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# Indigenous Health Agents in Amazonia: Creative Intermediations and a *Poiesis of Care*

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Amazonian indigenous health workers are masterful intermediators between worlds. From a public health perspective, they are considered important linking agents between communities and the official health services, with a crucial role as “translators” between biomedical and indigenous knowledges. Though translation is indeed a fundamental aspect of their agency, it is often either “black-boxed” or taken exclusively for an operation of rendering a set of meanings or categories from one “language”—in this case that of biomedical epistemology—into another. However, indigenous health agents’ intermediating agency goes well beyond explaining biomedical conditions or procedures in indigenous terms and vice versa. Indigenous health workers not only intervene in the epistemic realm of meanings; they also bring forth new practices of care. Their translating agency between worlds is first and foremost one of a *poiesis of care*, a notion I will discuss in the following sections of this introduction and that refers to a process of ontogeny with cosmopolitical efficacy.<sup>1</sup>

This special issue seeks to bring together ethnographies of Amazonian health agents that open up this space of “translation.” Though not all of the articles refer directly to translation, this special issue aims to consider pragmatic, relational, or material aspects of indigenous health agents’ intermediating agencies around the generation of care. This involves a constant process of making up the world in what Hanks and Severi (2014) have called an “epistemological space of translation,” referring precisely to translation as the communicational basis for how we know. In this sense, Hanks and Severi say translation does not just occur between societies, such as when indigenous health agents encounter doctors, but also within a given human group or culture. It is an everyday practice that goes beyond words and the linguistic domain to include other social forms such as values, theories and artifacts, and nonlinguistic expressions such as gestures, actions and songs (ibid).

For Amazonian societies concerned with encounters with alterity and resulting transformations, translation is an essential form of agency. Carneiro da Cunha (1998) argues that shamans are the translators *par excellence* in that they can bring into resonance different worlds by taking Others’ point of view in a Amazonian perspectivist sense (see Lima 1996; Viveiros de Castro 1998). This argument can help us elucidate the agency of indigenous health workers. Following Carneiro da Cunha (cited above), shamans’ translations are not simply about rearranging the “new” into old categories nor about producing coherent meaning; they entail linking divergent worlds and overlapping perspectives – of humans and non-human beings, but also the worlds of white or nonindigenous peoples and their things. Rather than searching for commensurability, shamanic and Amazonian translations in general remain intentionally incomplete or partial (in Strathern’s [1991] sense of a partial connection), acting out through controlled equivocations (Viveiros de Castro 2004) that maintain the necessary differences and incommensurabilities between worlds.

1. The concept of “poiesis of care” articulated in this introduction has been developed in collaboration with Reig, who is the co-editor of this special issue.

Although one of our contentions in bringing together this special issue is that too little of the anthropology of lowland South America has focused on indigenous health agents per se, a significant concern with translation and ontological articulations delineates important leads for unraveling health agents' creative potential in their dealings with biomedical practitioners, institutions, and technologies. Contrary to what many may think, especially regarding interculturality, translation does not necessarily result in a "hybrid" medicine with internal coherence, one that would bring epistemological or even ontological correspondence between different theories, practices, and materials. Translations in the domain of illness and healing happen in a space of intense existential uncertainty and risk in which therapies involve an iterative process of experimentation with practices or materials that may or not work (see Lewis 2000; Taylor 2014; Mol 2008). Rather than coherence, the aim of translations around healing is efficacy.

In that sense, Amazonian indigenous health agents do not adopt a biomedical rationality when they learn biomedical practices in training courses. As in other processes of contact, they intentionally maintain their differences with health professionals. Kelly's concept of antimiscegenation (2017) helps us perceive how instead of hybridity and fusion of identities during contact, there is a composite that maintains the differences between white and indigenous people. Likewise, indigenous and biomedicine (and other practices of medicine present in these contact zones) are coordinated but remain distinct, opening up an ontological politics of care in which certain actions and effects are possible in practice and others are not (Mol 2003).

In another translation example, Fausto and de Vienne, who examine a new instance of Christian prophetism among the Kuikuro in the Upper Xingu, argue that it is rare to be able to examine "the actual process of appropriating, translating and creating a new cultural form, particularly in regards to the pragmatic dimensions and the interactive frames of this process" (2014: 162). This is precisely what we often can see in regard to indigenous peoples' appropriation and incorporation of biomedical practices, as in, for example, the context of training courses (see Barra in this issue), in the introduction of biomedical services into their communities (see Reig in this issue), or in the emergence of new diseases. Therefore, paying ethnographic attention to these indigenous health agents' work provides a unique vantage point into an existential (ontological) practice of translation, one which is constantly experimenting with the uncertainty of how we know and how to best care for those who are ill (or who may become ill).

A personal inspiration for this special issue came from the perception that something very subtle happens when indigenous health agents perform apparently simple biomedical tasks. This is often invisible for biomedical actors, but it has the quality of a "ritual" creativity aimed at affecting the world in a certain way. My story involves seeing a Yanomami health agent inserting an intravenous catheter into an infant's arm while the rural doctor simply helped the health agent by holding the arm in place. Yanomami health agents had become better than these recently graduated doctors at inserting intravenous catheters, and rural doctors increasingly relied on Yanomami health agents for such care, especially in the case of very young or very ill children.

Putting aside for a moment my disconcertment<sup>2</sup> in seeing a doctor helping a Yanomami health agent (and not the other way round), there was something about this Yanomami health agent's meticulous actions that signaled something special was being conjured in that very moment. He placed all his tools neatly in a tray, held the baby's arm with care, and moved swiftly but certainly to capture the vein with the catheter. Most doctors assumed that this use of needles and medicines meant Yanomami had embraced biomedical theories of the body, disease etiology and pharmacological treatment, and therefore doctors often expected compliance by the Yanomami with their prescriptions. But behind this apparently evident

2. I relate here to Verran's phenomenological and epistemological concept of "disconcertment" as a bodily state that points to something that is other, that signals that something meaningful yet difficult to grasp from one's own ontologies is taking place, and the generativity of telling ethnographic stories about such moments of disconcertment (see, for example, Verran 1999).

biomedical act there were several other Yanomami theories of bodies, pathogenic hazards and healing agencies at play. Needles and medicines were also effective for Yanomami bodies, though not in the way doctors thought. This health agent coordinated his “biomedical” effects within a world in which perforating or crossing the skin is an important pathogenic and healing form of agency (see Chaumeil 2004 on pathogenic darts) and where certain plant, animal, or “spirit” substances inserted into bodies can cause important bodily transformations (see Lizot 2011 on Yanomami *hëri*).

This example of partial coordination followed from a process of learning that often occurred around health training courses or in the context of health posts, but which also included other forms of learning more akin to shamanic initiations—for example, learning as apprentices from other health agents, from other indigenous groups, or through dreams. In the performance of injecting, Yanomami health agents displayed important aesthetic and existential risks that we may identify as those relating to a ritual. They did not simply repeat a biomedical act, they reenacted a different “version” (Mol 2003: 84,88) of biomedical injecting, one that worked in coordination with Yanomami bodies and healing agencies. It was ultimately a version that remained unexplained, untranslated in the sense of the meanings that Yanomami and doctors attributed to the acts, bodies, agents, and materials involved, though translated in the pragmatic sense of a creative enactment of care.

This creative enactment of care is what Alejandro Reig and I have referred to, in putting together this special issue, as a poiesis of care.<sup>3</sup> We mean by this, in a first sense, the revelatory creation of new realities, instead of simply a technical production that builds upon a previously existing context. This poietic action is developed in a field of health and well-being care designed by outside actors with which indigenous health workers engage and reshape in novel, unexpected ways. Thus, with poiesis of care we point to their capacity to agentively trace new relational worlds within a wide field of caring attention to their people at different scales and by managing different sets of technologies and resources. Their practice includes both novel incorporated healing techniques and preexisting indigenous ones; the manipulation of social connections and positionings gained by their insertion into the administrative and professional apparatuses of the state or other external governmental systems; and the ability to reshape preexisting social networks and political relations beyond the realm of health.

Some articles in this special issue were first presented on a panel on intermediating aspects of community health workers worldwide.<sup>4</sup> The panel included African cases, but it was soon evident that the debates being considered were largely divergent and that there was something special about the successes and failures of Amazonian community health workers’ experiences that deserved to and could be elucidated through ethnography. After a more open call for this journal, we received other papers that addressed indigenous health workers from a public health and operational perspective which we hope to publish in another venue. The current selection of articles reflects precisely our interest to go beyond standard evaluations of community health worker programs and into an anthropological approach to what it means for these health workers and societies to deal with and incorporate new forms of caring and healing into their own practices and cosmologies.

As we shall see below, there is ample experience in training and working with indigenous health agents in Latin America, particularly in the Amazonian region. Most of this literature is unknown to an English- or French-speaking public and global health audience; it is also excluded from medical anthropology debates on health workers (see the special issue: Maes 2015). But there are important issues regarding Amazonian indigenous health agents that could contribute to the wider global health debate. For example, whereas in Africa and Asia community health workers reemerged mainly because of the human resources crisis in health systems as part of an effort in medical “task shifting” from specialists to less-trained cadres

3. This paragraph was written in collaboration with Reig.

4. At the European Association of Social Anthropologists MAGic2015 conference in Bristol on a panel entitled “Health Workers at the Boundaries of Global Health: Between Performance and Socio-Material Practices of Care,” chaired by Karina Kielmann and Johanna Gonçalves Martín, with Kenneth Maes and Françoise Barbira Freedman as discussants, and papers by Gonçalves Martín, Reig, and Scopel, Díaz-Scopel and Langdon that subsequently became part of this special issue.

(Campbell and Scott 2011), community health workers in Latin America are still considered agents of social change and fundamental to participatory approaches for healthcare. Furthermore, many of these programs are connected to a history of struggles for indigenous and other minorities' rights. Thus, whereas in other contexts community health workers are seen as representatives or technical agents of biomedical health services, indigenous health agents in regions such as the South American lowlands open a space for alterity and difference within health systems, as part of a debate on "intercultural" or "differential" care for indigenous peoples in the region (Diehl et al. 2012).

As Campbell and Scott argue in their article cited previously, the current global implementation of community health workers has somewhat neglected their "community embeddedness." Partly, it is also a matter of the methods used to evaluate their efficacy solely in technical, psychological or managerial terms. Anthropological approaches and ethnographical descriptions are better for understanding community health workers' own experiences and aspirations, their unique contexts and histories, and their relationships with local health systems and with transnational policies (Maes 2015). In the case of Amazonian indigenous peoples, there is a significant body of anthropological literature that, although not directly concerned with indigenous health agents, can help us elucidate some of the most important aspects of their relationships with their communities, with health services, and with other beings in their worlds.

As we shall see below, an important domain of Amazonian anthropology that is relevant for the analysis of indigenous health agents is the study of situations of contact and the importance of alterity as a mode of sociality in Amazonia, as well as the transformational effects of contact with Others on bodies and perspectives (see Viveiros de Castro 1998; Lima 2002; Vilaça 2005). These transformations are part of the pragmatic, nonlinguistic translations I have mentioned above, which may furthermore be seen as a cosmopolitics, in the sense of a cosmos that is constituted by multiple and divergent worlds articulated through a politics with ontological implications (Stengers 2005:995; 2018).

Cross-cultural studies of health and healing that consider these more-than-human and cosmopolitical relationships are not new. Whereas interpretative and symbolic analyses of medical pluralism predominated in the early decades of medical anthropology, in more recent times questions of comparative epistemics (Verran and Christie 2011) and ontological politics (Mol 1999) have come to the forefront. These approaches no longer start from the measuring stick of biomedical efficacy in which other knowledges and practices are taken as mere representation or interpretation of a reality. They convey instead the multiple and world-creative possibilities of engaging with Others in a context of contact and transformation in which the worlds people inhabit are evermore riddled with diseases and destruction and the political is a matter of finding options for living and protecting life.

Another relevant anthropological concept with a Latin American genealogy for analyzing health agents' intermediating or translating agencies is "intermediality" (see Scopel et al. in this issue). Greene (1998) coined the term, which Follér later used to speak about a space of articulation or "zone of contact" between agents of care and their different medical knowledges which is shaped by their historical and political contexts (2004:109). Greene's above cited ethnographical example concerns a shaman who introduces in his healing chants the image of an injecting needle. Rather than hybridity, Greene speaks of this as an instance of "shamanising biomedicine"—and indigenous health agents often state that it is Others' medicine that is "complementary" to their own. But most importantly, this concept opens an important social and historical reflection on contact and neocolonialism that is central for Amazonian contexts. In the next section we shall expand on alterity as a key dimension of indigenous health agents' encounters and appropriations of biomedicine.

## Amazonian Indigenous Health Agents and Their Others

Amazonian peoples are careful about approaching foreign Others, whose alterity is considered dangerous but also necessary for their own creativity and fertility (Lévi-Strauss 1996; Gow 2009). The book *Pacificando o Branco*, edited by Albert and Ramos (2002), brought distinct attention to Amazonian cosmologies of contact and how different indigenous groups interpreted and dealt with the arrival of new people, their things, and their associated dangers. As Albert says in the book's introduction, it is particularly useful to think about people in the contact zone with outsiders not from their identities but from their "reverse anthropology" of these Others and the ways that they seek to appropriate and "domesticate" outsiders' dangerous alterity.

It is not a coincidence that there is so much in that book about disease. As Carneiro da Cunha succinctly puts it in the first sentence of her preface: "The precursory signs are manufactured objects and germs, even before the arrival of whites" (2002:7; my translation). Indeed, for many Amazonian peoples the experience of contact is deeply intertwined with the arrival of new diseases, which decimated people and often disconcerted elders and shamans (see Albert 2002; Buchillet 2002; Briggs and Mantini-Briggs 2003). In Amazonia, the notion that Others are inherently dangerous goes side by side with the idea that these distant outsiders also hold powerful technologies, including effective medicines that can cure preexisting or new diseases (Bonilla 2009) or even revive the dead. Such thinking often relies on abductive reasoning based on empirical experiences (Fausto 2002). Therefore, probably ever since contact, shamans but also younger people have sought to experiment with foreigners' new healing technologies, domesticating them for diseases that often were new for them. Becoming a health agent, promoter, microscopist, or other health cadres is an expression of the experimenting, translation, and domestication of these new and powerful technologies and not a commitment to a biopolitical subjectivity.

Although it does not concern illness, the following story of the acquisition of reading and writing skills by a Piro shaman delineates an example of experimental appropriation of new technologies. It concerns an elder called Sangama who lived in the times of the rubber boom and who could read the missionary newspapers (Gow 2010). The kind of "reading" Sangama performed was not a cognitive skill he had learned from the missionary in school nor a sham decodification of an alphabet. Sangama could see and hear in the newspaper a woman who told him of planes and boats that would arrive loaded with things from "Manaus, Belem, and Europe," ending for the Piro the times of misery and want they were experiencing. When Sangama passed along this knowledge to his successors, who would later learn reading at school and become teachers, he did it in a shamanic way, by blowing his breath on his successors and asking them to observe food restrictions.

We can extrapolate some of these observations to indigenous health agents and how they learn biomedicine. As Barra shows in this issue, indigenous midwives may now learn in a training course, but they also require a previous "gift" to be successful. Training courses in themselves constitute a special kind of initiation in which people do not just learn biomedical concepts and techniques but also transform their bodies by being in contact with doctors, eating other foods, and engaging with the materiality of classroom-based learning. Literacy and numeracy skills are often an important aspect of these training courses, and for indigenous health agent trainees they are not just cognitive technologies that are ancillary to medical practice but medical technologies in themselves that allow them to engage with a medical materiality of censuses, epidemiological registers, and dosages (Gonçalves Martín 2016).

As mentioned above, not many anthropologies of contact in Amazonia have dealt specifically with indigenous health agents. Two notable exceptions are highlighted here because of their particular attention to intermediation or translation practices. Kelly's ethnography of

Yanomami people's relationships with the Venezuelan state and its healthcare system (2011) focuses on the relationship between a number of "interface" Yanomami people—including medical auxiliaries but also microscopists and support personnel such as motorboat drivers—and doctors from the Venezuelan state. In what he describes as an axis of transformation along a gradient of alterity from doctors to Yanomami villagers upriver, Kelly suggests that one of the main elements in the relationships between Yanomami and *napë* (white, foreign) doctors is precisely their condition of alterity. The mediating capacities of these interface Yanomami in relation to doctors' alterity are analogous to those of shamans with the world of spirits. The process of domesticating these doctors and their knowledge involves eliciting in them a Yanomami morality of being human with wide implications for care, while at the same time doctors are engaged in a rationalistic process of civilizing (and medicalizing) the Yanomami.

McCallum's 2014 ethnography of a functional anatomy training course for Cashinawa people in Brazil shows how biomedical and Cashinawa knowledges clash but also transduce into new ontologies. She refers to a process of ontogenesis occurring during the course in which, beyond a certain degree of epistemic violence in teaching the Cashinawa about the "real" body and its anatomy, it constituted another opportunity for Cashinawa people to creatively engage in the production of new realities regarding the body and healing. Though doctors sought to correct Cashinawa ideas of the body through corpse dissection, the epistemological practice of examining a corpse had potent effects on the reconstitution of Cashinawa processual and agentive ontologies, their ways of being and becoming.

### **Schools, Conversion, and Politics: Useful Comparisons for Amazonian Indigenous Health Agents**

The above story of an indigenous appropriation of reading and writing through a shamanic praxis of speaking to a newspaper as the body of a woman would perhaps seem unrelated to the domain in which indigenous health agents are immersed. It is not just that, for indigenous health agents, reading and writing are technologies intimately connected to or part of other materialities of biomedicine as argued above. More than that, this story speaks of indigenous peoples' general interest in learning from and domesticating white people and their technologies in diverse situations of contact. We can extend then our understanding of indigenous health agents' forms of appropriating and domesticating biomedicine by comparing with other similarly positioned interface indigenous peoples. Debates on the politics of knowledge at schools, on the dynamics of conversion, and on the power of political leadership may each present relevant similarities with and differences from those of indigenous health agent programs and the relations between traditional and scientific knowledge they embody.

The school is indeed a particularly relevant space for thinking about indigenous health agents because of the historical continuities of biomedicine with missions. Within the framework of a neocolonial civilizatory process, most governments in the region commissioned missions to provide healthcare and school education to indigenous populations that were considered alien and difficult to reach. States sought to integrate indigenous peoples into national identities and processes of state formation, enforcing the adoption of a certain religious and hygienic morality. Missionaries, in courses they designed and often implemented independently from national health systems, were some of the first foreigners to train indigenous peoples as health workers and promoters. Moreover, evangelizing texts (including school textbooks) often referenced practices of bodily hygiene, which for many indigenous peoples were constitutive of an embodied process of conversion.

Beyond the locating of the primordial origin of school education and biomedical health education in missionary conversion efforts in Lowland South America, several critical reflections on schools are applicable to health training courses, both in terms of their methodologies

and the characteristics of the knowledges that are meant to be transmitted in such courses. Indigenous schools pose an inherent contradiction. They are conceived as an instrument for empowerment in which indigenous peoples valorize their own knowledges and learn from those of another society, but they also constitute a trap for indigenous ways of knowing, which find no space for expression or embodiment in the limited transmission context of classrooms and school curriculums (Gallois 2014:509).

Intrinsically related to these methodological limitations of the school is its emphasis on transmission of knowledge as “content” rather than the cultivation of indigenous modes of relational knowledge. Schools’ methods often run against indigenous embodied and relational processes of teaching children how to become aware and how to understand their worlds, and against established hierarchies, rules, and relationships of learning (Cohn 2014:317–27; Oliveira 2019). But indigenous peoples’ persistent interest in schools suggests that these are not perceived as failed spaces for the construction of indigenous knowledge but as important relational spaces where indigenous people can learn how to live with alterity and how to articulate disparate ways of knowing (Gallois 2014:511). For all its limitations, the school constitutes an opportunity for engaging in a politics of knowledge that values other forms of knowing not just as “culture” or “traditional knowledge” but as Other, as difference that offers alternatives for all practical aspects of living on this planet (Carneiro da Cunha 2014:16).

These reflections speak directly to the problems inherent in health courses for indigenous peoples, which too often focus on biomedical concepts and ways of knowing (see Barra in this issue). In a similar vein, though one may criticize the epistemic violence present in health training curricula, many indigenous peoples appreciate and actually demand the possibility of learning from the medical efficacy of biomedical practitioners, though on their own terms. Failed attempts to incorporate indigenous “traditional healing” knowledges in “intercultural” health curricula is more a failure of the modernist state’s multiculturalist approach to medicine and difference than of an indigenous multinaturalist logic (Viveiros de Castro 2002) of co-opting the methods and know-how of Others for the workings of their own bodies.

The civilizatory process of schooling indigenous children and of teaching a biopolitical regime regarding hygiene and health control is underpinned by several intertwined logics, such as development and progress and cultural integration and miscegenation. In relation to the Latin American discourse on miscegenation (*mestizaje*), Kelly Luciani (2017) argues that although states have been strongly invested in the assimilation of differences into a new kind of national people with a single social, moral, and biological identity, Amazonian people are not interested in such hybrid identities. On the contrary, they struggle for a “mixture without fusion,” or what he refers to as an Amazonian ideal of *anti-miscegenation*. The historical incorporation of white peoples’ differences is done without erasing such differences’ origins. This describes well the case of the articulation of shamanic and biomedical medicine by indigenous health agents, who coordinate and juxtapose forms of medical knowledge and practices while keeping the differences intact.

Returning to the theme of the missionary processes of evangelization and Amazonian experiences of conversion, Vilaça (2016) shows how conversion for the Wari’ is also not a matter of mixing Christian and non-Christian elements into a state of hybridity or about a stable transformation. Instead, conversion is a matter of alternation between states of bodily transformation that are always unfinished and likely to revert. This inconstancy of indigenous conversion bothered missionaries in the past, much like indigenous peoples’ inconstancy in their commitment to biomedical practices bothers doctors today. The “biomedical inconstancy” of health agents may be explained through a constant process of empirical testing of new therapies in the face of emergence of new kinds of sickness or misfortune. However, it may also be linked to something that several authors from this



special issue note: state health services are similarly inconstant, and they fail to provide continuous supervision of and support for curative activities, leading health agents to feel neglected and to abandon their work. These periods of abandonment or rejection of state health services nonetheless alternate with renewals of interest. This further shows that intermedical articulation is not a matter of fusing ontologies into consistent hybrids but is a kind of fluctuating composite that leaves its fragments, connections, and gaps fully discernable and reenactable. Hence the added importance of examining community health worker experiences in a longer temporal frame.

Doctors' perception of indigenous inconstancy also reflects a certain ambiguity intrinsic to indigenous health agents' position between health systems and their communities. It has been overly discussed how they are accountable both to doctors and health systems and to their people and communities. Regarding the latter relationship, it has been often said that the mastery of biomedical knowledge would bring about an asymmetry and power differential between indigenous health workers and ordinary people, a thought that follows a Foucauldian link between knowledge and power. But we may read in Kelly's 2011 work that this ambiguity has less to do with power issues than with a double effort by Yanomami people in transforming themselves into *napë* (white people, foreigners, Others) and remaining indigenous while domesticating the alterity of these medical outsiders. Furthermore, the anthropology of mastery, power, and care in Amazonia leads to the questioning of the nature of the relationship between power and knowledge and what power is for Amazonian peoples.

In Amazonia, a master owes himself to his people(s) in an asymmetrical relationship akin to parent–child relationships in which mastery is less about property and more about caring and nurturing Others (Fausto 2008). Although shamans and masters do have “power,” this is not a unifying power over peoples' diverse intentions and agencies, nor is it a power of “representation.” Any attempt at converting power or prestige into coercion or domination is actively refused and neutralized by the collective, resulting in a form of “chieftaincy without power” (Clastres 1978; Franco Neto 2017). What Amazonian chiefs or masters—and their contemporary equivalents, such as political leaders—do certainly have is an influence over their kin. But it is underpinned by their responsibility toward nourishing and caring for others and by their moral qualities (being a good hunter, builder, orator, etc.). In the case of indigenous health agents, their mastery of biomedical technologies is not just a source of prestige but a responsibility for effectively and humanely healing their kin. An indigenous health agent who repeatedly mistreats people or commits errors during medical treatments is often quickly dismissed.

These positions of mastery and power—chiefs, shamans, political leaders, pastors, and teachers and health workers—very often entail an engagement with Others as an essential source of their creative agencies in constituting worlds. They are very often male, for reasons that may have to do with the inherent capacities of female and male bodies but also with a gendered relationality of knowledge. Men are more often engaged in dealing with “alterity.” But this does not always hold or necessarily determine all healing relationships. Though gender in Amazonia seems to be subordinate to the distinctions of alterity, it also delineates important forms of agency that must be considered in depth in the case of care and indigenous health agents. And in the context of relationships with states and their institutions and policies, there is an increasing demand for the incorporation of women and their perspectives. Two articles in this special issue consider female relational knowledge. Barra discusses midwives' knowledge that challenge a biomedical gaze over the body and Peluso details modes of articulations between male and female agencies that can and should be symmetrically explored in the implementation of indigenous health agent programs. In the context of a heightened concern with gender and intersectional feminism in global health, Amazonian cosmopolitan feminist perspectives (see Regitano and Nahum-Claudel 2021 for a current review of

Amazonian feminisms) can guide the implementation of biomedical health programs and the intermediating agencies of indigenous health agents.

## Community Health Workers in a Global and Amazonian Context

At the 1978 Alma Ata health conference, community health workers became the cornerstone of a primary health care (PHC) strategy promoted by the WHO, which is still relevant today in global health. Though most authors trace the origin of community health workers to Chinese “barefoot doctors,” the challenges of providing care for rural and also indigenous populations have led to a diversity of efforts in training people from the local communities to provide basic care (see examples in Newell 1975). Perhaps a first attempt at formally training laypeople who would assist doctors and provide rural care were the Russian *feldshers*, who operated as early as the eighteenth century (Sidel 1969; Ministry of Health USSR 1974:9). Another wave of efforts in training local health workers was seen in the context of the internationalization of rural hygiene and the creation of health districts in the 1920–30s, with the support of the League of Nations and the Rockefeller Center (Packard 2016:77–80; Chèn 1936). These initiatives to build comprehensive health services in rural areas, often in the context of colonial relationships, constitute an early attempt to consider the social contexts of care and to promote the participation and empowerment of local people in their health services, which predated the Chinese barefoot doctors and PHC strategy.

The training of local health workers opened a space for alternative forms of appropriation of and empowerment through biomedicine. In an example from the Pacific Island region in the early twentieth century concerning the training and implementation of native medical practitioners, we can see how such workers contributed to the indigenization of modernity by creating a space for traditional medicine within biomedical institutions and by advancing a nascent form of biopolitical citizenship within a colonial setting through which natives had new entitlements and responsibilities based on their biomedical work (Widmer 2010). Such experiences of native or indigenous health workers often challenge mainstream ideas of participation and empowerment in public health, both in the sense of local health workers’ relation to health services and institutional staff and their relation to biomedical knowledge (Nichter 1986, Maes 2015).

Very soon after Alma Ata, the financial crisis and structural adjustment plans of the 1980s that limited social and welfare programs also reverted global institutions’ interest in funding community health worker programs. It was argued PHC was too idealistic and unfeasible, which led to a “selective” package of PHC that could be measured (Cueto 2004). Of community health workers it was said there was no real evidence of their effectiveness—as if medical doctors and nurses required such epistemic proofs of their benefits for people! Some programs also showed high attrition rates, often blamed on the inconstancy of local health workers, but which were due instead to the lack of pay and poor articulation with official health services and support (Mburu 1994). Abandoned by most countries, community health agents have resurged in the past years, mainly following the human resources crisis brought on by the HIV-AIDS epidemic. Their reimplementaion, however, has entailed a limited role as technical agents (for example, distributing medicines and care for HIV and AIDS sufferers) and no longer as agents of social change (Campbell and Scott 2011).

This history diverges from what happened in Latin America, especially among Amazonian indigenous peoples. Rather than ceasing or becoming weaker, many of these programs and initiatives persisted, or in some cases even flourished, in the past few decades. Some of the factors that allowed for their persistence are their embeddedness in Latin American experiences of social pedagogy and community participation in health, and a collective medicine movement that emphasized social aspects of health (Paim and Almeida Filho 1998;

Breilh 2013). They were also related to political movements for social justice that promoted community-based activism (see Nading 2013 in Nicaragua; Maupin 2015 in Guatemala; Cooper 2015 in Venezuela).

More specifically regarding indigenous health agents in the Amazonian region, they have been key actors in the struggle for intercultural health systems or for “differential care,” though under each country’s different sociopolitical, institutional, and normative-legal configurations. Brazil is perhaps one of the best documented examples (see, for example, Langdon et al. 2006; Pontes et al. 2018; Garnelo et al. 2019; Scopel et al. 2015; Novo 2009). A comprehensive review by Diehl et al. (2012) traces the origins of community health workers in Brazil to an integrative PHC health system based on family health. The specific role of indigenous health agents emerged from the context of recognition of indigenous peoples’ rights to “differential care.” However, Langdon and Garnelo (2017) note that “interculturality” is not really part of the discourse on indigenous health in Brazil. They suggest that its absence in Brazil hints at an asymmetric postcolonial relationship of health professionals with indigenous peoples in which “differential care” becomes a highly standardized and normative-administrative health policy that does not consider the variety of indigenous peoples’ contexts and their expectations. This points to a gap all articles in this special issue identify: that between what is consecrated as a right to indigenous articulations of care and the universalizing and equalizing care that states actually prefer to implement.

Diehl et al. (2012) specify that in the early implementations of indigenous health agent training courses and programs in Brazil, led by universities, missionaries or nongovernmental organizations (NGOs), there was considerable anthropological attention to the diversity and specificity of indigenous contexts. Training of indigenous health agents subsequently became the responsibility of the National Health Foundation, under which such courses turned toward a more technical and biomedical focus. They also note that indigenous health agents’ curative and preventive roles are less ambiguous among more isolated indigenous peoples with less access to healthcare, such as the Yanomami, in the Xingu, and in the Upper Rio Negro, whereas in more urban contexts their roles are less understood by health teams and by indigenous populations.

Probably because they are less institutionalized—many programs are still undertaken by missionaries, universities, or NGOs—the academic literature on Amazonian indigenous health agents elsewhere in the continent is less extensive. Discussions seem to happen in a network of indigenous intellectuals and organizations working on interculturality and within the grey literature of NGO and health ministry reports. In Peru, Bolivia, and Ecuador, NGOs, missionaries or indigenous organizations with international funding originally led many initiatives of training and implementing indigenous health agents (see Hvalkof 2003; Cárdenas et al. 2017; Bastien 1990; Sebastián et al. 2001). More recently, all of these states have taken up a discourse of interculturality that has provided recognition and support for indigenous health agents, though often restricting their influence and roles. For example, in Peru the indigenous organization AIDSESP<sup>5</sup> began training “intercultural nursing technicians,” as these would have better chances of influencing healthcare policies than community health agents with health promotion roles. That some NGOs and indigenous organizations continue to implement some of these programs suggests a certain amount of autonomy for actors outside ministries of health to rethink and participate in healthcare. But it also entails limited support from official institutions and a lack of control over the limited resources of health posts (Yon et al. 2015).

In Colombia, health agents were officially trained for indigenous and nonindigenous communities, but the legal and financial reorganization of the healthcare system that began in 1991 led to their de facto elimination by the state. However, a strong indigenous movement

and demands for a differential and self-administered indigenous health system (Urrego Rodríguez 2017), and the lack of health services in most indigenous territories assured that they continue to practice in certain areas (Suárez Mutis 2001), though often with the support of NGOs (such as GAIA, Sinergias, and Amazon Conservation Team), missionary or indigenous organizations, or in the limited role of health promoters.

The case of Venezuela provides another interesting counterpoint in that from its beginnings it has been a state-implemented initiative. Inspired by the experiences of Iran and the USSR, a program for “simplified medical auxiliaries” was first introduced in 1962 for regions where “no doctor would ever think of working,” referring mostly to rural and indigenous areas in the southern Venezuelan Orinoco plains and Amazonian forests (González 1975). Venezuela’s wealth meant that this program was less affected by international changes in funding priorities. A new constitution in 1999 which recognized indigenous peoples led to an adoption of intercultural health policies in which indigenous health agents still held a central role (Sánchez Salamé 2006). However, the deep-reaching and extended Venezuelan crisis and a persistent uniformizing biopolitical bias of the state (or the “inertia of the state,” see Reig this issue) has meant that most of these health agents have had no resources to continue working, and many have abandoned their jobs.

In sum, the reasons for Amazonian indigenous health workers’ persistence depend greatly on the interplay between indigenous political struggles for recognition and diverse projects of state formation and healthcare, which include interculturality or differential care. Some caution in using the word “interculturality” is necessary, however. It is often rather an appropriation by the state of the term “culture,” understood as factors or practices having an impact on health outcomes that are sometimes respected or “tolerated” but which in most cases need to be “remediated” (Kowal 2008). Intercultural approaches often engage in a series of equivocal relationships between indigenous peoples and states or health organizations (Kelly Luciani 2009). But from an indigenous perspective, these discursive or legal-normative experiences of interculturality sometimes do carve out a space for alternatives to biomedicine. This is what some have referred to as an indigenous “project of critical interculturality” in construction (Walsh 2009).

The literature reveals a large number of terms for community health workers and a great diversity in their training, attributions, and mechanisms of insertion into the state or nongovernmental health institutions. This makes comparison rather difficult. But in general, these Amazonian experiences of indigenous health workers in relation to an intercultural discourse offer important lessons for other global contexts of pluralistic medicine. The character of indigenous health workers as “cultural brokers” or boundary agents is central: they are in a boundary zone between “communities” and official health services and between scientific biological ontologies of health and the body and other indigenous or native ontologies. However, this double position also entails a partial and often ambiguous accountability to their communities and to their institutions. Just as shamans, Amazonian health agents are in a constant process of being and becoming in translation between worlds, a translation that is in essence cosmopolitical.

## **Ethnographic Contributions in this Special Issue**

The articles in this special issue encompass several dimensions of indigenous health workers in Amazonian contexts: from a historical approach to long-standing programs to more recent implementations; from curative activities to the settings of their training; and considerations of a wide variety of indigenous health workers—from health agents to sanitation agents, microscopists, and midwives. Studies range over different nation-states and health system models for indigenous peoples. They reflect the heterogeneity of im-

plementation contexts that has been highlighted in the literature, but they also suggest important continuities due to Amazonian forms of sociality and relationships with alterity. Overall, the detailed ethnographic descriptions of the conditions of their work in relation to cosmography, space, gender, and embodied and relational knowledge provide readers with important tools for understanding and comparing these particular contexts of implementation with potential others.

Raquel Scopel, Daniel Scopel and Jean Langdon examine the context of care and relationality by Munduruku community health workers of the Kwatá Laranjal indigenous land in the state of Amazonas, Brazil, which included indigenous health agents, sanitary agents, and microscopists. The authors show how Munduruku health workers' agency is part of a larger and collective process of well-being by the Munduruku that goes beyond restricted biomedical notions of health and that is grounded in the history of contacts and relationships with human and nonhuman Others in their territory. Drawing up on the notion of "intermediality" as a contact zone, Munduruku community health workers are part of a process of medicalization and local biopolitics toward indigenous peoples but also of a therapeutic network composed by other indigenous groups and nonindigenous *ribeirinhos* (river people), while still being part of a Munduruku socialized cosmos of human and nonhuman persons. In this context, abundance and well-being are connected to the territorial management of relationships with spiritual mothers of game, plants, water, and other surrounding resources. This relational milieu, they argue, configures a diversity of "therapeutic itineraries" in which Munduruku ways of managing well-being join with territorial affirmation in the context of novel relations with alterity. Their effort in learning new forms of healing and establishing "partnerships" with their many Others not only delineates a cosmology of health and illness but also reveals a politics of relating with Others in which strategies of closeness and distance are important for managing a multidimensional territory. The authors end by noting that Munduruku health workers are not mere agents of biomedicine but, in fact, are central to the intermediation and negotiation of multiple therapeutic itineraries. This dimension of their work remains unseen by official health services, and the authors conclude that intermediality involves practices that are very often invisible to others.

Following with a concern over space, Alejandro Reig's article takes a multiscalar and spatial approach to the transformations resulting from the relationship between the Yanomami health agents and the Venezuelan state. Reig examines the introduction of health agents as a "biopolitical device" of the state, focusing on the work of a Yanomami health worker in a set of villages that had been largely ignorant of other state interventions. The combined actions of the health agent and the community in materializing an outreach post build up into an interface of transformations operating at several scales and loci, which include changes in people's everyday practices; tensions in intercommunity relations and spatial reorganizations of the villages involved; the appropriation of new sites and ways of communication with outsiders; of new materialities of diagnosis and care; and shifts in the health agent and his family's social positioning within the community. This multidimensional effort in setting up an "outreach health post" shows that what seems to be an individual accomplishment is inextricable from a collective effort of innovation and control in relationship with an assemblage of biomedical and political entities of the state. By focusing on the transformation of a young competent Yanomami forager into a responsible indigenous health agent, Reig argues that a key to its success is the overlapping of two ethics of care by which both bodily procedures of biomedical care and preexisting practices of Yanomami conviviality enact a *souci de l'autre*, or "care of the other." Finally, Reig shows how a well-intentioned initiative by a few people within the state is constrained by what he calls "state inertia," in which the state resists its own attempts at novelty and pluralization. But at the same time, the state's abandonment and failure lead to inventive adaptations by the health agent and his kin. He concludes that the improvement

of health does not hinge on the state but on community appropriation of external programs and resources into their own dynamics of transformation.

Daniela Peluso's article also looks at the failures and successes of a health promotor program. She documents a recent historical phase of indigenous–outsider relations in the context of health and environmental development in Madre de Dios, Peru, and the frictions reviewed can help understand gender-imbalanced systems of indigenous healthcare programs in a wider Amazonian transnational landscape. Her starting point is the sidelining of women at the beginning of an NGO health program project. Ignoring women's influence and skills in the management of the environment and social well-being reduced the impact of health and conservation projects and led to the NGO's reconsideration and future involvement of women. Women occupied a central place in relational practices of health and caregiving that involved humans, nonhumans, and the environment, in which women had a crucial role in producing cultivated food, tending medicinal gardens, and administering plant-based medicines. But external institutions customarily considered men as the mediators of community relationships with outsiders. By appointing men as health promoters, this NGO pushed women out of the more visible and public aspects of their roles as caregivers, whereas male health promoters, who were more engaged in their interfacing and administrative roles, were often not able to fulfil the expectations of their own communities, especially in regard to the care of women. Instead of adding a component of “women's health,” the NGO revised their policies to include women as facilitators and beneficiaries as part of larger “health teams,” an approach that wisely considered relational dynamics in the villages. Peluso's ethnography of a women's meeting organized by the NGO and of a plant-based treatment shows how women came to recognize a form of knowledge that came from relationships with female and male kin that they could now extend into their relationships with other women in the meeting and in their health teams. The inclusion of women also allowed for a more holistic concept of health, encompassing care for nonhumans and the environment. An important contribution of this article is its emphasis on how one must analyze how care is embedded in a gendered matrix of ecological knowledge and pay careful attention to the management of threatening, healing, or protecting abilities of human and nonhuman beings.

Also focusing on women health workers, Maria Christina Barra turns her attention to indigenous and public health ways of knowing in training courses and the construction of a category of “traditional indigenous midwifery” in a multiethnic area of Roraima, Brazil. Through a combination of analyses of discourses and of the enactment of health policies, along with a material-visual focus on writings and drawings developed during training meetings, she seeks to expose the frictions between indigenous sensible knowing around mother and child care and public health/scientific prenatal and childbirth care. Because becoming a midwife does not result from a standardized pathway of skill learning but is instead a relational and embodied form of being that reveals itself as a “gift,” the integration of traditional midwifery does not flow effortlessly into a public health program based on the systematic transmission of technical knowledge. The state might attempt a culturally sensitive intervention to recognize and valorize traditional indigenous knowledge and practices—and the author provides ample evidence of the different initiatives, administrative structures, and programs that have been created throughout the years in pursuit of the development of a differentiated indigenous health system. But in fact, not all forms of indigenous knowledge are deemed efficacious from the public health side, and indigenous midwives remain outsiders in relation to formal indigenous health teams. Indigenous women still warn about the differences in indigenous and white people's bodies that produce distinct bodily capacities and existential positionings. In that sense they distinguish between “indigenous prenatal care” that starts from early age, and includes all the practices, behaviors, and relationships that make up a woman's body, and “white people” prenatal care that starts with conception and regards physical and natural body

care detached from relations. But beyond these dichotomies, the training courses reveal how women inventively rearrange and assemble these different forms of knowing and caring. The courses themselves become part of midwives' "gift" or "call," and images and writings bring forth new forms of efficacy. In an entanglement that reveals new conditions of possibility for healing, midwifery is not just part of "women's struggles," but a claim for a different gaze over indigenous bodies and ways of living.

## Cosmopolitical Agencies in a Postpandemic World

The COVID-19 pandemic stopped the world in a way that no other preceding event ever did. It kept planes on the ground, interrupted schools, emptied streets, and paralyzed industries. It also revealed the limits of a global health apparatus that exacerbated existing health inequalities and resulted in more suffering among vulnerable people. In the Amazonian region, the virus swiftly arrived via the bodies of foreign travelers: tourists, agents of extractivism and other illegal activities, and itinerant medical teams and other governmental agents. These arrived in the context of insufficient health services and weak political mechanisms for guaranteeing indigenous peoples' equal rights to a life worth living. In the case of COVID-19, this meant that once people were ill, they had little access to advanced or even basic medical care. The lack of health services and statistics also entailed an epidemiological silencing of the dimensions of the pandemic in indigenous lands.

Biopolitical measures of pandemic containment and biomedical explanations of disease became contested sites of equivocal translations in regard to indigenous ontologies of disease. Some measures for pandemic containment even entailed existential challenges to indigenous ontologies, with one example being the forbidding of indigenous funerary rituals due to biosafety regulations for burials (Silva and Estellita-Lins 2021). Measures of confinement or social distancing also had an unequal impact upon indigenous peoples' livelihoods, especially urban populations, with no access to gardens, that depended on wages or the selling of products for feeding themselves. These situations raised ontological risks that brought about a series of "cosmopolitical" interventions by indigenous peoples that sought to open a space for ontological and other practical concerns.

For example, women in Rio Negro organized themselves to provide food and personal protective equipment for indigenous families affected by the pandemic and confinement (Olivar et al. 2021). The authors (including an indigenous woman) of this article comment on how this initiative opened a counterspace for other "pluriverses" to coexist (citing de la Cadena and Blaser 2018). In this space, within an assemblage of biopolitical and neocolonial public health practices, they were able to appropriate, translate, and engage in their own hybrid versions of scientific knowledge and health interventions. In other regions, indigenous peoples also organized themselves to learn the plants that were useful in the face of this new threat and ensure people had access to them. Indigenous organizations also began collecting epidemiological information on the pandemic in indigenous areas and presented it as a counterpoint to official statistics. A number of special issues, digital collections, and internet websites document the immense variety of indigenous contexts of COVID-19 effects and their creative—cosmopolitical—responses. A few examples can be found in the editorials by Belaunde et al. (2020) and Bolívar-Urueta et al. (2021) in *Mundo Amazónico*, the special issue of *Sentipensarnos Tierra* edited by Milanez et al. (2020), the reflections by indigenous students of the *Núcleo de Estudos da Amazônia Indígena* (2020) of the Universidade Federal do Amazonas, and the *Plataforma de Antropologia e Respostas Indígenas à COVID-19 – PARI-c*.

Whether pandemic relief measures were undertaken by formally recognized indigenous health agents or by other indigenous leadership in places where these are absent, their intermediation was crucial for the emergence of forms of care that worked better for their people

in the midst of the pandemic. Although the pandemic reinforced a biopolitics that seeks a unified and normative frame of action, one that erases differences and that further brings the world into a new wave of biomedicalization, these indigenous peoples' efforts acknowledged and worked from their differences.

The articles in this special issue reference a time before the pandemic. However, they precisely delineate in more ethnographical detail a space for divergence between biomedical and indigenous practices. They also suggest that the translations in which indigenous health agents engage do not always seek commensurability. On the contrary, they may remain intentionally partial; they can refuse certain worlds and reclaim others. We are not naïve about the conflicts and ambiguities that indigenous health agents may face vis a vis their own communities. We are well aware that in many cases indigenous peoples have also refused biomedical technologies for ontological reasons—more recently, for example, refusing COVID-19 vaccination. But understanding these issues through the lens of Amazonian relational concepts of knowledge, alterity, gender, care, or mastery goes a long way in inhabiting the equivocations inherent to the translational work in anthropology and in better comprehending what kinds of worlds indigenous peoples bring forth through their actions.

Just as the HIV-AIDS epidemic in the 1990s showed the world that a network of care closer to peoples' homes was needed to provide treatments for the chronically ill (and this entailed a resurgence of community healthcare workers), this pandemic is teaching us all something about collective and more-than-human forms of care that are lacking in biomedical individualizing and naturalistic logics. This is the sense in which we have referred to the "poiesis of care" as an aspect of indigenous health agents' creative modes of intermediation. A creativity in the assembling of care practices that is cosmopolitical, in the sense of involving multiple and divergent worlds, and "slowing down the construction of a common world, creating a space of hesitation regarding what it means to say 'good'" (Stengers 2005:995).

Many other articles have spoken about indigenous peoples' resilience in pandemic times (e.g., Sirén et al. 2020), but resilience is perhaps not exactly the metaphor that best translates indigenous peoples' experiences of this pandemic and other previous or impending threats. By "resilience," these authors precisely refer to the self-organization and medicinal plants of Kichwa indigenous peoples that, despite massive number of infections, contributed to a low death toll among them. Resilience implies a movement of rebound, of springing back after certain pressure. But for many Amazonians, this pandemic brought memories of the many previous ends of their world—which included other devastating pandemics since European colonization but also other historical exterminations such as in the rubber boom. Krenak (2020) speaks of the pandemic as a tragedy that came in an already tragic time of extermination for indigenous peoples. Instead of resilience, he refers to "resurgence." That is, to an ongoing history of "disappearance and resurgence, disappearance and resurgence" (ibid:51) that narrates the many previous ends of the world for indigenous peoples.

In that sense, indigenous health agents are also part of such resurgences through their translations of the affordances of biomedical technologies in these catastrophic times that have also been brought about by distant Others (Kopenawa and Albert 2013). Following Clastres's analysis of a kind of power that does not result in state-like formations, Sztutman (2013) argues anthropology should pay attention to the creative mechanisms by which indigenous peoples act politically in relationship with the state, refusing its attempts at unification and reduction and assuring a position of resistance and self-determination within a cosmopolitics that involves more than just human politics. The articles in this issue, though written before the pandemic, suggest ways in which emergent forms of indigenous care can remain Other, and simultaneously effective from a cosmopolitical standpoint, within new postpandemic sensibilities and the difficulties that await future generations.



The ethnographies collected here present us with a much more precise image of what it means to “intermediate” or “translate” for Amazonian indigenous health workers. Translations constitute more “partial connections” (Strathern 1991) than full correspondences. They bring together divergent worlds, while maintaining the differences that sustain indigenous peoples’ existences. The creative potential of Amazonian health agents lies precisely in the way that they connect new practices, peoples, and materialities of health into forms of care that nonetheless remain cosmologically indigenous. A focus on the poiesis of care directs our attention to these translations, while simultaneously opening a space for appreciating Amazonian indigenous peoples’ alternative versions of care.

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