would put it, a variety of subjective and partial representations incident on an external nature, indifferent to an individual representation; in the latter, one culture, with multiple natures, or to describe it more fully: a representative unit applied indifferently over an authentic diversity. Perspectivism is a multinaturalism, since the perspective is not a representation. This is because the representations are the property of the spirit, but in Amerindian cosmopolitics, the perspective, the point of view, is in the body. *The difference is conferred by the specificity of the bodies*.

Being able to occupy the point of view is a potentiality of the soul, and nonhumans are subjects to the extent that they have a spirit (or are spirits), but for the Amerindians the difference between points of view is not in the soul. The soul, formally identical in each species, only sees the same thing everywhere. The difference must be conferred by the specificity of the bodies. This explains why nonhumans, although people, do not perceive us as people. The animals see identically to us, but they see things differently to what we see, precisely because their bodies are different from ours.

II

"Our bodies are different from your bodies", affirmed the Piro woman in the encounter narrated by Gow. What was at stake in this kind of statement? Not physiological differences, obviously, since the Amerindians recognize the uniformity of the body.[4] In reality, Viveiros de Castro argues, the Piro woman

4 This assay relies most directly on the work of Viveiros de Castro regarding formulations concerning the body. However, the literature on the topic is already quite extensive. Since Seeger, Da Matta and Viveiros de Castro (1979) argued the centrality of the body in Amerindian cultures (see Vilaça 2005), a number of ethnologists have continued exploring the productivity of the theme and thinking concerning

is talking about the affects and affections of each body, i.e. what you eat, how you move and how you communicate. Body morphology is a sign of the differences in affection. The Amerindian definition of body, therefore, is not the physiology or anatomy, but a set of ways and means of being that constitute a *habitus*. The body is a bundle of affections and capacities, and origin of perspectives; hence, the claim by Viveiros de Castro: perspectivism is a body mannerism (Viveiros de Castro, 2002a).

The Piro woman maintains, therefore, a *non-biological idea of body*. In this case, childhood diarrhoea is not imagined or maintained as an object of biological theory. It is this disjunction that the encounter narrated by Gow performatizes. Her assertion concerning the difference of bodies indicates the existence of *another concept of body*: the body as perspective. She speaks of the body as a set of affections, body modes that can differentiate her body, for example, from that of a jaguar; that differentiates the body of the Piro people from that of the townspeople. In this context, there is no concept of body as representative of an extra-conceptual body, "*but body as internal perspective of the concept: body as implied in the concept of perspective*" (2002b: 140).

Within the teacher, the constitutive inertia of language produces an immediate adhesion to the signification *body*, which makes her forget the differences residing within the same term, differences highlighted by the Piro woman, who was not even surprised by the possibility that the teacher had another concept of body. The immediate and unquestioned translation, in which the 'homonymy' evokes the effect of understanding and agreement, gives rise to certainties concerning that which communicates exactly in translation processes which juxtapose distinct conceptual imaginations; certainties that constrain communication and understanding and hinder the passage through turbulent terrains. It is within this risky terrain that the healthcare professional who works with "indigenous peoples" is inserted. The *movements* that follow ripple around these problems and concerns of health professionals: the obstinacy in intervention, the dilemmas of translation, the persistence of a rationalized soteriology, the limits and differences

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the relationship between body and several other aspects: shamanism (Langdon 1995; Vilaça 1999), cannibalism (Vilaça 1998), infanticide (Conklin & Morgan 1996). See also, Conklin (1997), MacCalum (1998), Taylor (1996), Lima (2002), Vilaça (1998, 2005). Considering the limitations and intentions of this work, I have neither the space nor the conditions to address all the literature, to which, though obliquely, this essay is indebted.

in the encounter with radical alterity (Peirano, 1999), the lack of a *grammar of respect* and even the possibility of an impact on these precarious encounters.[5]

III

As I said, for almost two years I have been discussing this story with health professionals with the intention of debating the different concepts of body and to problematize the implications of the disjunction between these concepts of body for health practices. If this encounter does not show us a different view of the same body, *but rather another concept of body*, then the very action of health professionals should consider this difference in healthcare practices. Without seriously considering this difference, the actions are nothing more than an attempt at maintaining the "conviction" of that which is already known: the universality of the bio-body, disease processes and treatments, thus anchored in the supremacy of the biological view of body.

These discussions took place in diverse situations: classrooms, meetings with medical professors, encounters and interviews. The responses were varied, as can be observed during this essay. However, particularly among doctors and nurses who worked with indigenous healthcare, there was a recognition of divergent understandings concerning the body and the urgency of minimally getting to know "the concepts of the diverse indigenous ethnic groups, due to the threat of the ineffectiveness of healthcare actions". Many health professionals repeated the idea of "respect for what the Indians think". The term respect, persistent in public policies, manuals, documents and in the field of indigenous healthcare in general, however, reveals a distance denounced by the phrase that always ended these discussions: "*And the boiled water? What do I do about the water?*" Boiled water seemed to be a nonnegotiable variable.

The insistence of knowing what to do about the water ended up revealing an inescapable dimension of the universe of health professionals. These

5 Paul Valéry (2007) distinguished two types of movements: one that has a defined goal and another in which the goal is the movement itself. This essay is much closer to the latter. Therefore, the characters of these variations, my health professional interlocutors, are only mentioned and I do not dwell on elucidating them and the contexts of their enunciations more closely, questions that I have dwelt on elsewhere (Pereira, 2011). Again, what matters to me here is the *movement of the variations and what it can produce*. The hope is that this journey through water and bodies, with its risks and dangers, might teach something, since, as Guimarães Rosa (2005) teaches us, "Living is very dangerous... Because learning to live is living itself... A dangerous passage, but it is that of life".

professionals are trained to intervene. Intervention is central and pervades all moments and the activities performed. After a long conversation about Amerindian concepts of body, about the importance of knowing the minimum about the local culture, in order to achieve greater efficacy in therapeutic approaches, I always heard this kind of inquiry: "*but should we boil the water or not? And in the case of homemade saline solution for the weak, should we use possibly contaminated water or do we have to boil it?*"

The obstinacy of my interlocutors for intervention was consistent with George Canguilhem's (1965, 1984) definition of medicine. For him, medicine is a technique situated at the confluence of several sciences. The essence of medicine is the clinical and therapeutic: *it is a technique of instituting or restoring the normal, which cannot be reduced to mere knowledge*. A technique that is driven by *pathos* and not by *logos*, and organized around values. Modern medicine emerged with the purpose of understanding the laws of normal life and pathological life. Normal, however, is not only *that which is* most prevalent and presents as statistically constant, but *that which should be*. Normal is defined not by facts, but by values.

It is this conceptual machine that health professionals access to intervene in indigenous peoples; or rather, it is this conceptual machine that impels them to act and determines intervention as central. Obviously, there is no homogeneity that can cover all health professionals, particularly one that considers the wide variety of functions: doctors (health workers, clinicians, epidemiologists), nurses, nutritionists, dentists. Still, considering Canguilhem's definitions of medicine as a technique for re-establishing normal, we can understand the questions of my counterparts concerning the need to boil water. "*There are different concepts of bodies. Ok. But, the water? Do I boil it or not?*" was the lingering question. This story of boiled water and bodies is finally revealing the centrality of intervention in the forms of approaching and perceiving reality. Consider these relationships between body and intervention.

IV

A nurse was working in Amapá, at one of the community health centres within an Indigenous Territory (IT).[6] During the preparation of a course aimed at

6 In this case, I opted to include this story with minimal specifications, both to cede to the nurse's

training Indigenous Health Agents (IHA), she proposed an exercise to learn the indigenous names of organs and body parts. Given that health professionals generally do not dominate the local concepts of health and illness they need some understanding of the lexicon used for interventions, such as vaccination, antibiotics and other drugs, both to facilitate the process of sharing knowledge with the IHA and to facilitate subsequent action. The nurse asked the course participants to draw the body and then name each of its parts. For her, it could not be simpler and with the advantage of permitting the minimum required understanding at the moment of more technical actuation.

Following the completion of the course and while preparing to leave the IT, an anthropologist who had worked for over 30 years with the indigenous group arrived at the community health centre, and struck up a conversation with the nurse. The nurse quickly reported on the technique developed and presented posters with drawings of body parts elaborated by the students. Looking at the posters, the anthropologist intervened emphatically, explaining that the concept of body for this indigenous group could only be achieved if their cosmology was understood; in no way should the body be broken up like that, since the concepts and distinctions between the human and nonhuman body were philosophical and material themes essential to Amerindians; and that the exercise, therefore, affected concepts central to that community. She ended with the phrase, "*you, health professionals, always simplify the concepts of others*". Because the nurse was leaving the IT, the conversation could not be continued and, while understanding the dangers of simplification, she was left with some discomfort, which can be summarized in the laconic question that she elaborated while reporting the events to me: "how should we act?"

In our conversation, the nurse reiterated her unfamiliarity with the cosmology of the ethnicity in question, as well as their concepts of body, but still had doubts about "*what harm would come from stimulating the indigenous group to translate important dimensions for a type of intervention that was requested by the group itself?*". And, moreover, one doubt lingered, that of whether the heart of the activity of an anthropologist was not constituted, as we have

request, who preferred to remain anonymous, and because I felt the procedure would in no way harm the text: I would emphasize again that this essay seeks to approach the experiences and concepts of health professionals. Therefore, the occasionally rapid form of addressing the indigenous communities is not due to a generic concept of Indian (a concept that even *some* of my interlocutors sought to avoid), but to the actual direction of the arguments, *which are directed to health professionals*.

seen, in the main purpose of the work of health professionals: "what should we do, after all?"

When the nurse requested the naming of body parts, she sought translations of the terms of the indigenous language into Portuguese; or at least the joint construction of analogies that could help her with a minimal knowledge of the indigenous understanding of body, and how to act. The anthropologist affirmed that there is no direct correspondence between the terms of biomedicine and indigenous concepts of body and therefore direct translations were not possible. A literal translation would fail.[7] If health professionals defend themselves, claiming they are called to act, and that they have to do the work they are called for, irrespective of conceptual imprecisions, the anthropologist stresses that the work would be fruitless, since looking for direct equivalents would only impoverish and further alienate health professionals from indigenous concepts, thus raising the question: what action is reasonable when based on misconceptions?

Although falling into an epistemological trap, given the centrality and complexity of the body in Amerindian cosmopolitics, the nurse thought it would be harmless in a professional situation, and only wanted to superficially know the names of body parts in order to ask prosaic questions like: "I can apply a remedy to your arm?" The anthropologist, in turn, alerted to the epistemological violence of what was trivial to the nurse. While the nurse referred to biological body and is anchored in the biological theory of the body and its treatment, the anthropologist warns that Amerindian theories are much more sophisticated and that another concept of body exists.

As in the encounter described by Gow, the problem is in the 'homonymy', which raises translation difficulties and encounters involving precarious communication. This encounter presents the dilemmas of health professionals who, in their desire to intervene, insert themselves in a complex *search* for translations: an encounter of conventions and cosmopolitics, in a profusion of misconceptions and noise. A search that may indicate that something happens when dealing with these processes of translation misconceptions. We return to the scene of boiling water.

7 Concerning problems of translation, see Albert & Gomez (1997), Albert (2000), Albert & Kopenawa (2010). Concerning relationships and the possibility of collaboration between anthropologists and health professionals, see Langdon (2004).

V

Many of the replies to the imaginative interpellations were direct and surly. On one occasion, after I had again narrated Gow's story, a physician, in the classroom of first year medical students, said flatly that it was not the job of health professionals to consider these "fancy" concepts of bodies that do not require treated (boiled) water. Much had already been accrued in "science" so as not to "encourage" this kind of "confusion". The key was to remember that knowledge of asepsis is essential to medical practice and to any health professional, leaving only the task of explaining it carefully. The "mission" of the physician was to extend the notions of hygiene to everyone; even under authoritarian attitudes of the State, including among "indigenous peoples".

In this case, the response was not mocking (like someone who is surprised at the ingenuity of another's response), as in the history of Gow, but a stern and missionary commitment towards science, to biomedicine. Above all, it was a rationalized soteriology of technical salvation. Biomedicine understood as truth that enables rational intervention and "saves entire populations". The term "mission" is not accidental, rather reveals the concept of medicine as a set of ideas and practices that must be adhered to faithfully, as fervent belief in its power and its effectiveness (Pereira, 2011). There are no doubts: water should be boiled, despite what the Piro think, despite what anyone thinks, even if "unpleasant measures" have to be taken to achieve this.

However, this was not the only kind answer I got. In a debate with nurses, I read the scene narrated by Gow and commented briefly on the discussion concerning the body and about the need to be aware of the specifics, etc.. I was interrupted with a recurring discussion on the imperative of intervention. During the discussion, a nurse described the difficulties of working with "indigenous peoples, in the middle of the forest [i.e. without the biomedical technology that she thought was necessary], at the request of the Indians themselves". She said that the experience urged the health professional to conceive of their profession removed from what they had learned was the proper way to act.

After more than an hour of this and recurrent discussion, another nurse put forth a new point of view: for her, the issue was not getting into an unsolvable discussion about the veracity of concepts, after all, "we (Indians and whites) could be talking about completely different things, or misinterpreting what the Indians are saying". Indeed, the discussion had, until that point,

avoided the critical point of contention: people do not drink water solely at home. It would do the Piro woman no good to boil water for herself and her close relatives, since everyone circulated through various places with unboiled water (contaminated or unfiltered). From the river to the dwellings, everything should be discussed so as to figure out the possible sources of contamination. Circumscribe the action to a few people was a way of avoiding the more serious debate, which involved educational measures, notions of asepsis, sanitary practices. It would do little good for that Indian woman to boil water if we did not think collectively. Some recalled direct proposals to distribute filters to the entire village and the construction of drinking water storage on indigenous lands. What was insinuated in the formulation proposed by this nurse was an amplification of the scene narrated by Gow. The debate over whether the water should be boiled had widened to the need to consider the paths and forms of water consumption. A proposal directly related to discussions of public health.

The nurse was thinking here of John Snow, author of *On the Mode of Transmission of Cholera*. Snow (1990), who managed to record the geographical distribution of cholera in London thirty years before understanding its etiology – it was only in 1883 that Robert Koch concluded that *Vibrio cholerae* was responsible for cholera. Snow showed that cholera followed the path of the water. In an interval between two periods of epidemic, a change occurred in the distribution of water in London. One of the companies chose to pump water from the River Thames before it entered the city and became contaminated. Two other companies preferred to collect Thames water from within the city limits. Snow showed that cholera mortality was lower in the company which chose to collect water outside the urban perimeter. Cross-referencing water paths with mortality data, he presented a map of the distribution of cholera. The disease was linked to water and the authorities at the time demanded treatment of the water by the supply companies.

In consonance with Snow's approach, the nurse said that it would be interesting to follow the water paths and see how and where people drank water. The problem could not be resolved by the individualized and authoritarian obligation to "boil water" (as a metaphor of the obligation to consume treated water), first the intricate relationships between the social and biological needed to be verified. In one movement, the nurse had raised one of the founding narratives of modern public health and complexified the

initial scene which I was working with, the encounter of a Piro women and a schoolteacher in the Peruvian Amazon. All this with the authority of someone who had "worked with indigenous peoples". That initial interpellation, which spoke so much about ways of knowing and conceptual disjunctions, ended up being driven by the need for action and translation problems to the imperative of thinking about community health practices. "The issue was health policy", was what I heard at that time.

VI

"But the Indians make fun of sanitary measures", I heard on another occasion. "Try as we might, it seems that what we say does not take hold", a doctor once told me. Everything happened as if the "explanations" were understood by men and women eager for the knowledge that health professionals had to offer and, simultaneously, this knowledge was simply ignored. "What makes the Indians want our intervention and our explanations, but at the same time ignore them?", was a common question.

Stories of this "inconstancy of the wild soul" are many. Filters, hard-earned and rationally distributed, which then ended up being used for everything – to keep animals, to pot plants, in child's play – everything except the function considered by health professionals as essential. Dedicated nurses who, faced with an outbreak of diarrhoea in the village, prepared homemade saline in beautiful containers, distributing them among the Indians, who, as soon as they found themselves far from watchful eyes, threw out the saline and used the containers in unusual and creative ways. Finally, a multiplicity of responses on a panoply of measures concerning – using health jargon here – "health promotion".

One day, however, I heard the following sentence from a physician with more than 20 years experience working in indigenous health: "But do Indians drink water?" This doctor began to discourse on the subject: "at least in the Xingu, Indians only drink water as a last resort; they prefer a kind of liquid porridge made of tapioca and water". Throughout his experience at the PIX, he had only seen Indians drinking water when it was difficult to obtain this "porridge". "Hydration" took place from consuming this drink and not water.[8]

8 Here, evidently, I am following the formulations of my interlocutors. The goal is simply to follow

For that Piro woman, the doctor asserted, the schoolteacher's proposal of boiling water was totally inadequate. "Water was not drunk that way and when people get sick, the first thing the Indians do is suspend the water"; i.e. the question was not only the physical process of boiling, but the taste and forms considered for therapies – everything was connected. Thus, in that event, different cultural options merged, a complex elaboration that focused on developing therapeutics. Sure: all considered by the doctor, deductive assumptions of his experience in indigenous health, primarily in the Xingu (PIX). Either way, the conclusion that he drew from this conversation was that the schoolteacher did not know the habits of the Piro (do they drink water? how? where?), their therapeutics, nor their concepts of body. Thus, the doctor claimed that you needed to know the affects and affections (what they eat, how they move and how they communicate...) of the Piro people, without which the health measures were doomed to failure. "How can you think in general health measures without knowing even the minimum concerning the specificity of a people?", a sophomore nursing asked on another occasion, when faced with this discussion.

"Ignorance" of indigenous concepts was customary, a female doctor with extensive experience in the PIX assured me. Not once or twice, but innumerous times, health professionals came to discourse on the need to drink water (at least two litres a day!) to an audience who did not appreciate "that kind of hydration". What had been taught in universities did not make sense in the context of the PIX, and the stumbling blocks were common. However, while the situation can be more or less left as is, after all, the "Indians have alternative ways to hydrate themselves" and are not dying of thirst, it becomes a zone of turbulence in extreme situations in which health professionals see themselves as compelled to intervene.

As noted, when they fall ill, the Indians do not drink water. "The first thing they do," insisted the doctor, "is to stop giving water to the sick". This makes things difficult and complicates the work of health professionals, because dehydration is a risk factor in diarrheal diseases. In this case, the ideal from the biomedical point of view is the administration of "homemade saline". The question was naturally: "What to do regarding saline in cases of diarrhoea?"

Homemade saline is celebrated as an extremely simple and effective

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the narratives of water and bodies.

health technology to prevent dehydration caused by vomiting and diarrhoea. Saline is an aqueous solution composed of sugar and cooking salt. The idea is to replace the loss of water and mineral salts in diarrheal diseases. The consensus among medical prescriptions is that the saline should be administered every twenty minutes or every bowel movement. Oral rehydration therapy (ORT) is considered to be effective and low cost, to the point of becoming a government program. In 1987, the Brazilian government launched the National Homemade Saline Program, with campaigns in the media, sponsored by the National Conference of Brazilian Bishops (CNBB), UNICEF, Brazilian Society of Paediatrics (SBP) and the Ministry of Health (MS), with the aim of clarifying ways to deal with dehydration due to diarrhoea. Epidemiological studies show how this therapy has significantly reduced infant mortality rates in several Brazilian states, including among poorer populations. The reduction in mortality following the adoption of ORT is considered evidence of the "*potential of health intervention to control the risks of health problems*" (Guimarães et al 2001:477).

Homemade saline is, therefore, central to the health professional. ORT is directly related to more expensive concepts, whether clinical or public health. Biomedical techniques and health measures are resumed within this simple technology[9], which are proposed as universal. A technology that clashes with the choice of Xingu Indians to "interrupt hydration at the exact moment they perceive the illness". What to do in this situation? How to consider an actuation that is neither mocking and ineffective, nor authoritative and imposed (and equally ineffective), nor even educational measures that disregard the local context and the Amerindian concepts that the therapies are based on?

9 As far as I know, ORT remains uncontested. Even authors critical of the actuation of health professionals recognize the great value of such techniques in certain states of illness. Laura Pérez Gil (2007), for example, reported outbreaks of intestinal infection caused by contaminated water, which manifested itself with symptoms of acute diarrhoea and violent vomiting. She reported that in 1998, the disease struck a region in Acre, with multiple victims. In the Yawanawa village, where an anthropologist was conducting ethnographic research, one person even died. However, the action of the IHA and the leaders controlled the epidemic. The anthropologist concluded that, "These examples show that proper use of the techniques of biomedicine makes a very positive contribution to improving the health of the population. In the case of the Yaminawa, greater and more appropriate access to biomedical resources is indeed necessary for, among other things, reducing the high infant mortality rate that can be seen in the group" (2007:58).

VII

Diarrhoea is one of the principal causes of death among indigenous peoples. There is no direct technology to prevent diarrhoea, but as previously affirmed, ORT is effective. The etiologic agents are diverse, the most common being bacteria and protozoa. Rotavirus is also among the main agents that cause diarrhoea. Several authors have stressed that precarious sanitation in indigenous communities favours a high incidence of gastrointestinal infections. Moreover, they highlight the lack of adequate infrastructure for drinking water. Thus, both the need for fresh water and the centrality of ORT as therapy are central to indigenous health.[10]

Evidently, this scenario clashes with indigenous practices to interrupt the consumption of water in cases of illness.[11] Boiling water takes on a drama here that the encounter of the Piro woman and schoolteacher does not seem to reveal. The health professional cannot laugh with derision, but must negotiate ways to do what they have been prepared to do. Practices implemented from the top down are ineffective. Even well-intentioned actions like distributing homemade saline are sterile. Here, we reach one of those points in which the practices are only reasonable in a process of sharing knowledge, that of biomedicine and of the local communities. As we have seen, if the intervention is the first condition of doctors and nurses, under these circumstances, it results in agonizing situations, in intense social dramas, and the actions can only be reproduced within translation processes.

The *grammar of respect*, the way public policy is announced, is inappropriate. Respect, as I have said, implies a distance.[12] The scene looks more or less like this: someone is faced with other "opinions" or "customs" and,

10 See Coimbra, Santos Tanus & Inham (1985), Linhares (1992), Linhares et al (1981), Santos, Linhares & Coimbra (1991). Coimbra Jr. (2002) analyzed the difficulties of implementing oral rehydration therapy (ORT) in cases of exposure to intestinal pathogens. Another contribution is that of Haverroth (2004), concerning intestinal diseases among the Wari'.

11 I stress once again that the focus of my approach is health professionals and not the ways Amerindians have found to deal with diseases. It is worth remembering, however, that collectives possess their own preventive and therapeutic knowledge and the case of diarrhoea is no different: indeed, the presumption that "indigenous peoples" are dispossessed of ways to deal with the disease and are at "risk" (or are particularly vulnerable) is the habitual *motive* of professionals who work with indigenous health.

12 "Respect" often slides toward meaning "tolerate". But even in its positive sense, that which makes us face difference and enables the construction of ethical values distinct from those in existence, some authors continue to alert us to its limits (Cabral, 2003). These limits can be seen, for example, when *queer* bodies claim: "we don't only want to be respected, we want to be desired".

despite presuming the "mistake" of those who are different, "respect" compels them to "accept" or not to speak their mind. There are at least two problems with this. First, respect and tolerance are terms arising from "cultural relativism" and maintain stable and inalterable that which should enter – and be transformed – within the game: nature; the nature of bodies.[13] Second, the distance enables a reassuring non-involvement, while "acceptance" or "not speaking one's mind" does not imply change or movement on the part of those who *respect*. The *grammar of respect* is, therefore, a policy of non-affection and non-affectation, and its application, always mediated by a distancing exoticism, ends up moving between static statuses without the interweaving of knowledge.

The *grammar of respect* and the non-involvement it gives rise to, however, is not possible in a situation like homemade saline. Health professionals find themselves implicated, affected in the very process of actuation. The need to intervene, and intervene effectively, can produce an effect of immersion in the problems to the point where well-meaning attitudes (those who know and know that others do not know) slide toward negotiated actions – the fruit of systematic observations, in a continuous affecting. I am not affirming that this kind of affectation always occurs. I only sustain that distance does not resolve it and the implication is a possibility. Moreover, such situations compel health professionals to leave the safe, comfortable place of their knowledge for a relative affectation of others knowledge – the very condition of the reasonableness of their actions.

As my interpellations progressed, I realized that the more health professionals established closer contacts and relationships with indigenous communities, the more the dilemmas and questions were displaced. The intervention continued, but slowly other proposals, other ideas emerged. The greater the field experience and time working with indigenous health issues, the more questions exited the arena of certainty and conviction and became problems and doubts, thus becoming points to be resolved. In the case of professionals in the Xingu project, for example, it was from long experience they learned that in situations of chronic diarrhoea, it was simply not enough to prescribe ORT, or distribute pots of homemade saline as an educational and preventive measure. To deal with the situation, they opted to perform

13 I am grateful to Stélio Marras for this formulation.

assisted or intravenous ORT. During assisted ORT, increased focus and continuous work is demanded of the health professional, which can last as long as three days; during intravenous actions, the actions must also be developed with special attention and specific technology, since this situation involves risk to the patient.

What was sought by these options and measures was a negotiated solution. A complex situation from which the following conjuncture was drawn: health professionals have not stopped believing in the urgency of boiling water; Xingu Indians, in the words of my interlocutors, continue to interrupt water consumption as they get sick. However, doctors and nurses, understanding that the Xingu indigenous communities perceive the assisted or intravenous form of saline administration as an adequate therapy, dedicate themselves to this task, which demands far greater attention, but achieves greater effectiveness. This change in the way of acting is not only a technical and operational amendment, but represents an attempt to *listen* to the other. It is not simply about *respect* for the distant and exotic, but an act of engagement with the dilemmas of the other, even when precarious and even without an agreement on whether or not water should be boiled.[14] Professionals with effective engagement in indigenous health cannot achieve a *solution* on the question of boiling water, but they can produce *responses*, though provisional, allowing these to become productive, occasionally leading the work of thinking in the record of action and of affection.[15]

If the confusion of bodies and 'bodies' remains a persistent imbroglio, and if Amerindian thought still appears as an unknown to health professionals, as we saw from the encounter between a nurse and an anthropologist in Amapá, these practices, developed after years of PIX experience, still seem to move around constitutive affects and affections of Amerindian bodies. And if the body is a set of affects and affections, as Viveiros de Castro tells us, then even when failing to strongly define the differences between bodies and 'bodies', or translate these ambiguous concepts that the 'homonymy' obscures,

14 There is also a change in the form of perception and relationship of indigenous communities with biomedicine. Maj-Lis Follér (2004:137), for example, tells how the Shipibo-Conibo people mix artefacts of medical discourse to local ways of managing health practices. She speaks of a cholera epidemic in 1991, in which *intermedicality* constructs occurred in a fusion of knowledge to address the effects of cholera. Decoctions of vegetable drugs have been used to prevent dehydration and some preparations were derived from antibiotics, in a process toward the *indigenization of medicine*.

15 Here, I rely very loosely on the work of Paul Ricouer (2004).

some approximation occurs between the parties. There is something in the translation that escapes and flows, something in the translation process that moves, producing this approximation, even in precarious encounters.

VIII

It was precisely concerning these precarious encounters that, one afternoon, on leaving a meeting at which I had again discussed the scene of the Piro woman, without planning it, a homeopathic doctor came over to talk, weaving a long narrative about his "experiences in indigenous health". This doctor had accumulated more than 10 years involvement in mediating actions in the field at Xingu and healthcare services in São Paulo. The calm voice and tranquillity of the homeopath contrasted with the wealth of stories narrated, which he described as "wonderful". I will focus on two of these.

The first was the story of a Kuikuro boy, the only case of "mental health" that he had faced throughout his experience. Before beginning the narrative, he made a point of emphasizing: "mental health, between quotation marks, very much between quotation marks!", and then continued. In the Xingu, as the physician responsible in the area at the time, he was following a "committee of Kuikuro shamans", whose discussion concerned the disturbances that this kid was suffering from. At this meeting, the shamans came to the conclusion that "they were unable to handle it". The physician administered medication right there in Xingu, but the drug had no effect. Given the severity of the condition, and with the acquiescence of the shamans, the young Kuikuro male was brought by plane to São Paulo. He did not speak Portuguese, a fact that worried the physician, who was waiting for the young patient at the airport, and from where they went immediately to the Emergency Room. Once again the biomedical actions proposed did not work. The young Indian was not sleeping and became aggressive, even physically attacking girls who he encountered. The situation worsened. The homeopath sought out a well-known psychiatrist. The psychiatrist prescribed medication that helped the boy to finally fall asleep. And, sleeping, he was able to dream. The dream changed the boy, who suddenly started talking. His brother, who was also in São Paulo and who spoke Portuguese, began translating the conversations. The sick boy immediately described his dream to his brother. The dream was communicated to the shamans and was key in them being able to

complete their healing process, completely eliminating the patient's suffering. The shamans discovered that the boy's suffering was caused by amorous adventures, which he had prohibited during the sports competitions in the events surrounding Brazil's 500th anniversary of "discovery" in 2000. The homeopathic doctor said at the end: "A beautiful story, with two interpretations. Where your own ignorance, and you assume this ignorance, is what leads you to understand the disease".

The second story is that of a kidney transplant performed following the intermediation of the Indian Clinic. In order to receive the transplant, a Suyá man needed to stay in São Paulo for a relatively long time and became friends with the homeopath. When he died five years after surgery, due to complications other than the transplant, his wife was in the Centre for Indigenous Health (CASAI) in Parelheiros. The doctor went to say goodbye, since he was departing for Xingu. The scene was described more or less like this: the doctor, the widow and her son, all together at the CASAI. The widow speaking in her language, which the homeopath did not understand; the son was making occasional interventions, translating bits of what his mother was saying, and crying. This scene deeply touched the homeopath, making him feel, somewhat, as if he were in a Babylonian scene, as if he were experiencing some kind of communication and understanding. He told me: "For me, the great journey of that moment was to see what unites us in difference. And it was not something that I had when I came here, within me. It happened while working, consulting, coming back here to handle each case. Not having anyone to turn to, having to create a solution for each case. And each case is always an unusual case. Each case is a person and a culture you have to understand, while intermediating with your own, with hospitals, with the doctors from here".

These stories provoked me to understand more about the characters and situations being narrated. How were the sophisticated concepts of Kuikuro and Suyá healing manifested in these encounters? The temptation is to criticize the abstraction of these stories in their nebulous profusion of events and characters with no defined configurations, situations without clear dimensions. The criticism, however, had already been elaborated by the homeopath, who never tired of alerting us to the precariousness of communication and the encounters. A clear a desire to explore these stories more thoroughly was evident and the "conceptual ground of perspectivism" would be fertile. I meander at this point, however, because what I am trying to understand is how

these experiences *affect* health professionals. What I want to know is: What is the homeopath's formulation of these encounters? How can an encounter with precarious communication be "wonderful"? What is it that made these precarious encounters something wonderful? What was this doctor trying to tell me?

It took me a while to perceive that he did not want to discourse on indigenous specificities, nor talk about concrete situations. Rather he sought to talk about the encounters and about their possibilities or precariousness. If he concluded with the difficulty of these encounters (in which ignorance is perhaps the central element), he also wagered on a level of interaction and on the possibility of communication. He was talking about translation practices that are not easily resolved, yet insinuated themselves in the flux of the process, in the errors, in the daily practice of dealing with alterity. The homeopath wagered that these precarious encounters made a transformation possible.

IX

All this leads us to think that translation processes are not just conceptual. For Deleuze (2007:171, 1992), *concept* houses two other dimensions, those of affect and percept, indispensable for *movement*, for *becoming*. Although *concept* is being "something different", it has "no sense or necessity without the corresponding 'affect' and 'percept' (Zourabichvili 2004:4). If the translations mobilize the "other dimensions" of concept, they can alter the *affects* and *percepts*. And, although they do not completely subvert this "something different" that is *concept*, they could be involved in moving affects and percepts.

Thus, these variations around water suggest that the complex process of translations, which slide into simple linguistic translations to zones of apparent incommensurability, *can affect* health professionals. From the physician who has never had contact with indigenous health and discourses with scholarly wisdom regarding the microbiology of water, to the insecure doctor who marvels that "Indians do not drink water"; from the health professionals who wonder at indigenous resistance to adopting "sanitary measures", to the nurse seeking translations in an attempt to act more effectively, or to the homeopath who tells wonderful stories about the possibility of communication in precarious encounters; from the insensitivity of pre-produced truths,

to unstable professionals on uncertain searches for therapeutics compatible with local concepts-affections. These slidings suggest that something has moved and changed: *affect is this change. These imaginative interpellations signal, therefore, that the more dense the experiences of professionals in indigenous health, the longer they are engaged and the more they are exposed, the more they can be affected and, thus, invent ways to deal with crucial issues like water and bodies.*

It may be that accompanying these changes will allow us to move from a *critical sociology* toward a *symmetric anthropology* and, returning to health professionals, recognize the multiplicity of forms of relating and negotiating with biomedicine itself. Who knows, perhaps we will encounter more ambiguous professionals than we supposed existed, more inclined to negotiations than we imagined, less bound to biomedicine than we believed... after all, perhaps we should understand that for both the health professional and the Amerindian, Nelson Rodrigues' assertion holds true: "*Human beings, as we imagine them, do not exist*".

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