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The construction of citizenship and the field of indigenous health:

A critical analysis of the relationship between bio-power and bio-identity

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Resumo

O presente artigo discute dois contextos de pesquisa etnográfica em saúde indígena, através dos quais buscamos refletir sobre o tipo de cidadania que está sendo fabricada na interlocução entre políticas de governo e participação política indígena nas ações, normas e discursos da saúde. Tratando-se de mundos sociais em que práticas de governo incidem sobre corpos individuais e populações, nos perguntamos se é possível falar de uma bioidentidade emergente na saúde pública para os povos indígenas no Brasil. Nossos objetivos estiveram pautados, portanto, em dois momentos: (i) refletir sobre os efeitos das políticas de governo para a saúde indígena no campo rico e complexo das conexões entre a biologia e a política; e (ii) ponderar sobre o potencial compreensivo daquelas categorias para as identidades políticas em jogo neste campo.

Palavras-chave: saúde indígena/etnografia/cidadania/biopoder/bioidentidade

Abstract

This article discusses two contexts of ethnographic research in indigenous health, through which we reflect on the kind of citizenship produced in the political dialogue between the government and indigenous political

participation, considering their actions, norms and discourses about health. In the case of social contexts in which governance practices focus on individual bodies and populations, we ask if it is possible to speak of an emerging bio-identity for indigenous peoples in the Brazilian Healthcare System. We have organized our discussion in two stages: (i) reflect on the effects of government policies on indigenous health, regarding the rich and complex field of connections between biology and politics; and (ii) reflect on the potential of these categories to understand political identity in the field of health.

Keywords: indigenous health/ethnography/citizenship/bio-power/bio-identity

The construction of citizenship and the field of indigenous health:

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Introduction

A question inspires and shapes this paper: what kind of citizenship is being constructed in the meeting ground of government policies and indigenous political participation in actions, norms, and discourses on health? As we are dealing with social worlds in which government practices affect individual bodies and populations, we ask whether it is possible to speak of an emergent bio-identity in public health for indigenous peoples in Brazil. When we specify our theoretical and ethnographic position in this debate, we must inquire how mutually close or distant are the concepts of “bio-sociality” (Rabinow 1999), “biological citizenship” (Petryna 2002), “sanitary citizenship” (Briggs & Martini-Briggs 2003), and, in a more diffused way, “bio-citizenship” (Filipe 2010), and “bio-legitimacy” (Fassin 2012a). After all, these are constructed categories, as they always are in the human sciences in specific empirical contexts, but, some more than others, have overflowed to very different ethnographic universes. Hence, we have a double purpose: (i) to reflect upon the effect of government policies on indigenous health in the rich and complex field of the connections between biology and politics; and (ii) to think about the power of those categories over our understanding the political identities at stake in this field.

With this in mind, we present two ethnographic anchors that support our analysis. Each will focus on both government discursive practices and indigenous rhetoric in action, observing their specificities. Lastly, we shall return to

the issue of the place of “life in itself” in the construction of indigenous political identities through the understanding of mediators and mediations of the technologies that take the body as a government object and instrument in the context of the broader political involvement of indigenous peoples.

First ethnographic anchor: indigenous participation in national “social control.”

The current indigenous health policy follows the legal landmark of the 1988 Constitution in which health becomes a State duty and a right of all Brazilians. It contemplates not only the improvement of health conditions, but also the democratic management of policies and health services in what became known as “social control” in government parlance, that is, social control exercised by organized society over the State. The articulation of the indigenous movement with the movement for health reform appeared in the initial phases of definition of the new health system, the Unified Health System (*Sistema Único de Saúde* - SUS), which was implemented with the return of democracy in Brazil.¹ This articulation guaranteed that a specific committee for indigenous health – Intersector Committee for Indigenous Health (*Comissão Intersetorial de Saúde Indígena* - CISI) – created in 1991, organized the first set of committees to advise the Council of National Health, the highest body of social control. At that moment, these committees assured the creation of a forum for institutional participation mostly composed of indigenous political leaders who, in 2006, were to gain two chairs at the Council of National Health, as well as CISI’s coordination.

In terms of organization of the health service, in the late 1990s, the institution acquired a sub-system for indigenous health. It permitted the decentralization of basic health services through the creation of the Special Indigenous Health Districts (*Distritos Sanitários Especiais Indígenas* - DSEI). These districts were directly under the Federal Government rather than municipalities, which the Indian movement regards as predominantly hostile to indigenous interests. Furthermore, the sub-system contemplated the opportunity for formal indigenous participation both at village and DSEI

¹ We should point out that in 1986, during the eighth National Health Conference, which defined the bearings of what was to be the Unitary Health System, the First National Conference on the Protection of Indigenous Health took place. It proposed the creation of a System of Indigenous Health Care.

levels. These spaces would be, respectively, local consulting councils and district deliberating councils.

Thus, indigenous leaders organized around regional and national political articulations and legally conceived spaces of participation within the State (“social control”), and, with the agreement of traditional leaders, were successful in stating the proposal to construct a sub-system with special attention to the Indians. That meant a service and a participatory organization, which contemplated these peoples’ specificities, according to the principles of universality, integrality, and decentralization that guided the creation of the SUS system.²

Given this scenario, we have elected social control – the process of legal participation – carried out at the government federal level as an analytical referent, due to its relevance vis-à-vis the indigenous movements, and its spinoffs regarding the central issue of this article. As an ethnographic framework, we focus on the participation of indigenous leaders in the process of change within the government body responsible for policy management and the health services to the Indians. This process culminated in 2010 with the creation of the Special Secretary of Indigenous Health (*Secretaria Especial de Saúde Indígena* - Sesai), after a strong resistance by the National Health Foundation (*Fundação Nacional de Saúde* - Funasa), previously responsible for the “mission” of managing indigenous health policies.³

Throughout 2009, we observed a number of public strategies on the part of Funasa to affirm itself politically, in order to retain responsibility over indigenous health. Among these, we stress the workshop organized in Brasília about a consortium⁴ contracted with funds from the World Bank to

2 The information contained in these brief paragraphs contextualizing the recent history of indigenous health and indigenous social control comes from Teixeira, Simas and Costa 2013. For more details, see the dossier on indigenous health published in *Tempus. Actas de Saúde Coletiva* 2013;7(4).

3 This research on indigenous health social control began when Carla Teixeira was a representative of the Brazilian Anthropological Association at CISI from 2006 to 2010. Since then, she has been a permanently invited expert to the committee. Part of her observations and documental surveys occurred in the context of the project of scientific initiation submitted to ProIC/CNPq/UnB in 2012-2013, carried out by Diego da Hora Simas, Nilton Miguel Aguilár de Costa, Sara Godoy Brito, and Marcos Júnior dos Santos Alvarenga.

4 Comprising Health without Limits, the Brazilian Center for Analysis and Planning (Cebap), and the Institute of Development Studies (IDS) of the University of Sussex, England, the consortium was contracted in the context of Project Vigisus II, the result of an agreement between Funasa and the World Bank. It lasted five years, ending in late 2009. Project Vigisus II/Funasa is one of two components of the second phase of a Loaning Agreement (APL) between the Brazilian government and the World Bank for the strengthening of systems of health surveillance and disease control in the country.

present, for the first time, a proposal of goals and models for care, organization, management, financing, monitoring, and evaluation of the Indigenous Health Sub-system. In the first “technical” reports by consultants, the subsequent debates were moderate, according to the managing tenor of the event, but at the end of the first day, the Indians imposed a politicized agenda. While the consultants described their proposals with apparent indifference as to which government institution was leading the management of indigenous health (“Organization Responsible for Indigenous Health”), the Indians introduced to the debate the relevance of this definition and the health crisis in the villages. They did it competently and effectively, for these issues underscored the meetings that followed.

In focusing on this episode, we intend to systematize our thoughts about the rhetorical competence of the Indians in the processes of decision-making regarding indigenous health.⁵ We shall first focus on the arguments of a Shavante leader during the above-mentioned meeting sponsored by Funasa (we will spell out this choice below). Then we shall analyze the internal logic of his arguments, with the purpose of highlighting the discussion about indigenous citizenship as it is woven into the management of indigenous health policies, which concludes this section.

The national workshop: turning the tables

The “National Workshop” to discuss the reports of the above-mentioned consortium based on situation diagnoses of the various components established by Funasa (care, organization, management, financing and monitoring, and evaluation of the Indigenous Health Sub-system) took place in Brasília on May 20-21, 2009.⁶ Among those present were the presidents of the Indigenous Health District Councils, indigenous regional representatives, members of the Inter-sector Committee for Indigenous Health, Funasa technicians and managers and other government bodies in some

⁵ This paper is part of a research that began in 2008 in the context of the Research Group on Political Anthropology of Health (sponsored by the National Council of Science and Technology (CNPq)). These efforts attempt to contribute to the understanding of processes of indigenous participation in areas known in the Ministry of Health as social control.

⁶ For those interested in the report presented at the workshop, see http://bvsms.saude.gov.br/bvs/publicacoes/modelo_gestao_saude_indigena.pdf - assessed on January 5, 2015.

way connected to indigenous health, and a World Bank representative. The same proposal was presented at regional workshops, but it was the Brasília national workshop that set the political tenor. It became stronger along the process that led to the creation of the Special Secretary of Indigenous Health in 2010.⁷

The program proposed for the first day the presentation of five reports and, for the second, a discussion among the participants about changes to the proposals presented. However, the organizers could not stick to that agenda, as the Indians present did not limit themselves simply to ask for clarifications about the first day, as scheduled.

A Shavante leader's intervention was the turning point. He spoke a few minutes after Dr. Antonio Alves, the current Secretary of Sesai,⁸ had made some remarks about the relevance of funding human resources (training, contracting, and paying) and indigenous sanitation (for its direct effects on health). Immediately afterward, we heard the explanation by the consultant in charge of the "Financing Component." According to her, the exclusion of sanitation from the diagnosis reference term was due to an incompatibility of logic and rationality between sanitation and health procedures. In her words, "we don't feel comfortable to incorporate and force [sanitation] into this model." Her interlocutor did not contradict her, and that phase of the workshop was apparently coming to a smooth end.

At that moment, when the activities of the first day were about to be concluded, the Shavante leader took on the issue of sanitation that had been previously broached by Dr. Antonio Alves, and made a long speech with much applause at the end. We have transcribed some excerpts of his speech, which, it is our hypothesis, expresses strategies that complement political action and key elements in the rhetoric of demands for indigenous health rights in Brazil:

7 Approved by the Senate on August 3, 2010 and published as a decree on October 19, 2010.

8 At the time of this workshop, Dr. Antonio Alves was the head of the Secretary for Strategic and Participative Management of the Health Ministry and coordinator of the Ministry's Work Group in charge of discussing the management of indigenous health. We can interpret his posing the issue of sanitation as a political act to provoke an explanation about the dispute around the destination of indigenous sanitation without directly confronting the Funasa managers present. Would it stay at Funasa, or follow indigenous health along the lines proposed by the Ministry's Work Group? We based our interpretation on the fact that sanitation was not part of the reference term presented to the consortium by Funasa, and, hence, this issue was not for the consultants, but for the Funasa managers to pose.

Your presentation was good, financing ... (...) basic sanitation is financing! Why didn't the consultants raise this? This is a disaster! A chaotic situation! I would like to put this on record. Dr. Wanderley of DESAI [Department of Indigenous Health] is here, but the director of DENSP [Department of Public Health Engineering] hasn't come ... I would like to put on record here that the whole Shavante Condisi [District Council for Indigenous Health] went to the Federal Public Ministry this past day, and in a few days we'll have a public hearing! About the entire situation that is under way. (...)

So, once more as a leader, a user, a village dweller, I'm leaving on Friday. I'm sorry, Wanderley [DESAI's director], but bring me one or four boxes! Of coffee filters, because where I live the children are filtering water! No one lives without water! Even the richest countries in the world are looking at Brazil's clean water. We need it, for God's sake! As a leader, I'm letting it off my chest ... (...)

This is sad! Very sad! Even living beasts, reptiles, need water! To reproduce themselves! It's the same with human being, us ... (...) We want to strengthen the sub-systems, but we need a decent policy! Indians don't want to create a State against the country, no Sir! At least [we want] respect, dignity, to guarantee our rights. We want to survive! (...) We want to discuss sanitation.

The strategy to reinforce sanitation actions as relevant to the debate about the models of indigenous health management, started by Antonio Alves and advanced by the Shavante leader, at that moment, indirectly, brought forth the removal of indigenous health from Funasa. Why? Because for the majority of indigenous leaders, if health care were to move to a special secretary within the Ministry of Health, indigenous sanitation should also go, and Funasa betted on the possibility of keeping it. After all, the Department of Public Health Engineering (the absence of which the Shavante leader stressed in his speech) is responsible for all the sanitation actions at Funasa, and handles a good part of its budget. However, we must make clear that we do not mean with this comment to diminish the political dispute over financial interests.⁹ Rather, our remark points out the fact that indigenous sanitation, being separate from indigenous health in the institutional organization chart, its removal from Funasa sets in motion political forces that are not limited to managers and professionals involved in health services as such.

9 The budget for indigenous sanitation was not significant when compared to the other Funasa sanitation programs, that is, sanitation in municipalities with over ninety thousand inhabitants, which includes the majority of the approximately five thousand Brazilian municipalities.

These discussions unfolded on the second day of the workshop and, as we have said, resounded through the regional workshops that came later. The technical argument of the difference between the rationalities that guided health care actions and sanitation to justify the exclusion of the latter from the requested consultancy succumbed in the course of the political debate. The new secretary was created amidst the growing dissatisfaction with the services being offered, the accusations of political partisan use of Funasa's institutional apparatus, and mutual allegations between the Minister of Health and Funasa's president. In this context, the political participation of indigenous leaders was outstanding, as they took advantage of that broader conflict, guaranteed institutional change, and avoided the separation between health and sanitation services.

Indigenous rhetoric and the construction of citizenship

It was in this broad context that the Shavante's discourse politicized the event. But his arguments were radically different from the sanitation logic that underlined the speech of his antecessor. At no moment did the Shavante leader refer to the impact of sanitation measures on health, nor did he mention epidemiological data (although most indigenous leaders handle well the legislation and information on indigenous health). Instead, other elements appeared. Let us see.

After denouncing the chaotic state of sanitation on indigenous lands, the leader presented his viewpoint by affirming his triple authority to speak on this subject: "leader, user, and village dweller." He thus stated his position as a local leader (*cacique*), a representative of indigenous users of the formal structure of participation in the health system (as President of the District Council of Indigenous Health), and an Indian who knows the reality of his people (everyday experience of the village health conditions). He amplified the political scope of this statement when he later declared himself the spokesperson for all Indians, by declaring: "Indians don't want to create a State against the country, no Sir"! The generic Indian deployed here, besides the fact that it showed him to be in synchrony with the indigenous movement, not just with the Shavante people, rejected the rhetoric of certain national sectors (the military, big agribusiness producers, etc.) that generally

accuse the Indians of threatening national security. He thus succeeded in connecting not only local and national knowledge, but also life experience and political and institutional transit. Hence, he used his knowledge of formal mechanisms to call into question government officials in charge of indigenous health when he mentioned the juridical procedure at the Public Ministry and the expected public hearing. This demonstration of knowledge acquired a meaning that went well beyond his capacity to deploy formal expedients to denounce and demand better public health services. In part, he transformed his knowledge into a broad political strategy that crossed various spaces for applied work, discursive practices, and lines of action.

He further extended his construction of an authoritative position when he chose specific subjects to refer to the hardships of indigenous life resulting from insufficient sanitation, namely, women and children. The political force of this reference resides in the fact that these categories most often elicit the idea of vulnerability, a concept so dear to the field of health, in a sharper and forceful way. As epidemiological data show, women and children are the most vulnerable among those deemed vulnerable *par excellence*: indigenous peoples. Therefore, they are victims in the strong sense of the word, that is, people sacrificed to the interest of others without defense means. However, the indigenous life to which he refers is not only a way of life, what anthropologists would call culture or material conditions of existence. It is mainly vital existence in the biological sense. Hence, his comparison with reptiles makes sense, as does his allusion to water as necessary for reproduction.

It is as though sanitation policies, in dealing with access to water and disposal of human waste (garbage and residues) could bring to light the biological body in dimensions often hidden in public debate. This possibility arises in the disciplinary approach to the exercise of power, in the Foucauldian sense. Teixeira (2012) discusses this mechanism in her analysis of the *Manual for Indigenous Sanitation Agents*. It is a technical guide published by Funasa in 2006; it states as its goal the training of Indians in the maintenance of sanitary equipment, on the one hand, and, on the other, in health education with emphasis on combating intestinal parasites, that is, hygienic habits. Teixeira's article explores the disjunction between the images and the text in the manual, shows the precariousness of its technical information, and the eloquence and profusion of illustrations of Indians defecating on the ground and near streams and rivers. The argument is to teach the Indians the

transmission cycle of parasitic diseases. A close examination of the overlapping text and images in this manual showed its strong potential to produce and reinforce the feeling of disgust and repulsion that is diffuse, but recurrent in the dominant society regarding the Indians.¹⁰

However, at this point, what we wish to emphasize in the Shavante leader's speech is that the biological body, when inserted in the political field via State processes, also becomes a potential channel of demand for rights from State entities. The mention of scarcity of clean water, for instance, exposes bodily suffering that evokes a level of unquestionable legitimacy: the right to life in its crudest dimension, that is, physical survival. Here, moral suffering becomes inseparable from the illness of the body reduced to a precarious specimen of the *homo sapiens sapiens* species. At stake here, are not the Shavante conceptions of body and life, but the political management of Western categories in the construction of legitimacy of indigenous demands at that moment.

We can then find in a single discourse:

- political strategies proper to shared citizenship (denunciation to the Public Ministry, participation in sites of control of governmental actions, and the articulation between the position of user of the health system and of political leader);
- the affirmation of a specific membership (village dweller) and the evoking of citizenship rights (with emphasis on differential rights);
- the demand for moral recognition, dignity and respect; and, above all,
- the demand for rights based on the physical body, which, ultimately, do not emanate from the human condition, but are interlocked with denunciations of suffering of the body that might come about.

Thus, temporarily, the rhetoric of human and civil rights seems to have become secondary. In contexts of destitution of basic life conditions, the struggle for greater political efficacy in the application of rights already legally guaranteed turned to nature – irreducible and unquestionable in certain modern representations – for irrefutable arguments that the language of citizenship and democracy failed to provide. The body that government practices attempted to discipline showed here its underbelly and revealed its

10 For those interested in the maintenance of feelings of disgust and repulsion regarding the Indians in the context of education, see <http://www.diarioliberalidade.org/brasil/repressom-e-direitos-humanos/36752-chamados-de-sujos-e-fedidos-,ind%C3%ADgenas-s%C3%A3o-expulsos-de-sala-de-aula.html> (assessed on July 31, 2014).

multifaceted potential as a political tool in the arena of indigenous health and, more specifically, in its link with sanitation.

However, unlike what has been observed in other national contexts (Fassin 2012a), the discursive presentation of the physical-moral body as a legitimate argument in the struggle for rights displeased government authorities. It signaled a certain expertise of indigenous leaders to explore and enlarge the limits imposed by the rules of the political institutional game. Consider the meaning of this discursive expertise, its management of connections between biological body and political identity, specifically in the construction of a differential citizenship in indigenous health policies. This is what we shall do now.

Management of legitimacies in fighting for rights to indigenous health

In the event described above, we have noticed the dissatisfaction of State with the exposé and accusation by the indigenous leader of the precariousness in village life, the suffering of women and children caused by scarcity of water, and the comparison with reptiles. It culminated with the demand for action to diminish that dire situation, and for guarantees of survival. We have seen its immediate efficacy to shift the conduction of the event from technical and administrative to political terms; we have also followed the successful process of creation of Sesai in the terms aspired by the indigenous leaders (linking health care to sanitation). This success, however, occurred in the absence of feelings of pity and compassion and their asymmetrical sociological nature, which emerge in similar contexts of humanitarianism, as those dealt with by Fassin (2012a). In other words, what governors, congressional representatives, and public managers into action was not just solidarity with indigenous suffering, nor was this their main reason. The power relationship that qualifies the interaction between donors and victims failed to impose itself, despite the presence of elements that could potentially spark it. The ultimate truth about the body was always constrained within the framework of the political life also evoked by the Shavante leader at the National Workshop focused here when, besides demanding respect and dignity, he mentioned the Federal Public Ministry, his position as a political leader and a user of the health system, and the guarantee of rights.

Now, we turn to the meaning of the argument of life as a value in itself, in this specific context of political negotiation by indigenous leaders in the setting of State powers to establish public policies and to change the running of indigenous health. More broadly speaking, in what way is the life argument appropriated by indigenous representatives in the everyday construction of the State (as organization and ideology, Abrams 1988) and of indigenous citizenship in the field of health?

First, we must understand that the precarious context described by the Shavante leader has come into being, intentionally or not, as a daily reality that has deteriorated, but is not an exceptional moment. That is, it was not presented as an event capable of raising the moral feelings that move collective actions in situations regarded as intolerable for their dramaticity, exceptionality, and hence, with a sense of urgency (Fassin 2012a, Agamben 2007). The ongoing structure of degrading conditions of life in the indigenous villages moved the audience during the changes in the event in question. Nevertheless, it is important to underscore the fact that it was not regarded as a tragedy, nor did it create commotion. Therefore, it did not lead to short-term actions.

Second, and perhaps most importantly, the indigenous leaders attended the National Workshop as political actors struggling for recognition of rights, rather than as victims looking for benevolence and generosity. Life, as they wished to share, is the life of human beings who enjoy similar moral values, but find themselves in precarious conditions historically and politically created. The moral feelings they invoked belong to the field of injustice, which must be politically restored, whereas the physical body is both instrument and object of that struggle. It was not a matter, as on other occasions,¹¹ of claiming respect of cultural diversity or traditional practices, but rather of overcoming difference as inequality and disdain in the distribution of public services (health and sanitation) to which the Indians, as Brazilian citizens, are entitled. The politics of care and assistance that

11 In the Newsletter *Funasa Notícias* (May 2007), we read: "The Vigisus II Program also understands this importance, so much so that it includes in one of its sub-components the incentive and respect for Indigenous Traditional Medicine. 'This is a work of respect for the cultural roots', affirms the national director of the Vigisus II Project, Williames Pimentel". One of the activities promoted by this sub-component was the II Meeting for Monitoring Projects of Indigenous Traditional Medicine (2010). Both authors attended the whole event and could make a comparison with the ethnographic contexts analyzed here.

disregards the other is at the core of health policies for indigenous peoples (but not only for them), but the political dispute described here seems to have shoved it aside. Another dimension of care present in indigenous speeches is a form of State action, which, in investing in the management of the precarious health of indigenous peoples, creates the necessary political elements to perpetuate this condition. After all, despite the chronic suffering of the Indians, the government administration has invested funds and actions to minimize it. This, in modern bureaucracy, seems to have become more relevant than the results achieved. It is a similar process to that observed by Gupta (2012) in India, when he considered poverty to be a kind of bio-politics. Gupta argued that governments in India, in including the poor in their agenda, revealed the intimate connection between care and structural violence, which constitutes a specific form of State action, namely, the legitimate exercise of sovereign power over life and death in the government of population. It would be far from “letting die” (the poor) from absence of care, as Foucault (1977) argued.

Lastly, we must consider that the identity of indigenous peoples in Brazil and elsewhere is anchored on distinction, which, in democratic regimes, requires the translation of cultural and historic differences into differential rights. Biological life or rather, the so-called bio-identities tend precisely to blur individual biographies and other collective belongings when they redefine trajectories and self-conceptions from the experience of illness and therapeutic relations (as we shall see below). What the experiences that have inspired our theoretical thoughts about bio-rights indicate is a certain erasure of historic, political and social diversity of individuals in favor of shared experiences based on bodily processes that allegedly equalized them all. In the case analyzed here, this erasure seems to be a tactical element to uphold indigenous political rights and articulate categories as weapons in political combat. At stake here is the construction of a certain indigenous citizenship, specifically, the power of the Indians to define the structure of health and sanitation organization and its place in this structure. Engagement of indigenous leaders in bio-rights would become a political tool in specific contexts, far from a moral adhesion to the value of life as such, or a redefinition of the indigenous identity in question.

Second ethnographic anchor: Some thoughts on bio-politics

In this section, we consider the possible spin-offs in use of the Foucauldian notion of bio-power in the relationships between government agents and contexts and the target populations of public policies for differential health. We set the issue of indigenous health in an ethnographic framework that stresses the daily actions of health care in the villages. Such considerations seem to us to be indispensable to the extent that we distance ourselves from any reification of care relationships as acts of disinterested benevolence. However, we should not confuse this epistemological position with accusations of incompetence on the part of specific health professionals, not even taken in general. To the contrary, the bibliography mentioned below seeks to highlight the relationship between the hygienic discourse and the hierarchy of powers, as manifested in different organization models of public health from which campaigns focusing on women and children are naturalized and their targets perceived as victims *par excellence*.

Therefore, we are interested in reflecting upon the political production of indigenous health as a process rather than as a model (what should be). We endorse a theoretical debate that takes the State (Abrams 1988) as a political practice rather than as an external entity that interprets political practice. To think about these practices is clearly to debate the actions of government agents, but it does not mean reifying their practices and identities. An analysis, inspired in Simmel (1955), of the conflicting scenario of basic care in indigenous health depends on thinking about its actors as complex subjects, also disputing identities and values in a daily process of negotiation of treatments, exams, etc. In this way, we can keep away from a merely normatizing perspective on the actions of health professionals. We thus avoid judging them as good or bad, but encourage a reading of this or that professional's actions as a trace of other moments, objects, relationships, and powers comprising the broad scenario and the subjects' crisscrossed trajectories.

Inspired by the concept of bio-legitimacy (Fassin 2012a, b) to think about the ethnographic context of indigenous health in Brazil, we can identify a political shift in the category of the sick in the contemporary world. At first, the concept originated in the French experience with changes in the policies for immigrants in that country in the last twenty years. The author incites us to think about the category of bio-power beyond the sphere of power

hierarchies, by intertwining a structured form of historical relationships related to the development of national states with the logic of the actions of government agents as a value order, which guides their actions in the political sphere. The author shows how the sick person's experience and his difficulty to access specific treatments have in general been taken as more relevant than the violence inflicted on bodies by authoritarian regimes, which was the common reason why immigrants had access to French citizenship. This overlap of a generalized human rights discourse on the more specific right to citizenship was incorporated to a theory that tries to recover a midway term between what Foucault called power over life (bio-power/ government agents) and what Fassin called power of life (bio-legitimacy/ representations of the body). Rabinow & Rose (2006) add to this analysis the perception that such transformation elucidates the emergence and strengthening of humanitarian organizations that have health as their main working tool. Far from engaging in a sharp critique of such organization models, the authors highlight the emergence of new collective forms of organization by bringing together different authors, interests, or even spatialities (Rabinow & Rose 2006). The main feature of these models is the connection between Bios and Polis. Still on the issue of bio-legitimacy, in considering contemporary human rights policies, the sick body has proved to be a central category. A change in discourse transpires in the dwindling value attributed to interpersonal violence (in civil wars, etc.), as compared to the violence generated by nuclear disasters or by the impossibility of people to receive treatment against specific diseases, such as cancer and AIDS in their countries of origin. We could understand this change as resulting from deeper changes in the conception of human rights and their target populations, that is, in the wake of a debate over the notion of bio-power. This is these authors' hypothesis.

This pattern allows us to visualize a new way to understand the responsibility of states in the health/illness process. This is because such experiences are part of a value order whose roots are in a conception of power of life in itself as an absolute and universal moral value, rather than of power over life situated in the debate on population control by national states.

This specific centrality of the body as a universal element of human existence – almost as a literal translation of 'human right' – highlights the opposition between a political existence and a biological or physical existence, and

seems to point out that this argument may make sense in similar contexts of human life control. The authors in Brazil who have worked on indigenous health have pointed out the enormous sociological void with regard to representations of the body in specific health policies (Teixeira 2012), particularly in favor of a notion of salvation of sick bodies, which unfailingly decontextualizes the accompanying political signs.

There is at least one problematic dimension that is common to the recent literature, particularly that which discusses indigenous health policies in Brazil since the 1988 creation of SUS (Chaves, Cardoso & Almeida 2006, Marques 2003, Magalhães 2001). The notion of the sick body – a result of infectious-contagious diseases related to the lack of effective sanitation measures – always seems to subsume the specificities of the ideas of body and disease, thus altering and shifting the meaning of cultural diversity, that is, the specificity of bodies is perceived as a lack of resources rather than of recognition of differences. Why should one annul the other? Precarious conditions of life and the diseases related to them have become the touchstone to reflect upon health policies, because this dimension is commonly confused with ways of life. Therefore, indigenous ways of life would then be obstacles. To this extent, ways of life become an element in a power hierarchy that administers indigenous lives at the expense of their cultural premises. We are far from reinforcing inequality. Our intention is to show the shift that authorizes action in the name of indigenous survival and at the expense of their own notions of health and well-being. To give an ethnographic example from this second anchor, the nurses at the Munduruku village where one of us did fieldwork frequently mentioned a high incidence of digestive problems. They raised several hypotheses: excess of industrialized food, excessive loss of teeth among the elderly, as well as excessive use of alcohol. They also attributed high blood pressure and diabetes to these same problems, although in smaller numbers. The nurses never considered any of these factors to be the result of interethnic relations, but to the choice of some Indians to live in this way and not look for assistance. Perception that the value of care in itself was the fundamental criterion explained the position of these health professionals, whereas for the Munduruku, what made sense of those diseases were the problems coming from a violent and always disrespectful contact. If, on the one hand, epidemiology tends to treat contagious diseases as the result of precarious material conditions, on the other, the clinic and its exams

emphasize individual choices as responsible for damaging results. For this reason, every diagnosis issued by health professionals as described in the ethnography has, for the purpose of this article, an interested and political character, although interests are diffused in the order of the most cherished values to the nursing teams, namely, care and its daily management (Dias da Silva 2014).

The political struggle ensued in the 1990s by indigenous movements and allied non-governmental organization (Garnelo 2004), and expressed in conferences on indigenous health (Teixeira & Silva 2013), tried to reverse this picture and open a space for the indigenous peoples themselves to manage health problems. The creation of the Indigenous Health Sub-system in 2000 was the most important measure in this respect. While it legitimated the sphere of action of health policies, which produces a not always conscious distinction between physical and political existence, this sub-system opened up interlocution channels through the mediation of Indigenous Health Agents under the premise of “cultural translation” from body/illness bio-medicine notions to indigenous notions.

In this second anchor, the data presented here are part of an ethnography carried out between 2008 and 2009 in one of the thirty-six Special Indigenous Health Districts in the country. It is located in the state of Pará and its main interlocutors were health professionals and indigenous health agents. The idea of cultural mediation is often used as a device in paradoxical situations, such as to convince relatives of the need for a medical treatment the meaning of which contradicted what the group attributed to the form of transmission of contagious diseases. Several authors have tackled this issue (Novo 2010, Smiljanic 2008, Langdon 2004) and called attention to the limits and possibilities of these agents when facing disputes of meaning and contextual political cleavages. We attempt to understand the attribution of mediator status to the identity of these indigenous health agents, as a government practice (technique and morality) to construct bio-identity. Therefore, we must keep in mind that the very idea of mediation is conceived by the national policies for indigenous health as being, in itself, the exercise of a shift in legitimacy. Hence, the most general justification for saving lives (empirical agents) seems to be part of the logic of action in the political sphere (persons). In focusing on the dynamics of relationships between members of health teams (especially Indigenous Health Agents and various

nursing personnel), we try to understand how the domain (order of values) of biological life manifests itself as a natural justification for life in society.

Furthermore, the contradictions resulting from the co-existence of health professionals and indigenous health agents unveil incommensurable aspects of a dispute, which, besides the power hierarchies easily identified within the Sub-system organization, is at the core of a moral economy and of a humanitarian reason (Fassin 2012a). That is, these contradictions can and must be understood by tackling a value system (political existence of the subjects) that includes cultural difference as an “embellishing” feature (it aggregates occult, mystical, and poetic meanings), but regards it as incapable of defining or guiding health actions, lest the precepts of life saving and humanitarian reason be lost. Thus, the “dialogue of the deaf” observed in the research cited above points at an opening for theoretical frameworks capable of identifying and making visible the forms of interaction that mark the relationships between government policies for indigenous health and indigenous policies for their own health.

We look at the indiscriminate use of the prefix bio- as a possibility to understand vast and distinct ethnographic contexts. On the one hand, we try to consider to what extent the form of dichotomous association between physical and political existence has been appropriated in demands, such as the right to a specific way of life. This is a central feature of indigenous health in Brazil. Indigenous leaders’ discourses have projected its inseparability from physical existence. Nevertheless, it is important to ask at this point in what way does the government’s discourse about life, taken as a power device, preclude the possibility of cultural mediation in village contexts. Outstanding leaders in the national scenario acknowledge the efficient management of this association. However, at the local level of assistance in the health post, health professionals have as a clear strategy a profusion of retaliations toward these peoples’ traditional knowledge (Langdon & Garneiro 2004; Smiljanic 2008). They exercise a power of life, that is, a rhetoric that recognizes the right to live, on the one hand, and the right to a way of life, on the other. Therefore, our anthropological outlook questions the nature of this dichotomy as it has been engendered, lived, and perceived by government agents – particularly in constant and daily interaction with the Indigenous Health Agents – in order to identify the political tactics to shift the legitimacy of indigenous knowledge in the organization of health actions. The

bio-identity attributed to indigenous peoples – as societies whose value turns almost exclusively around the issue of survival – might be a valid theoretical tool to understand which interests are mobilized in the name of survival. We thus reiterate that both for Rabinow & Rose (2006) and Fassin (2012a, b) the discourse of physical preeminence is a political tactic to be thought via its daily strategies, better observed when we add this theoretical trajectory to a multilocal ethnography (Marcus 1995; Coleman & von Hellermann 2011).

These thoughts lead us to a value order the practical meaning of which thrives in terms of a cultural mediation that bifurcates into two scenarios: access to natural resources and bodies as such, and management of indigenous knowledge of their own resources and bodies. We shall now attempt to explore the way in which cultural mediation slips from one scenario to the other. We stress the limiting points of the arguments and conflicts of basic care, including the place of the Indigenous Health Agent (AIS) and the Indigenous Sanitation Agent (AISAN) regarding hygienic discourses. We attempt to show how their relationship to the so-called natural resources/nature and biological life, as well as the management of clean/dirty water, for instance, is inevitably shrouded in power devices of a juridical-discursive order (Foucault 1977).

Cultural mediation and bio-identity among professionals at the local level. To think of cultural mediation in the local context of indigenous health requires that we define a specific framework of bodily practices that would guide the routine of care and conflicts. We shall discuss corporeality or corporatized processes (Csordas 2008), starting with the notion of care/conflict established along an education front set up via professionals who operate at the local level. It can also come about via a way of life culturally given (hygienic practices), but mainly perceived as spontaneous (naturalized). The relation between hygienism and corporeality is not limited to the problem between environment and individual biology, but is rather an expression of power that legitimizes or delegitimizes knowledge/practices in the field of health. We thus explore the implications of taking such hygienic practices as a set of “care practices in themselves,” or as part of a “pro-active posture” intrinsic to professional competence, as commonly seen in nursing. This, it seems to us, is a converging point of bodies and powers through which “bio-legitimacy” in the discourse on access to citizenship is constructed by means of current public policies for indigenous health. Focusing on the link

between a specific conception of hygiene (that is hegemonic) and the idea of access to citizenship allows us to see how the (de)politicized body is at the core of humanitarian logic, which recognizes rights and guarantees access to health care in the villages. We shall approach this issue via two relevant points: (1) the dynamics between hygienic practices and the construction of AIS and AISAN identity, (2) the emergence of the notion of individuality as a bio-political expression of care in itself.

Hygienic practices and identity: power dynamics

We now present some excerpts of field diaries that clearly show the dynamics of care and daily conflicts involving body hygiene and identity (social markers of difference). The identity of the caretakers is infused with surveillance of the other's customs, particularly with regard to hygiene.

'It seems they don't love their children. They don't care.' This is the general opinion of nursing technicians and nurses. They don't recognize any sign of care or worry in the parents-children relationship. (...) Perhaps that's why they make dramatic speeches about the measures needed to treat flues that turn into pneumonia, malaria cases and other situations that can only be controlled with intensive care. These cases are always described as complicated when they blame the Indians 'in general' for lack of hygiene, lack of care, etc. (...) If anyone dies, especially children, accusations fall on dubious care behavior toward children or reluctance to follow the nurse's instructions. (...) If the patient doesn't get better, they blame the Indians' ignorance, their stubbornness in not following some procedures, such as avoid bathing at certain times, control the children so they don't walk in the rain, take medicines, go down to town, do exams, medical appointments, etc. (Silva, field diary, 2009).

These excerpts show a variety of lived situations of care provided by the nursing team at the health post in one of the Munduruku villages. With about seven hundred people, this is one of the largest villages, two hours from the nearest town where the Indigenous Health House (CASAI) is located. We notice that much of the nurses' talk about the universe of "care" tries to displace the legitimacy of cultural mediation when facing health injuries, whether shared or imagined. Shared or known injuries – those that are typical, such as the increase in malaria cases in the rainy season – are

associated to careless individual behavior. We must also notice the patchiness of technical recommendations, such as not bathing in the river at certain times, not taking the children to the fields, etc. Beyond their technical and allegedly neutral profile, these recommendations signal the construction of a reified and generalizing indigenous identity. However, health professionals could also attribute the imagined or anticipated injuries to a flawed infrastructure, such as paucity in transportation. Added to this is the supposedly superstitious behavior of Munduruku families who insisted in the presence and participation of shamans in their daily life. Thus, in their discourse on health care, the nursing team constantly invalidated the Munduruku type of prevention. Practices to safeguard the children, such as taking them to the shamans for cure, and the use of necklaces to protect them from typically infant diseases were subverted as superstitions. Common to both discourses is the concern that infancy is a period of additional care and critical vulnerability. However, whereas the Munduruku related hygiene and disease prevention to personal relationships within the logic of sorcery, the nurses expressed their concern with individual behavior and, ultimately, with the mother-child relationship. Everything the health professionals regarded as a problem of individual behavior (bodily practices and hygiene) they placed beyond the issue of interculturality. Rather than a dialogical and egalitarian premise, a socio-educational and tutelary approach superseded the scheme of cultural mediation. The way health education delegitimized the other's "culture" appeared in discourses and practices, comprising the most important meaning of hygienist habitus taken as a complex whole of actions, conducts, and values.

Meaningful examples from daily life were the frequent accusations flung at the Indians about the incidence of illnesses related to lack of sanitation. We could mention many other diseases in other contexts. However, our choice of infectious-contagious diseases derives from the strength these have had in anthropological analyses of indigenous health and related government policies, particularly on the issue of epidemiology (Santos & Coimbra Jr. 1994, Menéndez 1998, Coimbra Jr. et al 2003).

The dynamics of hygiene procedures appears in various scenarios of interaction as the feature that characterizes basic care. In the indigenous case, it is striking that the accusation of lack of hygiene and health care centered in "cultural" choices, bringing together, in ways not always discursive

or intentional, Muduruku life ways and a set of obstacles to improve community health. Much has been said about the possibility of making mediation pacts and that to invest in interculturality might be a possible and desirable way to guarantee recognition and specificities (Follér 2004). However, we may hypothesize a bio-legitimacy driven by the increase in health agents, that is, by the construction of the most recent identities in indigenous health – Indigenous Health Agents and Indigenous Sanitation Agents. We could then understand the extent to which this identity emerges as an extension of the hygienist habitus (in the Maussian sense) within the politics of health. There seems to be a privileged way to encompass the notion of interculturality within the hygienist demand in indigenous health. We suggest that this hygienist encompassment occurs via the creation of bio-identities whose political efficacy resides in contrasting culture, as an ideological and representational issue, to the irreducible nature of sick and sickly bodies. AIS and AISAN are crucial to think about the sort of correlation of forces built in the so-called interculturality process. Again, we argue that it is important not to reify the meaning of cultural mediation and observe the transitory stabilizations that occur in specific contexts.

The moments of identity building of both interlocutors in this ethnographic context – Munduruku families and professionals at the local level – referred to the embodiment of prevention/hygiene procedures. Through these elements relationships, dyads, and triads were constructed. Thus, the relationship between an AIS and a nursing technician was marked by the double membership of both in other relationships: the technician's discourse was similar to the flimsy manuals of individual procedures to prevent infectious-contagious diseases, whereas the AIS's resembled the criteria for the prevention of sorcery. This (mis)encounter was rooted in the corporeal abilities/anticipations to avoid the notion of cultural mediation, a power device for this purpose.

Bio-identity for whom?

In the numerous speeches about the universe of personal hygiene, the nursing group explicitly mentioned self-care. They often said, "I must take care of myself. One has to be careful." The ethnographer noticed that their concern was only meaningful when accompanied with an obligatory

socio-educational approach to hygienic conditions. In the wake of these broad naturalizations of health and body, it was common to see women refuse pre-natal exams, which would involve monthly trips to town for the so-called routine exams. This statement is good to think temporality of health institutions in the dominant society. As the concept of routine is linked to the idea of exam, unavoidably, a connection is made between medical procedures/treatment and ways of life. When we shift this concept of routine to the quotidian of Munduruku women, we do find a “routine,” albeit “another routine” that turns the production of exams into a simulacrum of other women’s bodies, of other women’s lives. These other temporalities enclosed in time concepts such as “routine” set up a specific way of life far removed from the life of Munduruku women. For this reason, they made an issue of it as expressed in their refusal to give up so much of their daily time to constant trips to town. “Life in itself” – an all-inclusive argument in health actions – appears as a political tactic through the logic of daily time and behavior. The Indians may question the authority of biological reason, but cannot ignore it, as it imposes itself in the very apprenticeship relation between nurse(s) and AIS/AISAN. Therefore, the expansion of professional categories centered in managing the environment and bodies on the precept that hygiene constructs bio-identities, to the extent that it shifts the legitimacy of the other’s cultural argument (his way of life) to life conditions related to infrastructure works and individual behavior. The confusion between ‘ways of life’ and ‘material conditions of life’ is not a blunder of the Indigenous Health Sub-system and its government agents, but rather it represents the major everyday tactic to implement the processes of so-called cultural mediation in local contexts.

The naturalized discourse on the relationship between individuals, as a political expression of care in itself, was not uttered exclusively in the village, where the presence of a nursing team was the strongest. It also occurred in town, at the municipal hospital, but here with regard to physicians. The Indians had access to doctors in private appointments when additional exams were requested. In a conversation between the anthropologist and one of these doctors, his vision of the relationship between the Munduruku and “nature” was so dramatic that he had to expand on his understanding of the (im)possibility of cultural mediation:

The doctor complained that his feeling in attending them was of an unrewarded effort. He was solicitous, treated them kindly, but got nothing in return. According to him, he was surprised when visited by nice, very polite Indians, who know how to engage in a conversation and even “melt” over the doctor. He was curious to hear which books on the Munduruku I could recommend, but soon afterward, he said he found some of their words guttural, letting slip he was interested in some sort of “primitivism.” This projection of an image about anthropology as the study of the archaic, frequently confused with archaeology, was also evident in our conversation. I replied that Munduruku language has more vowels than Portuguese, that is, a variety of forms to articulate more vowels unknown to us, which makes understanding quite difficult for Portuguese speakers. But this information, which suggests a similar or greater complexity than any other human language, was not “heard” or noticed. It was as though the Indians were completely alienated, with no sense of reality, living in a world comparable to that of disqualified persons, such as autists in our society. About attendance in medical offices, he gathered that translations by a third person, in general an Indian who worked at CASAI, an AIS or AISAN, leave him insecure about what the patient was saying and what was being said to him. He also remembered the case of a girl in the hospital who received the visit of a shaman who ordered the oxygen machine removed from her. He pointed out that when this sort of situation happens, they, the doctors, call the CASAI infirmary to ‘come and talk.’ He commented that culture ends up interfering in the procedures and the doctor is confronted with it and for them it must also be a confrontation. About the description of symptoms, he said one has to be careful with some questions. For example, to ask the patient directly whether he had diarrhea is no good, and he said he had tried to ask the question in that way and got a negative answer; but when he asked whether the patient had ‘the runs’ and a bellyache, the answer was positive. These were “communication flaws” that made Munduruku patients special to the doctor, in need of “special attention.” He actually kept a list of Munduruku words describing symptoms like headache, stomachache, bellyache. He would write as he heard them, but said he had difficulty in getting their words right, because people gave contradictory information, one would say that this means bellyache, the other, stomachache. They were, as he said, attempts to be independent from a translator (Silva, field diary, 30/06/2009).

What stands out in this report is that the form and content of this conflict do not differ much among health professionals, but, from the point of view of medical doctors, it was not up to him to mediate between knowledge and practice. We must remember that cultural mediation is inserted in the field of health education, hence, it is a problem traditionally associated to educators, nurses, and caretakers. That specific doctor speaks as a specialist and demands distance from the mediation process. Moreover, only educated individuals would be able to gauge the dangers of lack of hygiene and of refusal to follow medical recommendations. Therefore, it was always necessary to call the “CASAI nurse.” It did not matter whether the requested person was a nurse; he/she had to be, necessarily, someone from CASAI, that is, from the field of “indigenous health.”

How can we think about this logic, which orients the political dispute about illness diagnoses and meanings, as a privilege of the socio-educational approach to professionals’ actions and competence? Let us see the detailed content of this approach. 1. Communication flaws, on the one hand, are attributed to the translator’s unwillingness, thus brushing off the issue of dispute and political meaning as a strictly “technical” problem. 2. The feeling of “unreciprocated effort,” on the other hand, comes up clearly, when my interlocutor (the doctor) tried to explain his impressions of indigenous patients. It was as if they did not recognize the centrality of the doctor’s position. On various occasions during fieldwork, local indigenous leaders stated that it was difficult to distinguish between a doctor’s work and that of the nurses; they saw no complementarity, but only that the former were more absent and harder to access. Refusal to follow certain treatments was blamed on stubborn individuals. Attempts to persuade, often doomed, came in the wake of care, but even so, it was the most established alternative in everyday life. However, at no point was cultural mediation between knowledge and practices declared to be a political problem, but a one-way question of education; one needed to teach illness prevention, despite the fact that the technical means available were very poor. The AIS and AISAN always felt that their accountability for the field in the villages was like an accusation of incompetence and disinterest. The incommensurable relationship between the diagnoses of bio-medics and shamans was mitigated by the need to educate the Indians, particularly those who had never left their villages and had little “notion of reality.” In this context, the AIS absorbed accusations from both

sides. This situation is common to other indigenous sanitary districts in Brazil (Novo 2010, Langdon et al. 2006, Garnelo & Sampaio 2003).

Munduruku families mentioned several ways to deal with health professionals regarded as 'difficult': they ignored their presence, missed consultations, complained to the AIS, AISAN, and the village leaders. Health professionals had their own similar strategies: they ignored stubborn patients, made small word lists to 'resolve' the problem of communication, and complained to the AIS, AISAN, and leaders when people rejected emergency actions. Nevertheless, although these statements were similar, there were differences in the irreducible logic oriented by the power over life. Children were the object of care, and the frequent deaths among them became conflicts involving both sides. Women were also an important target of campaigns for pre-natal, gynecological, and other exams. Local and national government agents follow these indices closely, for they measure the quality of the services. However, to see the problem of indigenous health as a political issue, in the Foucauldian sense, is to understand that these favored victims, women and children, are not at the center of disputes because they are naturally vulnerable, but because they have countless spokespersons who legitimize and reproduce bio-power.

Final remarks

Following up our proposal to discuss indigenous health via two complementary ethnographic anchors, we affirm that relationships between indigenous peoples and government agents are contextually experienced. As a concept that encompasses both scenarios, in the present case, the perspective of power over life appears both as the confronting strategies deployed by the Indians in the villages and as structuring interculturality discourses delivered by health professionals, especially in attempts to regulate moments of irreducible conflict. We can see this "irreducibility" as a sort of interculturality performance. To the extent that it is often projected on everyday situations, it is questioned by many of the anthropologists cited here as a pseudo cultural mediation, because it fails to take the indigenous discourse seriously. As we have argued, the nature of these relationships can change when we shift from a local to a national scenario. In local relationships, government agents construct their legitimacy with the separation of Bios and Polis, in

opposition to the perspective of the Indians with whom they interact. They list, on the one hand, technical-organizational problems, and, on the other, difficulties with individual behavior regarded as cultural obstacles.

In the villages, the health professionals affirm the predominance of life in itself in defining their relationship with the Indians, but this was not the case when indigenous leaders and government agents met in the national scenario focused here. The National Workshop mentioned in the first ethnographic anchor revealed a complex discursive game, which flung the precariousness of village life at the Indians like a political weapon. To compare the Indians to animals was, in this context, to unauthorize government action not only in basic everyday assistance, but, especially, in the plan for the institutional engineering of indigenous health that government agents intended to reinforce. Although biological life was handled as the reality referred to by the Indians, at stake was to politically guarantee the construction of the Special Secretary of Indigenous Health in charge of managing health care and sanitation.¹²

It seems that the Indians' replacement of civic with biological legitimacy was possible within a clearly political framework and only temporarily. Their strictly political arguments were not sufficient to guarantee their active participation in the process named social control of health government policies. Thus, in a demonstration of oratory excellence, they gave up the political dimension by making bio-legitimacy explicit, in order to reshape the political game in their own terms. However, their position does not mean that life in itself has no value for indigenous leaders in political disputes, nor does it for men, women, and children regarding care in itself in the villages. However, here and there, material conditions of life are only the *mínimos vitales*, as the Colombian Naya people affirm (Orsina 2014). Alternatively, they are but a part of a healing process instituted by the Canadian First Nations (Royal Commission On Aboriginal Peoples 1993), from which they construct, affirm, and renew their indigenous identity as a nation within a nation.

From this point of view, if in the national political scenario bio-legitimacy can be an indigenous weapon, in the context of health services in the villages, this would not occur. After all, it is often the main way to deny

12 For those interested in similar processes, see the fine article in which Kent (2012) examines the way in which the Uros (Peru) permitted and appropriated genetic research within the *Proyecto Genográfico* as a main strategic in their demand for political rights. Like in the context focused here, their management did not result in biologizing Uros identity.

an indigenous differentiated cultural and political life, by individualizing hygienism and health education provided by health professionals.

We adopt the view that takes values are central to political life, without reducing this life to a power system, government techniques, or interest conflicts (Weber 1999, Foucault 1977, 2006, Fassin 2012a, b). In this sense, the ranking of values in political contexts and in indigenous health assistance involves two distinct inclusions. At one level, the Indians give bio-legitimacy a leading position; at another level, government agents do it. At neither is life in itself as a value a stable core element in the constitution of the rights under dispute.

Therefore, it would be inappropriate to use in a definitive way any of the various conceptions of bio-citizenship mentioned at the outset. From the perspective of government basic care practices in the villages, we can see similarities between hygienism and sanitized citizenship, as did Briggs & Martini-Briggs (2003) when they analyzed the way the Venezuelan government handled a cholera epidemic in the early 1990s. Its measures included responsibility of the individual for the illness and its cure, emphasis on health education (with pamphlets about cholera showing stereotyped images of Indians defecating on the ground), and indigenous obedience to hygienic recommendations about the body, water, and utensils. These were conditions for the Indians' inclusion in the distribution of vital government services (sanitation, water, and health assistance).

Nevertheless, if we consider the indigenous political performance in formal spaces of participation in government policies, this does not occur. What stands out is the handling of various sources of legitimacy. Bio-legitimacy, as proposed by Fassin, becomes an instrument for the Indians to construct differential rights in more favorable communication conditions. In other words, we may not be able to speak strictly of a biological citizenship, but the power of life as a value allows us to connect politically the biological body to the political body. Undoubtedly, the biological dimension and its correlated valorization of life and of a universal body are fundamental in contemporary political disputes. Nevertheless, in observing Brazilian policies for indigenous health in distinct contexts, we realize that the combination of Bios and Polis has always to be scrutinized by ethnography, lest we disregard the meaning the subjects attribute to their interactions in specific processes and situations – precisely what originated anthropological thinking about bio-identities.

With this viewpoint, we now return to the question that opened this article, namely, the repercussions that our thoughts may have on the understanding of citizenship in the construction of indigenous health.

To summarize, the two ethnographic anchors presented here are the political dispute between indigenous leaders and State agents to define a government policy in the country's capital, and the indigenous everyday dispute in defining care vis-à-vis health professionals in the villages. They have allowed us to see the relational and contextual character of the arguments deployed in the affirmation of the indigenous condition in question. Moreover, they have mainly underlined the central place of the exercise of power in the villages by and for the Indians in the construction of their differential identity and citizenship.¹³ With these comments, we emphasize that, in none of the situations described here was the preservation of the objective content in itself the focus of discussion, be it as a cultural and political practice, or as a vital condition. Very clear to us was the process that connected in a differential way all of these resources in each ethnographic context. This connection would guarantee the recognition of the Indians' right to decide how to lead their lives in illness and cure, as well as in the organization of indigenous health services. Ultimately, these would frame the institutionalization of health care in the villages. Thus, the Indians in a leadership position or as subjects/objects of health services, managed to escape the trap of remaining atemporal in order to continue to be Indians (culturalist citizenship), and the reduction of their identity to the struggle for the preservation of a certain physical existence (bio-citizenship). However, we must consider the disjunction we have observed in indigenous citizenship. On the one hand, the recognition and prestige of indigenous leaders' political citizenship at the federal level; on the other, the daily disregard in health services, that is, in the exercise of civil citizenship. Therefore, everything points to an unequal inclusion of indigenous peoples and individuals in the current democratic process in Brazil.

This being said, we notice that in both processes (local and national), the exercise of citizenship by the Indians has redefined the guarantee of diversity and difference as a *difference in power* (political-strategic and moral). This

13 In these thoughts about the politics of indigenous identity, we praise the work of Roberto Cardoso de Oliveira on interethnic identity (especially his re-reading of identity studies in the 1960s and 70s in *Caminhos da Identidade* (2006). More recently, we mention the relevance of our dialogue with the Canadian situation based, specifically, on Shouls (2003).

difference in power is to be reverted in their favor, not simply, but also, as a conquest of specific rights guarantors of their specificity – as in the so-called “new social movements.” This shift permits that the frontier between indigenous and non-indigenous remains dynamic and demarcated according to the political, historical, cultural, and social priorities as lived by indigenous peoples in specific contexts. Thus, the indigenous struggle for a differential citizenship and for self-determination and autonomy (Teixeira 2010) concurs once more in the contemporary field of indigenous health, now in overcoming the dichotomy between Bios and Polis.

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