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Health Agents on The Move: Yanomami Agency and The Struggle For Wellbeing

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This paper examines the health outcomes and socio-political impact of the work of a Yanomami health agent in the Upper Ocamo area of the Venezuelan Amazonas State, and its relationship with the national health system and argues that these build up into an interface of transformations. This is an interactional milieu composed by a dynamic mesh of incorporations and transformations working at different scales and in different directions: the public health system incorporating a hinterland cluster of villages, a village at the centre of this cluster incorporating the resources of the outside world, a young adult incorporating the potencies of outsiders and transforming into one of them, and other villagers entering the field of transformations.

The paper attempts to answer a couple of related questions: how a young adult mastering Yanomami socioenvironmental practices and unacquainted with the outside world got to be transformed into an outside-healthcare provider for his people, and how the villagers managed this transformation and the larger ones provoked by healthcare intervention. It is based on my experience as a collaborator with a Yanomami health agents training program during my doctoral research between 2007 and 2011 in a group of villages known to outsiders as *Shitari.* The argument is developed along two convergent avenues: public health and policy outcomes of the case; and their interpretation within debates on Yanomami and Amazonian transformations, mediation and, laterally, translation. I begin by introducing the group of villages studied in the context of the expansion of state healthcare in the early 2000's. Then I provide an ethnography of the incorporation of the recently trained health agent to his village, together with the arriving anthropologist, and the start of healthcare routines. These routines were grounded in specific built spaces, but, with the participation of villagers, they triggered a wider transformation of domestic spaces and practices. I then present the results of three years of healthcare routines and of the neglect of the health post and agent by the state and show that the latter's failure was counteracted by the initiative of the health agent. I then examine different scales and loci of transformations of the health agent and the community and how they construct a novel scenario of well-being which, however, puts into play secular processes of Amazonian sociality. The discussion explores how individual and collective changes in practices, spaces, and routines are linked in the building of a transformational interface, resulting not in a definitive transformation, but in an oscillation between poles of difference. This offers a complementary and contrasting case to be analysed through J.A. Kelly´s influential framework to understand relations between the Yanomami and the outside world through the lens of the Venezuelan healthcare system (2003, 2011, 2016). The conclusion suggests that discontinuous healthcare policies and fluctuating health betterment in hinterland communities expose the limits of state inertia. However, instead of being tied to the failures of top-down healthcare interventions, wellbeing improvement relies on the local management of the interface constructed between health agents, the community and

the state. While providing further insights into Yanomami processes of social reproduction and transformation, the case contributes to an understanding of wider dynamics of relation between nation-states and indigenous peoples.

Outreaching the Shitari/ Outreaching the State

In mid-2006 Francisco Sutiti, a Yanomami boat pilot working for the regional health system in the downriver village of Ocamo, entered the village of *Shakripiwei* with his brother-in-law Jorge from the village of *Arat^{h}a*, located a couple of walking days away on the banks of the Ocamo river. *Shakripiwei t^{h}eri* is nested in the forested slopes of the Upper Ocamo Mountains of the Venezuelan Amazon, and it comprises, together with the villages of *Aranai t^{h}eri*, *Isi t^{h}eri*, *Okonaripiwei t^{h}eri* and *Yaure t^{h}eri*, a population ensemble of five interrelated communities that has come to be known as the *Shitari*, then accommodating approximately 220 persons. Situated at an average altitude of 550 meters and in a rich environment of sub-montane evergreen forest, the *Shitari* enjoy a continuous food supply of game, forest gathering resources, and garden produce.

When Francisco and Jorge entered the plaza, they were received by a dozen of bows and arrows pointing at them, amidst the cry of "*wayuu, wayuu*" ("enemies"). Testimonies say that Francisco then impassively cracked his shotgun open, after which the arrows were lowered, and the cries changed to a more apologetic "*Shori, shori, kafe weti, kafe weti*?" ("Brother-in-law, what, who, are you? Where are you from?"). "*Ya Iyewei t^{h}eri, ipa shori Jorge Arat^{h}a t^{h}eri a kua, wa tai*" ("I am an *Iyewei t^{h}eri*—an Ocamo village person—and you already know my brother-in-law Jorge from *Arat^{h}a*"), Francisco replied. The fact that the *Arat^{h}a* have a historically tense relationship with the *Shakripiwei t^{h}eri* and their neighbours, including past armed raids, did not make the encounter smoother. But the fact that Jorge was bringing them into contact with his relative living in Ocamo, a downriver village with a health post, a school and a mission, appointed by doctors from the state capital, provided an opportunity for connections already sought by the people from these villages.

The incident took place during a trip commissioned by the leaders of the *Plan de Salud Yanomami* (Yanomami Health Plan or PSY), a high-budget government effort started in 2003–4 to provide comprehensive healthcare delivery and expand direct medical assistance to the Yanomami people. It entailed training community health agents, *Agentes Comunitarios Yanomami de Atención Primaria en Salud* or ACYAPS (Primary Health Care Yanomami Community Agents), and providing the conditions for their work by bettering existing health posts and opening up new ones. Until then, the provision of continuous healthcare in the Upper Orinoco was basically limited to riverine Yanomami villages in the contact axis of the Orinoco and a few other major tributaries where mission schools and health posts were located, and one or two isolated enclaves close to an army base or a mission post. This visit to *Shakripiwei* responded in fact to a specific decision to expand healthcare to previously unserved communities via a planned strategy that included doctors and state officers. But the visit itself had been triggered by a previous move from the people of this distant area. Some months prior to it doctors had reported that a young man with a broken foot from neighbouring *Aranai th^{h}eri* had been carried five days uphill from *Shakripiwei* to the Parima B enclave on the back of another young man, seeking medical attention. Parima B is a cluster of villages in the upper reaches of the mountain range and closer to the Brazilian frontier, where a health post and a military base are also located. This effort motivated the professionals then responsible for setting up the PSY to consider that the remote cluster of *Shitar*i villages deserved to be included in the program of community health agents, and to look for a candidate to join the group of twenty youngsters from different corners of the Yanomami area that were to become students. *Shakripiwei* was in fact the village most removed from contact with health facilities

to be included in the program, although it was not geographically the most distant. Francisco asked for a boy with a "soft head" (still able to learn) that he could take downriver in order to make a trained nurse out of him. A young man called Feliciano came forward, and the next day he grabbed his few belongings (according to Francisco just a bark-made hammock, bow and arrows and a quiver) and bid farewell to his weeping relatives, who entrusted Francisco to keep him safe in the trip across territories of potential enemies and further away in the land of the *napë* (whites, *criollos*, Venezuelan nationals or foreigners).

The effort to incorporate the *Shitari* villages into the healthcare network should be understood as an outreach of state services towards previously unincorporated areas. However, as we have seen, it had been preceded by an episode of outreach towards the state by the hinterland population of *Shitari*. Establishing who made the first move will be a matter of perspective, but we will come to see that this bi-directional incorporation is crucial to the construction of the interface that links both sides. And regardless of the standpoint from which the social developments of the remote *Shitari* villages in recent years are assessed, it is clear that these are tied to the last wave of expansion of the Venezuelan state's health assistance network in the state of Amazonas, of which the PSY was the spearhead strategy in the Upper Orinoco. My documentation of the life of these villages at that time surfed on this wave of state healthcare reaching out to them, as I formed part in August 2007 of the next steps of their integration. The plan consisted in the opening up of a helipad and the inclusion in the training program of Feliciano Yoakai, who would set up a health post for the villages. In the context of the support I was given for my doctoral research, I was asked to assist the work of this novice agent, who would be returning to *Shakripiwei t^{h}eri* when I was to settle there. While accompanying this expansion effort of the health administration, my contribution would be to observe how the communities incorporated and appropriated health services and how this effort played into existing intra- and intercommunity relations, rendering this perspective to the authorities of the PSY and CAICET *(Centro Amazónico de Investigación y Control de Enfermedades Tropicales Simón Bolívar)*, the tropical health institution supporting my work.

The *Shitari* population group was in general poorly known, and anthropological information about them was scarce and fragmentary. Existing reconstructions of historical migrations (Lizot 1971, 1988), show them following in the late 19th century a linear and independent migration from one of the five "mother" population groups from which all the central Yanomami descend, moving from the Upper Putaco interfluve to the Upper Ocamo. But demographic information concerning them is scarcer than that of other populations that spread North and South from the Parima highlands. Before the early 2000s, they had only received a few short visits from outsiders, and were not integrated into the grid of healthcare. Most of the children and many adults had never been in direct contact with the *napë* before that time. My research also uncovered that *Shitari (*or *Shiitari)* is a relative and charged socio-geographical locational and identifying concept: it was never an autonym and it is generically applied to these villages and to others in the upper Ocamo area by Yanomami people from the lower Ocamo. Only because it has increasingly become the name by which state institutions identify them has it started to be adopted by locals after periodical contact and radio communications were established.

At the time of our first encounter with the villages, the population seemed healthy in general terms, and without apparent malnutrition. The majority of children survived beyond four months, a parameter that doctors use as an informal indicator of a healthy community, and infant mortality rates did not appear to be significantly different to those of villages with permanent access to healthcare and industrialized food. Because of altitude and sloped terrain, the area lacked significant *Anopheles* populations, and back then malaria cases were rare and "imported" from the lowlands[1]. A transverse study made in July 2008 by the bioanalysis unit of CAICET yielded that intestinal parasite infections were generalized (Sánchez 2008),

1. As of 2017 and 2018 this situation changed dramatically, with many malaria cases and deaths in Shitari thought to be the result of contact with wildcat miners in other areas. This is in the context of a generalized resurgence of illegal mining throughout the whole Amazonas state and thus a situation in which malaria is probably still "imported" (although this has not been studied yet). This is in consonance with the widespread resurgence of vector-borne diseases throughout Venezuela (see Hotez, Basañez et al 2017).

but malnourishment cases were very rare. The institution's onchocerciasis unit classified the group of villages as hyperendemic but with a low prevalence for river blindness and incorporated them into a schedule of biannual visits for Ivermectine treatment. Notwithstanding this generally good health situation, my historical reconstruction later yielded testimonies of events of famine and epidemics in the not-so- distant past, very present in social memory, which explained in part their open attitude towards outsiders and health personnel.

The Yanomami Health Plan inaugurated a qualitative change in state healthcare in the region, introducing a participatory and intercultural approach, an emphasis on the training of Yanomami personnel, and enjoying an unprecedented logistical support from other state offices (Kelly and Carrera 2007:371–375). This program was the materialization of a vision shaped after more than a decade of work and debate between doctors, public health officers and regional medical research institutions, social organizations and indigenous leaders, under the guidance and coordination of CAICET. As such, it promised to fulfil expectations of improvement of the health situation. It was well grounded in local institutions, and it enjoyed significant support from professionals in the area. The web of healthcare institutions was experiencing at the time an expansive phase, in the context of a more generalized enlargement of the presence of the state in Amazonas, supported by the economic affluence of the initial years of the Chávez government. Healthcare coverage increased significantly, stretching towards previously unserved areas of the upper Orinoco. The production of demographic and geographic information aimed at reducing knowledge gaps about population and social matters was one of the challenges taken on board by the state's outreach effort in a territory still largely uncharted. As a participant in this enterprise, part of my work consisted in documenting new villages, making reliable censuses, and exploring the conditions for stabilizing and increasing the healthcare coverage. A demographic snapshot of this moment, at the times of my settling in the villages is given by the following population figures, registered between November and December 2008 (Table 1):

Isi t^{h}eri: 66 (36 male, 30 female);
Shakripiwei t^{h}eri: 64 (35 male, 29 female);
Aranai t^{h}eri: 46 (26 male, 20 female);
Yaure t^{h}eri: 27 (15 male, 12 female);
Okonaripiwei t^{h}eri: 23 (11 male, 12 female).
Total population: 226

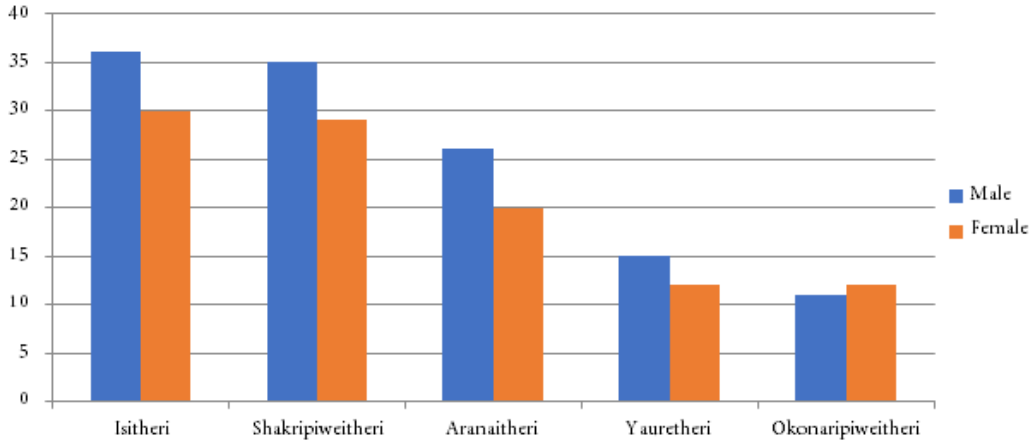

table 1. Shitari population, December 2008.

The community health agent Feliciano started to work in *Shakripiwei* in those final months of 2008. During this time I contributed by installing a solar-powered radio station and

negotiated with villagers for the construction of a big Yanomami-style house where I would live and receive medical teams and which served initially for health consultation.

Yanomami Incorporation of a Health Agent, a Health System—and an Anthropologist

The outcome of setting up a health post in an area with no other contact with national services, and whose primary health care routines were to be overseen by a Yanomami youngster without any previous knowledge of Spanish, reading, writing or basic arithmetic and of course, no biomedical training, was uncertain. Some of the PSY organizers and other actors in the health system considered it to be a risky bet. Until then most if not all of the Yanomami nurses in the Simplified Medicine Program had been educated in primary schools run by missionaries in the riverine villages of the Upper Orinoco. The *Shitari* villages were far away from these areas of contact and intercultural education. While the results of this bet rewarded the confidence of the heads of the PSY and the *Shitari* people, it also opened up a brand-new game, with a playing field set up between the new actors of health administration and the local population, the rules of which would go beyond the control of the health system. As it turned out, contrary to the expectations of some resilient health bureaucrats, and to the surprise of senior nurses and educated Yanomami from downriver villages who expected a failure of this investment in upriver "wild" Yanomami villages, Feliciano's dedication and engagement with the community was continuous and enthusiastic from the start. It included and went beyond the five villages of the residential cluster, surpassing the limitations imposed by the family and village-centered Yanomami ethos.

Why and how did this take place? How did it happen that a 17-year old hunter-gatherer-cultivator, who had never gone out of the forest prior to his employment, became transformed a year and a half later into a dedicated nurse for two or three hundred of his people? How did the villagers manage this transformation and the new state of affairs produced by his health post and attention routines? Fieldwork provided me with an unexpected opportunity to witness this two-way transformation. And to offer some answers, a review is necessary of how this state of affairs came to be after the "capture" of this young adult by the public health system described above.

A year after the troubled visit in which he was recruited as a candidate for health agent, Feliciano had finished the better part of his training and he joined me in my first journey to *Shakripiwei*. This was the first entrance done on foot to the mountain *Shitari* villages by state institutions, as the place had only been visited two times by health personnel by helicopter in previous years. A decade earlier missionaries and a couple of anthropologists had separately paid them brief visits, walking from Parima B. The team also included a doctor, an onchocerciasis technician, a Yanomami microscope technician from Ocamo, the still-under-training health agent, and Francisco, the boat pilot from Ocamo, who from then on came to adopt me as my guide and transporter upriver to the *Shitari* mountains. In this our first hike together up the mountain, this middle aged man, now used to riverine routines and untrained in trekking, complained loudly about the effort, insisting that we should convince the *Shitari* to settle on the banks of the river—if they wanted to be taken care of by doctors they should move closer. While this message was probably inherited from his time working with missionaries, who decades ago encouraged downstream moves from remote communities, it also expressed his own expectations. This is a usual attitude of those Yanomami in the axis of contact towards distant communities not yet integrated into circuits of exchange with the *napë*. It was the first time back for Feliciano after 12 months absence and his reception by the villagers was jubilant. During this trip I would meet the people in the villages, ask consent for my research, negotiate the building of my house, and later settle there on Feliciano's return when his course finished.

When I came back with him some months later, people were happy to describe my arrival as a restitution, and this had a lot to do with the warm welcome I enjoyed: I was returning their child taken on a faraway journey by downriver people of whom they were always suspicious. On top of the benefits of the radio and health post I was instrumental in setting up together with Feliciano, the fact that the *Shitari* Yanomami had no trading relations with any *napë* made me a valuable asset as a source of relations and goods.

Feliciano's healthcare routines started swiftly, initially seeing patients in the big house built for me, where I studied the language, conducted interviews and took notes. The house was large enough to receive visiting medical teams and accommodate our separate activities, and it allowed me to witness closely Feliciano's work. After a while, however, it became clear that we could not share the same working space. Eventually we arranged for another house to be built in the space between mine and that of his family, to serve exclusively as the health post. These spatial details are not without significance: my house had been built by the community after a negotiation in which I made a list of the tools and materials asked in payment by each of the 20 or so villagers that participated in the effort, mostly adult and young men, but also some women. Two months after that agreement I came back to find a wide, high, and elegant *yãno*[2] (around 64 m2) built for me and secured until my arrival. I paid each worker and this initial act of postponed and then accomplished exchange was significant in setting the tone of my relationship with the people of the community. The construction materialized an operation of exchange with the *napë* and also an act of capture of the *napë*'s potencies to channel resources from the outside world. Feliciano's health post had a similar value, with the added feature that the management of his resources could be more tightly controlled than that of the *napë*. These two edifices, built by the villagers, came to be spaces that introduced totally new activities into their routines. Word spread in a wider radius that *Shakripiwei* had a nurse, medicines, a helipad and a residing *criollo* in communication with the wider world and the inflow of inter-village visits was animated with these new attractions. People from both close and more distant villages came to get treatment and also to meet the anthropologist, eat with him and exchange stuff, or just to sit down and watch Feliciano and me working. By engaging with the things that we did that enlivened community life with a potential to change customary routines, residents and visitors could become participants in those changes.

As Feliciano had done previously in my house, in his own place he attended basic health needs: children´s diarrhoeas and respiratory infections, parasitic infestations and digestive sicknesses, fevers, wounds and aches, snake bites, prenatal care of pregnant women. He was responsible for healthcare in all five villages of the cluster that shared kin relations and were linked by exchange relations. Visits to a more distant cluster of villages around the *Motoshira* community, located nearly one day's walk away, even if tiresome, were undertaken periodically. His presence also mobilized more distant villagers, who walked several days to bring wounded, snake-bit or sick people. Bypassing the codes of reciprocal alliance and enmity, when armed conflict erupted between the five villages and two more distant ones, women and children from these antagonist groups would still come to be treated by Feliciano, staying at his family's hearth. He reported the health situation to medical authorities in the municipal capital of La Esmeralda and the state capital of Puerto Ayacucho via the radio. He also sought the support of doctors and senior nurses on cases beyond his knowledge and requested helicopters for emergency referrals to the regional hospital. He created detailed censuses of each village and kept a notebook to register healthcare data. He insisted on delivering weekly health reports via the radio just as other doctors and senior nurses did from better provisioned bases, an unexpected initiative from a Yanomami agent in a remote village whose broken Spanish most novice doctors could not even understand. My duties included supporting him in all the above described tasks, reenforcing his mastery of arithmetic and Spanish language, and monitoring his reinsertion into the community as well as its socio-political impact.

2. A *yãno, yãhi of yãfi* is a house where a family lives in the *shapono,* communal house or village. It can be either an independent construction or a section of a continuous roof without separate structural units.

Transformational Agencies and Spaces

It was soon evident that all these new activities introduced in village life had a strong mobilizing effect, setting in motion a dynamic of change. This did not appear as a sweeping change and evidence for it emerged slowly. Everyday routines continued and this was more about the addition of a register of things to do, both related to healthcare needs and to leisure and sociality (watch the new resident and the new things going on, stalk and create opportunities for exchange). People undertook the same everyday chores. Hunters would go out at sunrise for daily foraging and families would go to work in the garden. Women would fetch wood and occasionally go on crab-gathering expeditions. The afternoon was a period of village sociality. Men and women returning to the *Shapono* would gather around the fireplace to cook, play with their children, talk to kin and neighbors, and receive bodily care and attention. In the late afternoon, male adults and youngsters would gather in the plaza for *epena* (hallucinogenic drug[3]) sessions, and at night faction leaders and other adults would often deliver speeches from the edge of the central plaza directed at the whole village, commenting on different matters. I became especially attentive to the clustering of people around the hearth when families reunited after foraging, that stood out as the most joyous and warm moments of social interaction. These activities have a fundamental role in structuring village conviviality through mutual feeding, grooming, extracting parasites from each other, playing with children, cooking and news-sharing. The physical engagement with the body of loved ones, repeated every day in these situations, is a cornerstone of the Yanomami ethics of care (Reig 2013, Ch.6). While watching the health agent receiving and examining children, young men and women of his own generation and elders, an insight crystalized about the bridging of two care registers. Witnessing how he took his time to visually inspect, touch and listen to their bodies with his instruments, asking questions, measuring doses of medicine on a syringe or counting drops, and then taking pills and putting them in the hand or mouth of the patient, or applying an injection with scrupulous precision, I realized that something pre-existing was being reproduced here in a new setting and with new instruments. The fact that he performed his caring duties while being observed closely by relatives of the patient and visitors seemed to sanction both the continuity and the novelty of the situation.

This performance of his new abilities raised his social status by means of a behavioral enactment of a preexisting caring ethos, but they also afforded him a placement in another, convergent register: it allowed Feliciano to raise his political status in the village. His new capacities were acquired when he was moving from one generational category to another, and they would position him in the path to adulthood. No longer would he be just a *fiya,* a youngster.[4] Some weeks after his arrival, as did other young aspiring leaders, he began to deliver night speeches. This was not only made possible by his healthcare abilities: among the new resources and prerogatives he enjoyed as part of his salaried position were helicopter flights that enabled him to fly to the state capital three times a year to get paid, an occasion he would use to buy tools, materials, food and clothes. He had to redistribute this wealth when coming back to the village, mostly by paying for services (as the building of the health post, for which he hired young men from his own and neighboring villages). But he also had to give away stuff to those who demanded it, or risking having his goods stolen if he did not show enough generosity. This new wealth and the resources to maintain it became an attraction for relatives living far away, who came to settle in the village. Among them was a young girl whom he started seeing discreetly in the forest and who would join him late at night in his hammock in my house. She eventually became his wife and is today the mother of his children. Significantly, his new resources allowed him to bypass the obligations of moving to his father-in-law's village to garden and hunt for him. Instead he provided tools and clothes to

3. In this case made from the tree *Anadenanthera peregrina, (Leg. Mimosacea*).

4. In the upriver speak of the *Shitari*, *huya* in the lowlands.

his bride's father and family for a certain period of time, perhaps evidence of a strategic shift from bride-service to bride-wealth (Hugh-Jones 2013) in a context of increased availability of objects.

At the center of the transformation that he embodied and was instrumental in mobilizing in a larger context was his performance as a caregiver credentialed in the outside world. When visiting more distant villages, Feliciano would exhibit his newly acquired *napë* attire in full, walking in the forest with a red wine-colored soccer t-shirt of the Venezuelan national team, health worker pants, rubber boots, and his PSY backpack. At these villages where people had no foreign clothes and had never received medical attention, he could express impatience at their anxious demand for our plates, machetes, spoons or food, but his performance was impassive and dignified. He took all his time to examine patients with his stethoscope and his other tools—tongue depressors, lantern, gloves—witnessed in awe by the villagers. The full extent of his *napeprou*, "becoming white" (Kelly 2003, 2011), would be evident then and underscored by consulting the diagnostics with me in Spanish, unintelligible to the audience.

His new positioning also entailed new lines of social cleavage. In July 2008 a medical team visited us, including another health agent, Martín, well versed in reading, writing and calculating in numbers who came from a village with an evangelical missionary presence. Feliciano and Martín made a tight alliance during health care routines, doing their job efficiently and mediating between the doctor, the health technicians and the community. During their spare time they explored an electronic gadget with games, while discussing the whereabouts and doings of the rest of their classmates. It became clear that these partners belonged to a differentiated nascent grouping: the "Peseyés" (agents of the PSY),[5] that set them apart from the other health technicians, from the doctor, bioanalysts and the Yanomami microscope technician, from the anthropologist and from the rest of the community. This new social grouping shaped their views on different matters jointly and shared information about and characterizations of the health personnel. In early 2008, Cuban doctors were regarded by them as inferior to Venezuelan ones, or even worse ("everybody knows that a Yanomami woman should never put his child in the hands of a Cuban," was the line I gathered from a group of health agents). However, a year later, when the presence of doctors trained in Cuba became generalized in the Upper Orinoco, including those in administrative positions that monitored the "peseyés", and a diligent and kindly-speaking doctor led the group of health workers from this country in the municipal hospital, this characterization was no longer so clear cut: "he is great", Feliciano said to me then, speaking about the leader of all "*cuanos*" (Cubans). The "Peseyés" were also attuned to changes in the political landscape.

Looking at it from a wider angle, Feliciano's endowment with a paid job, the setting of the health post and the opening of the helipad had several effects on the life of the *Shitari* villages, beyond health. The dynamics of health provision and its support infrastructure opened up expectations and produced socio-political mobilization. Other youngsters of Feliciano's generation were impelled to seek equivalent empowerment. Once it was realized that being ill opened up the possibility of being air-lifted to the municipal capital, a manipulation of this option was at hand, together with the attempt to bypass its control by the health agent. We had to handle situations of kin wanting to ride on the military helicopter during evacuations in order to serve as additional caregivers for a patient, or not reporting an emergency to Feliciano and instead hopping through one of chopper's side doors when soldiers were distracted in the chaotic flurry of the touch-and-go operation. Many adults also enlisted in an emerging Yanomami political organization, *Horonami*, trying to secure a place in this context of increasing state welfare and political mobilization. Significantly, in written reports and radio communication Feliciano appropriated for his own village the name of the cluster of villages given by outsiders, *Shitari,* adjusting local geographic categorization to state administrative nomenclature—while remaining at the center of it.

5. In the Parima area around the same time, Johanna Gonçalves registered that the same social grouping was called ACYAPS instead of "Peseyés".

As it turned out, Feliciano's health post, my house with the radio station and the helipad came to be transformational spaces, nodes of communication with the outside and incorporation of their practices. Transformation, however, was not restricted to these settings, which proved to be leverage points for a broader incorporation of the outside. Back in November 2007, I had found myself nearly forced to teach a group of very shy youngsters how to play soccer with a bundle of leaves tied up into a sphere in the helipad, a game some of them had seen in Parima B. In hindsight, it is funny to remember how I resisted becoming an agent of their sportive globalization, which is what they were expecting from me. For my next field stint, I was asked to bring a soccer ball, the playing field had moved to the central plaza and matches that grouped youngsters, children and adults of the five villages became a weekly fun event. But the moving of the playing field to the *Shakripiwei* plaza was just one among other gradual spatial changes. By July 2008 the ring of houses had expanded backwards towards the forest, partly to avoid the repeated impact of stray balls against cooking pots over the fire or people in their hammocks and partly to incorporate my house, which was built just outside this circle where I had initially outlined it on the ground. Among the three villages located closer to each other, all fissions of one mother community 20 years ago, *Shakripiwei* had a distinctive morphology. Both *Aranai* and *Isi*, the other two, were constructed as a continuous circular shapono (communal house), with family dwellings aligned one after the other, each roof contiguous to the rest. *Shakripiwei*, on the other hand, was made up of separate nuclear or extended family houses, some closed with walls from all sides, others open at the front looking towards the plaza. But when I came back in 2011, *Aranai, which* in 2007 and throughout the following years had been an enclosed and tightly contained circular *shapono* on the top of a hill, had been broken up, its unitary structure becoming a scattering of closed houses with a football pitch at their center. To accomplish this the houses had been relocated to a nearby area of level ground. *Aranai* was a village without many elders, and most leaders belonged to the same generation of Feliciano. This seemed to set the tussle for control of new resources on a more explicit plane. The continuous circle of the communal house had been broken up and family units were now separated into different houses. Finally, just as in *Shakripiwei*, the football pitch was placed in the center. But additionally, some of the leadership's new defying attitudes seemed like an attempt to compensate for the perceived imbalance of their being distant from the center of the new events. Feliciano complained, for example, that the hunters from *Aranai* were disrespecting *Shakripiwei*'s hunting grounds, which they used without asking permission as was previously the custom, or even communicating their intentions.

By witnessing village life in the span of these years, a canvas of attitudinal and spatial changes emerged, suggestive of deeper societal changes. Although tempted by the strong evidence, I realized I could not reductively explain what was going on as an effect of the impact of the health initiative. My later reconstruction demonstrated that the dynamic of changes in village groupings, settlement patterns, house morphology and garden units responded to a wider set of motivations throughout time (Reig 2013, Ch. 3). But it was clear that in this short time the presence of the health post and the activity of the health agent had a key impact on the dynamics of change, one that allowed one to interrogate the tensions between the domestic sphere and a wider political one (Fausto 2001:240-241). The composition of these spaces and forces of change was to form the dynamic pattern that built up *Shitari* as an interface area for the incorporation of the outside world.

Effects and Disaffects of a Healthcare Handover

The period between 2007 and 2009 saw the peak of the implementation of the PSY's original plan to delegate primary health care to the communities. It was followed by a drastic decline, already reaching its lowest point in 2011, when I came back for a last 2-month fieldwork

stint.[6] I was able to gather from Feliciano what had happened since my last visit and review the demographic situation of the villages and their general wellbeing. The results were impressive. There was a generalized increase in the population of the cluster and in the health situation of all the villages, due to the survival and wellbeing of the babies I knew in 2009 and most of the new ones of mothers pregnant back then, and to the arrival of people from other villages (Table 2):

	DECEMBER 2008	DECEMBER 2011	VARIATION
Shakripiwei t^{h}eri	64	82	28.125%
Aranai t^{h}eri	46	60	30.43%
Isi t^{h}eri	66	60	-9.09%
Yaure t^{h}eri	27	20	-25%
Okonaripiwei t^{h}eri	20	15	-25%
TOTAL	223	237	6.27%

table 2. Percent Change in Shitari population between 2008 and 2011.

The testimonies underpinning these figures revealed that the general increase was due to fewer deaths and absorption of people from other population groups. The growth of *Shakripiwei* and *Aranai* was due both to a significant decrease in child deaths and to the attraction of people from neighboring villages already affected by disease and conflict in 2008 and 2009 (*Okonaripiwei*, *Yaure*). During this period the slight decrease in the number of people in *Isi t^{h}eri* was due to migrations because of marriage or marital service to other villages of the same population group. In contrast, the decrease in the numbers of *Yaure* and *Okonaripiwei*, which had already lost people due to violence and disease in 2008 and 2009, was due to migration of people to villages of the same group or to more distant communities (*Kurikaiamopë*, *Waparashi*, Parima B).

A general recomposition of the populations of the five villages was evident, reflecting some processes initiated before the PSY health initiative and others directly related to it. And it could be said with reasonable certainty that the building of the health post, the work of the health agent, and the increase of periodical vaccination and doctors' visits, together with referral of patients in previous years, had increased general wellbeing compared to the previous times of epidemics. This improvement and the presence of the health post had also motivated the inmigration of young men who got married and worked in their father-in-law's gardens, expanding cultivated plots and opening new ones, resulting in increased food production. Some young women also moved in and formed new families. All this contributed to a strengthening of the *Shakripiwei* and *Aranai* villages and to the general wellbeing of the whole cluster.

In retrospect, it seemed that the plan that began with the launching of the PSY and its health agent program in 2003 had worked well. However, this success turned out to be extremely fragile. During the three year period from 2009 to 2011 the regular supply of medicines to Feliciano was interrupted. Additionally, the radio broke down, cutting off communication with the health system and forcing him to search for alternative means to get his messages through, and forcing him to travel to the municipal and state capitals to ask for support. This meant walking two days to *Arat^{h}a* in the banks of the Ocamo to wait for some motorized boat to pass and ask for a ride downriver. His projected retraining was all but abandoned and his math and reading skills declined. The plan for continuous retraining of agents in the nearest health post was forgotten. Rather than being supervised by doctors and nurses at

6. In the years after 2011, not analyzed here, things developed for the worst and also marginally for the good. The original project of the PSY retained only logistical competencies. A generalized health crisis overtook the whole state and the health system did not respond well. The critical situation of the central health administration, however, permitted the continuation, under duress, of the work of some local institutions and professionals attempting to implement a model of healthcare sensitive to indigenous difference and incorporating indigenous workers. Although not the subject of this paper, these developments confirm the simultaneously stagnating and productive facets of inertia (see conclusion).

Ocamo, if and when he managed to go out, he went directly to the municipal or state capitals (la Esmeralda and Puerto Ayacucho). Thus, instead of favouring the build-up of a system of sub-regional support between villages and a sharing of knowledge between veteran and new Yanomami nurses in a network of spatially proximate population groups, this choice favored recentralization. Of the original cohort of twenty-one health agents, those from remote villages had been left with no medicine due to abandonment of these new links of the supply chain. They thus became unable to carry out their duties in their communities and were reposted as assistants to the doctors, in places far from their communities in the health posts in the municipal or state capital. The educational support given to them by the PSY authorities became quite restricted, as it was limited to sending them to attend classes in one of the educational "missions"(social assistance programs)[7] during the intervals in wich they were in the provincial capital while waiting for a flight back to the Upper Orinoco after having come out to get paid. The programs not only lacked the intercultural angle of the original PSY training, but in fact work in favor of the project of nationalization and reduction of indigenous difference in its novel, Bolivarian version (see Kelly 2011, 2016).

In the same period, there was a dramatic turnover of authorities at all levels: four regional health directors, four municipal health directors, three PSY coordinators, and three health ministers. As a result, continuity in health programs became daunting if not impossible. The PSY lost 85% of its budget, was downsized, and maintained mostly logistic capabilities, such as transport and housing of the health agents in the state capital (see Kelly 2011: Chapter 9). A new cohort of doctors with no prior knowledge of the context or aims of the PSY assumed all the positions in the health posts. The regional network of health was atomized, and the communication flow between previous expertise and new actors was severed. This was also an effect of political changes at a national level, in which an increasing military takeover of positions in the governmental structure sidelined veteran technical personnel at different levels. But the conceptualization of the Amazonas state as a strategic frontier lent a particular cast to these changes. A new governmental office entered the scene that took a clean-slate approach to healthcare in the region. It introduced a new contingent of Latin-American doctors trained in Cuba (some also Venezuelan) that gradually substituted most of the Venezuelan-trained doctors in the field. The new doctors belonged to a parallel structure directly dependent on the office of the presidency. They were structured as a "battalion" with a military-type organization and the participation of Cuban health officers, doctors, and technicians. This group was taught that there had been no healthcare in the Amazon region before the revolution and that they represented a revolutionary vanguard in the upper Orinoco. These newly introduced doctors were motivated and hard-working and some were highly politicized. But they had no knowledge of the PSY and its aims. In fact, many of them lacked knowledge about Amazonas, its indigenous people or Venezuela in general. They were pioneers in a salvationist effort directed towards destitute people, and in their narrative the limits of their reach just reflected the secular injustices that they were there to combat.

For Feliciano and the people in *Shitari*, and to other health agents at large, the departure of the doctors with whom they had established a relationship of familiarity was a setback. Some agents in remote areas experienced bizarre one-day visits of Cuban health personnel ferried in by choppers who asked villagers for blood samples and left without sleeping in the village. While more remote villagers adapted to the incoming doctors, they began to experience the same instability of the health personnel as Yanomami living in the axis of contact with national society (see Kelly 2011: Ch.3, 224-225). Among the new doctors, even those more inclined to engage with the Yanomami thought of the health agents as field aids, helpful translators with minor roles as healthcare assistants. They thus reconstituted the conventional pre-PSY perspective previously dominant among health workers. The sporadic "penetrations" of the new field doctors to remote villages depended more on their own motivation—if and when

7. The "misiones" (missions) were social assistance programs launched during the first government of Hugo Chávez. They were initially set up to provide health services in poor areas (Misión "Barrio Adentro") and later expanded into education, food distribution, the provision of identity documents and many other areas. They were financed through mechanisms outside the control of the state bureaucracy, served the complementary purposes of redistribution of oil income to the poor and of recovery of electoral support in a time of low government popularity, later enabling clientelism and political control of the population. For a critical revision of these programs see Penfold-Becerra 2006 and García Guadilla 2015.

fuel was available—than on institutional guidelines. Because of my acquaintance with the people that set up the PSY and my witnessing of its initial steps and because my fieldwork was developed after the program had stalled, I became a sort of ambassador of a disappearing nation for all these new doctors and health professionals that now comprised the support network of the health post and agent in *Shitari*. I informally told them about the goals of the program, the significance of the health agents and their duties, how they offered an opportunity for a strengthening of their health care practice in communities, and gave them hints about Yanomami society and culture. At times I facilitated communication with the Yanomami working with them. This mediation succeeded when doctors managed to understand the Yanomami expectation that they behaved as kin as a pre-requisite for undertaking a task. This moral demand was not affected by the fact that the community workers (indigenous nurses, motorists, microscope technicians) had a paid job that put them in a hierarchically subordinate position to the doctors. Usually, this understanding only required that doctors would learn to listen to what their "subordinates" had to say when they were assigned a specific task, instead of expecting them to passively follow orders.

Changes in the wider political sphere also had an impact on the relationship between the state´s healthcare efforts and remote Yanomami communities. For example, the confrontation between the Venezuelan and US governments resulted in a severance of the supply of chopper spare parts, undermining capacity to airlift patients in critical condition. The substitution of the fleet with Russian aircrafts and support personnel would still take some years and in the meantime a drastic reduction of air transport to remote villages ensued. Shifts in state policies and inter-state affairs impacted on the healthcare effort and in the villager's perception of it, as shortages and gaps in previously regular healthcare rounds became the norm. These changes were a consequence of political developments in the government, the complexity and breadth of which are beyond the scope of this paper. State inertia will be discussed in the conclusion, and it could be argued that, instead of a failure, the abandonment of the original PSY plan could rather be seen as a success of the established governmental logic, by providing a good excuse to return to interventionist approaches. Certainly, this case brings to mind the idea that development failures are nevertheless successful in introducing a rationalization of livelihood activities in hinterland populations, and making them state-dependent (Ferguson 1994). But, putting aside critical interpretations of development policies, and from the point of view of the perceptions of the well-motivated professionals, veteran doctors, researchers and health technicians who contributed to build the PSY and helped train health agents, this was just an evident fiasco of public policy.

This institutional failure, however, was counteracted by the success of local initiative. Endowed with not much more than his job and personal capacities, Feliciano took care of all the communities in his area. When the health post collapsed, he paid for the construction of a new one with his own resources. He had been distributing, and thus socializing, his new material wealth. In the absence of communication and transport, he made his way out of the mountains to hitch a lift to the regional and state capitals to get paid, and made his way into the offices of health authorities asking for his radio equipment to be repaired. He brought back as much medicine as he could. In *Shitari* he used his newly gained authority to promote the idea of staying in the mountain environment—bountiful and without malaria vectors—and spoke in favour of resisting pressures from downriver Yanomami to migrate. He made persistent demands on health authorities for resources and assistance and sought out allies for *Shitari*. I am convinced that it was the "agent's agency" that transformed a story of outside stimulation of local empowerment and subsequent abandonment into one of grass-roots mobilization and bottom-up production of social wellbeing. So, what is it that works well? Is it state action or local co-option of it?

Scales and loci of change

The crisis of the support system that made the health agent's work possible was a failure of a state initiative that lacked time, political intention or resources to get consolidated within government bureaucracy. This failure did not, however, stop the interweaved transformations that started to take place in *Shitari* during those years. When analysing them, an initial demarcation appears of individual and collective scales and loci of change: what happened to Feliciano and what happened to his village and related villages (two dimensions only analytically separable). A third locus, only briefly touched on, is that of the health system as a corporate subject embodied in the people enacting its duties. But if individual agency constitutes a main force in the story, it comes in tandem with that of the community, highlighting a key feature of the Yanomami ethos in which collectivism and personal autonomy stand in tension. Other health agents of the same cohort, also abandoned by the health system, made a different choice than Feliciano. Facing the hostility of their villages because failed support made them in turn fail the collective expectations created by their transformation into *napë* health providers, they moved away from their community, settling in the municipal capital to work in the hospital. These cases would require a separate consideration, but they show a different sort of individual and community response than that which emerged in *Shitari.*

The connected transformations taking place in the *Shitari* villages seem to reconfirm some key characteristics of Amazonian sociality, such as the fundamental role of difference in ensuring relationality and social reproduction (Overing Kaplan, 1981; Viveiros de Castro 2004). The production of difference and its management underpins both situations of social reproduction and social change and, in a context such as this one, the control of differentiating practices constitutes a fundamental part of the warp of everyday routines. In this respect, it is illuminating that, before becoming change agents, the health agent and his father embodied traditional values of Yanomami sociality. In the times prior to his journey downriver to start his health agent training, Feliciano tended a very big garden, the fallow of which still was interspersed with productive plants that people would continue to use many years later. He was *nihite*, a good shot, and after his return he would still help his father with his gardens when his healthcare routines allowed. When medicines were in short supply and despite the disappointment of his fellow villagers and the pressure to resume his duties as a health provider, which was impossible without medication, he dived once again into the everyday foraging routines of other adults of his generation, as if becoming fully Yanomami once again. The switch in roles indicates, as in the case of the Wari', the fact that an Indian/white oscillation is key to this relational dynamic (Vilaça 2015:204). His father Kahewe, a widower, stood out as a dedicated farmer and a provider for many, tending two big gardens and opening up a new one, while most other heads of family worked only one medium-to-small-sized garden. Kahewe expressed how happy he was that his son had *totoroprariyoma*, transformed into a doctor. He was happy that he had gone away and happier that he had returned transformed. But Feliciano had been very good at what he did before, and both him and his father excelled in producing and procuring food. Feliciano had been an exemplary Yanomami youth when he went away to be transformed. The difference that he embodied on his return was individually sought for and collectively embraced but also controlled by the community. Kahewe complained that jealous people robbed him of his stuff at home and in the garden after his son came back as a nurse even though he was generous in feeding others and giving away food. His household, where his son had settled with his new wife, was periodically supplied with the stuff Feliciano brought from his outings to the state capital, creating a concentrated abundance that the community felt the need to redistribute from either Feliciano's or his father's possessions.

Coming back to the questions about how and why an efficient forager turned into a dedicated nurse, I would first and foremost underscore that Feliciano's transformation is key to the success of his job of delivering healthcare. It is because he stands out differentiated among the rest—and providing both curing services and opportunities for social interaction with his people—that his new position can work for the villages. Secondly, at the community level, ongoing changes should be looked at in terms of the creation of an interface of transformations in the surface of contact between two worlds.The two sets of interconnected transformations, that of Feliciano and that of the villages, are expression of the different scales in which Yanomami society simultaneously operates the absorption of otherness for stability and social reproduction, "a scaling factor that makes the self/other divide necessary to the constitution of the person—inwards from the community limit - and of aggregates of communities—outwards from the community towards the limits of the ethnic group, further to those considered Indian *vis-à-vis* whites, and in a perpendicular direction to this axis of alterity, to the non-human persons that populate indigenous cosmologies" (Kelly 2016:75).

Looked at it from the perspective of the health agent's transformation, its success should be explained within the following coordinates:

1) The labour of the health agent fits into (and enriches) a pre-existing Yanomami ethos of care and is thus incorporated effortlessly into the moral system, since he uses his resources to take care of his kin, his village, his proximate neighbours. Despite its grounding in the wider cultural ethos, it does not by itself operate at the level of an "ecumenical" religious or political pan-Yanomami practice since his labor of care is controlled at the level of the locality (villagers do not agree that he should extend his caring services beyond the cluster of neighbouring villages), and its workings respond to the atomized and multicentred nature of the socio-political system.

2) On a more restricted scale, the new panoply of manual procedures of bodily care that he has learnt and uses builds into a system together with equivalent indigenous practices of conviviality. To "take" a vein (find it under the skin, puncture it and administer intravenous treatment), to inject, to clean a wound, to sew it or apply a cream, are procedures that become incorporated in a continuum with indigenous practices of searching for lice and sand-fleas and pulling them out from hair and skin, extracting a spine, or painting each other. These practices of subjectification and tending the individual configure an Amazonian "souci de soi" (Foucault 1984) in its own right, and a "souci de l' autre"—care-concern of the self/care-concern of the other.[8] Because of this continuity these practices are easily learnt and performed by the health agents and accepted by patients.

3) The transformation achieved by the training of the health agents increases their social capital and material wellbeing so that their local socio-political status is reconfigured and they are given a privileged position as intercultural brokers; as established by Kelly (2005, 2011) for "interface" Yanomami (see Discussion section) in general.

4) Concomitant with the repositioning of aspects of individual agency, their training and transformation served to create a new societal sub-group, the "peseyés", united along generational lines and with a common purpose and life project. The emergence of this subgroup and its developments deserve continued research similar to what has been done in other contexts with indigenous teachers or pastors.

5) Intersecting the build-up of this subgroup we find the governmentality strategies of a corporativist state, one that introduces subgroup differences, registering them and placing them in bureaucracy as both agents and subjects of welfare policies and political control, a key dimension of the overall dynamics of state assistance, which would also merit study.

6) But beyond the dialectical play of forces that allows them to come into being (governmentality/local empowerment—co-option), from the agents' point of view in this particular

8. See Alès (2000, 2006:162-166,) for a parallel formulation of "souci de l' autre" in the Yanomami convivial *ethos*.

case, the emergence of the peseyé grouping with its inner solidarity, sharing of news and joint assessment and characterization of their wider social and labor landscape, is precisely what allows them to navigate the uncertainties of variably dwindling and expanding welfare policies and state intervention.

Looked at it from the point of view of the people in the village benefiting from the health agent's work and who hosted the health post and the helipad, the whole package of new resources and functions endowing one of its members generated an intense dynamic of social mobilization. The redistributive pressure put on the health agent, together with the appropriation of the new communication, transport, and exchange options that were opened up illustrate the Amerindian drive to combat the accumulation of individual power (Clastres 1974). And their strategies for "socialization" of the newly incoming resources proved to be successful. Rather than being restricted to health-related communication, the radio provided the opportunity to exchange news with distant communities and was thus used by some young adults and villagers leaders. The health post presence gave increased importance to their village within the cluster, while the helipad ensured privileged political inclusion (for example, *Shakripiwei* residents said "the helicopter of Chávez" had come to air-lift just *their* wounded in the conflict with neighbours). This spot of cleared land for *Shakripiwei* became in fact a portal, the launching point from which Yanomami could tour the *criollo* world at the expense of the state. A helicopter trip could result in healing for the sick, but also the opportunity to tour the criollo world, eat *napë* food, get hired in the municipal capital to grind manioc in a machine or clear a garden for the Ye'kwana (indigenous neighbours historically experienced with whites) in exchange for pots, pans, and t-shirts.

Notwithstanding that the health agent was abandoned by the health system and could only do his job for limited periods of time, the fact that he continued mobilizing his knowledge of the *napë* world to secure materials and support for his work made him an asset for the village, "our man on the outside", so to speak. They trusted that he would eventually resume the channelling of connections and health resources, and in fact he still travelled sporadically to get paid and during such times he was able to bring back stuff villagers could have access to. And this communitarian production and maintenance of an interface agent (after all, they had sent him downriver to become a *napë* healer, and then provided him with the possibility of doing his job by becoming his patients) stimulated other people of his generation to aspire to similar transformations. Two of them went to primary school in Parima B, another one aspired to become a microscope technician to assist Feliciano, and candidates for a next round of training of health agents were waiting in *Motoshira* and *Shetiti t^{h}eri,* villages located in the medium-range vicinity. This outreach post of the National Health System provided an opportunity to capture much more than just health. For the people of *Shitari* it was all about an expansion of the known world through the incorporation of a whole system of outside connections.

Discussion: Stable and Unstable Interfaces

The analysis of ontological and political transformation developed by Kelly was based on fieldwork among riverine Yanomami villages in permanent contact with national society. These had a mission with an intercultural school, a health post, a majority of children who attended school, and many bilingual adults inserted into the *napë* world as teachers, nurses, and political or state administrative appointees. In contrast, our ethnography was developed in a group of remote monolingual villages with no presence of outsiders in which the health agent represented the first occurrence of a local "interface Yanomami." Kelly uses this term to speak about bilingual adults whose participation in both Indigenous and nonindigenous worlds allows them to broker the relation between the health system and the Yanomami

population. They do so by imposing upon doctors demands of Yanomami sociality, controlling the behaviour of the former, performing "Yanomaminess," and embodying community expectations towards them. With respect to the Yanomami community this group embodied the capabilities of the outside world and exercised control over outside resources. In Kelly's framework, transformation is culturally framed as nested in a "napë transformational axis" that can be understood as a dynamic elaboration of the rather more structurally static model of "Yanomami socio-political space" produced by Bruce Albert (1985). Albert's portrayal presents relations between Yanomami villages in terms of a blueprint of increasing alterity and enmity directly correlated with geographical distance. Kelly's findings demonstrate that Yanomami conventional space is structured by a dynamic characterization of selves and others along a gradient of transformation from "real (traditional) Yanomami" living upriver with no contact with the *napë*, to downriver napë-yanomami that have undergone the process of transformation into whites. Despite both polarities being predicated upon actual geographical spaces, neither of these models are to be understood as literally dependent on physical distances. Testing Albert´s model, we can verify the dynamic nature of the socio-political system and the unstable equilibrium of intercommunity relations with reference to the common fact that formerly allied neighbouring villages may be reclassified from friend into enemy, even in the absence of relevant change in village location (other than temporary strategic resettlements due to armed conflict). In the same way, in Kelly's "axis," distant and/or upriver Yanomami are characterized by downriver interface Yanomami as embodying mythical/historical ancestors with no knowledge of foreign people or their ways, but the same differentiation can be at work between different people within interface village clusters. The crux of the distinction is not based on people being located faraway or close by, but whether or not they have incorporated the habitus of whites.

The transformational axis is well exemplified in both its categorizing and agentive dimensions by the way in which my guide from downriver Ocamo used his position in the logistics of my field entries throughout the years. Francisco befriended me and became my sole guide and boat pilot in each of my entries into the field. He used the fact that his role was indispensable to me to try to control the whole undertaking. His initial proposal urging the *Shitari* to move downstream did not persuade the villagers or the health system officers. But in each of my trips (and in others he made alone to look for Feliciano when the latter had to travel out), he brought gifts to a young woman that he was wooing to marry and settle with him in Ocamo. He sought this union because his first wife was now too old to conceive children. He also publicly recalled his role in taking Feliciano out of the mountains to be educated and compared the boy's prior poverty and ignorance of the napë world with what he had now become. His indispensable role in navigating the journeys to *Shitari* allowed him to enact his role as a "civilized" Yanomami/napë establishing exchange with the "real" (uncivilized) Yanomami. The Yanomami understanding of being civilized does not entail a domesticating overcoming of their Indianness—as *criollos* conceive it—but implies instead the acquisition of the *napë* habitus, the embodiment, in fact, of the Yanomami/napë duality that entails the incorporation of *napë* sociality (Kelly 2016:47–50).

Initiatives coming from the outside world and with Yanomami participation always serve the purpose of different interacting groups of actors and their trajectories are defined by the push and pull of their respective aims. Considering the engagement between the state and the *Shitari* we have said that it is difficult to establish "who captured who." At a less inclusive level of mediations, it was evident that downriver Ocamo Yanomami were also capturing the anthropologist and the health system's effort. In my trips upriver from Ocamo it was mandatory for us to disembark briefly in *Arat^{h}a*, an operation called in local slang "arrimar" (to come close to land). This entailed an interruption of the trip and a diversion of some resources. When he got there, Francisco would let his brother-in-law Jorge know that he was around,

and he would give some goods or food to his family. He also might take the opportunity to do some fishing on the nearby *Arat^{h}a* rapids after leaving me in *Shakripiwei*. During the stop at *Arat^{h}a* I would inevitably be stripped of some of my cargo. These stops became a routine over the years and a group of lively women would always shout the same requests from the bankside as we arrived, with an intimidating performative energy. They punctuated their demands with the argument that every time I went upriver and up the mountains I was fat and healthy and had sacks with plenty of food and stuff and I always came down emaciated and poor because all the women I had in *Shitari* sucked away all my strength and food and stuff. Why did I not stay there in *Arat^{h}a*, take a young wife and share all my food and stuff with them instead? Men would also participate in the demanding troupe, asking for specific things such as lanterns, fishhooks, or knives. I became more adept at dealing with this recurrent episode when I learnt to speak and negotiate with them and I distributed beads, fishing rods, hooks, and sometimes also food in exchange for plantains, which are plentiful in the gardens of *Arat^{h}a*. Eventually my anxiety during these episodes decreased and I became more comfortable with my control of the situation, but obviously I was the one whose movements had been controlled by multiple parties.

As the furthest point of the axis from the perspective of the downriver Ocamo, the *Shitari* villages were formulating their own transformational dynamics in a quite explicit way. During the last year of my work I gathered this most telling statement from a young adult man giving a night speech in *Shakripiwei*: "*feithehe pemaki iriamou napë a mãyõ hami,*" ("we are now playing in the field of the whites"). Feliciano was besides me in another hammock when I heard the statement and noticed my amusement. He realized I was trying to make sense of it. I wondered if the man was speaking about the volleyball playing field where my old house used to be, the football pitch at the centre of the plaza, or the whole situation of enacting their becoming white. He grinned at me and said "all of it, my brother-in-law, all of it." As an agent of mediation/translation, he was showing me not the different words for the same situation, but the [transition between] different worlds designated by the same words (Vilaça 2015:205). People in these villages were experiencing their own place as a novel scene of a transformative incorporation of the potencies of the outside world, one in which they had been active agents from the start. *Mãyõ,* the word used in the speech to speak of the playing field , signifies a trace, a footprint, an open field, and a path (in the sense of the trace of someone's passing)—it is the physical mark of an action (Lizot, 2004: 210). It is also a marker of causality: "*kafe a mãyõ*" means "that was your fault" (you are responsible for that; it is the result of your actions). Approximately around the same time Gonçalves (2016) describes a similar sociological process with a complementary expression in Parima B. People there defined their situation as "we are now walking the path of the whites" (*napë pei yoka hami yamaki huu*) and "the path of health" (*salud pei yoka*) stood out as one of the most important among its different trails.

Feliciano was the only one so far that had, in his father's words, "*napëprariyoma,*" turned into white. He did it by "opening up the path of health," to use the expression collected by Gonçalves in Parima B. But other youngsters marked their imprint in this new playing field by means of other efforts. Those who had gone away to school in Parima B came back in 2011 to visit, exhibiting their knowledge of writing in Yanomami. To Feliciano's annoyance they used a different spelling system since Parima B had been an enclave of the evangelical New Tribes Missions which used their own alphabet. Feliciano had learnt to read and write with the international phonetic alphabet used in the Salesian schools of the Orinoco axis. One of the young men taught the people to jog around the village plaza as the soldiers did in the Parima B garrison. It is evident that Yanomami men were competing with one another using knowledge derived from their respective experiences in different areas of contact. Similar tensions could be seen between displays of "*Tiosimou*" ("to do the God thing"), when Feli-

ciano playfully chanted his own Catholic mission songs and those who had gone to Parima B would boast aloud their knowledge of evangelical prayers. The mostly older people starting to coalesce around the *Horonami* organization would stage communal meetings in the village plaza. During these events people would sit in a circle and pass around a flyer written in Spanish and Yanomami announcing a big conference in the lowlands, printed with the help of an indigenous rights NGO. Although it was examined appreciatively by everyone, no one, in fact, could read it. While I sought to distribute gifts to women and children at the end of fieldwork stints, diligent young adults ushered everyone to make an orderly queue, mimicking the procedure they had seen in downriver villages where politicians bring their loads of stuff to give away during electoral campaigns. Following Vilaça (2016), we should consider these mimetic behaviors or absorption of *napë* bodily habits as acts of translation.

However, instead of translation, this paper is focused on transformation, more specifically on the way in which the interface is composed by a set of sites of transformation that I have called transformational spaces. These are replicated at different scales: the health post, the anthropologist's house, the agent's house, but also the plaza, public space *par excellence*, in more than one village. Superimposed upon its traditional ceremonial and political functions, this became the space for jogging, playing football and volleyball, lining up to receive gifts, loudly chanting out religious songs, attending a meeting, and "reading" a flyer. Spatially speaking, *Shakripiwei* could appear as performing the role of a center in this field of transformations, with the other villages converging upon it and imposing their participation in order to attempt to control it. And certainly, it was seen by the four surrounding *Shitari* villages as *the* site of transformation. But on a closer look this appeared much more as a process based on individual initiatives, collectively catalysed and not determined by village location or residence, and not even exclusively crosscut by generational lines (although young men were an important driving force). The process was intensified in the transformational sites of *Shakripiwei* that became the setting for continual enactment of the new routines. But it was in the context composed by all these places in different villages that the Yanomami/napë duality was maintained. Over the range of locations and scales, incarnated in different activities and people, the experience of two bodies interacting in a double identity resurfaced, without a final transformation into one or another pole, a reversible process in which oscillation and alternation are ongoing (Vilaça 2016: 9,11; 2015:200, 204).

All these interconnected happenings coalesced to provide a specific dynamic to the interface milieu that the *Shitari* villages were becoming. This was a far-from-stable interface, unlike what Kelly described in downriver villages. Many activities could effervesce at the same time, giving the impression of a quickly developing ongoing process. But then customary practice would once again dominate routines and things would seem to return to "normal", concealing the previous atmosphere of change. What stands out here is the process of construction of an interface setting, which, wherever its future developments may lead, was at that particular time characterised by the simultaneous incorporation of different outside practices that were embodied in competing agents, and which held the potential of creating a stable transformational context.

Conclusion: State Inertia, Membrane of Transformations and Local Mobilization

This paper has sought to examine the process of creation of an enclave of primary healthcare run by an indigenous health agent in a remote Yanomami village and its development over a three-year time span, across two convergent registers: health outcomes in spite of a practical abandonment of support by the health system and the social transformations set in motion by the initiative. Both of these registers are defined by dynamism: a transformative initiative improving the availability and quality of indigenous healthcare and then marred by bureau-

cratic discontinuity, alongside a process of incorporation of the outside world by the villagers targeted by the initiative, that destabilized inter-and intra-community relations and created a context for societal transformation.

Within the register of health policies and public health outcomes, what happened during the years of decline of the PSY can be placed within the wider transformation of the health system in Venezuela. This broader arena was being shaken by economic and political crisis, the recentralization of health and other services, the military takeover of technical responsibilities, and attempts to make up for the lost capability caused by the migration of health professionals. In the Amazonas state during the period analysed here (2007–2011) this turmoil resulted in a takeover of the control of health from authorities of the institutional structure of the Ministry of Health to a parallel command structure that depended directly on the office of the Presidency. Most of the Venezuelan-trained doctors in the field were replaced and the autonomy of regional institutional actors with experience in health and research fields were politically neutralized for a time.

Beyond the specificity of this case, one can see how the inertia of the state provokes crises that undermine new policies and that end up re-establishing the usual way of functioning, even in the face of reforms promoted by the state itself to improve healthcare. What I call inertia is not staying put. Rather, it consists in not interrupting the customary flow of procedures to ensure that the status quo remains. In the achievements and misfortunes of health provision in the Amazonas State in the last 30 years, this has expressed itself in many ways (Reig, in press). Several factors structure this inertia. First, we have the break in the flow of knowledge produced by the departure of the original team of doctors and leaders of the program and the lack of power of those who stayed to uphold and defend the new approaches. This impeded the transmission of the previous experience of a critical mass of actors central to the success and growth of the enterprise. Secondly, this schism played into structural weaknesses of the public sector, none of them new. It encouraged new actors to act as "pioneers" (a chronic institutional malaise in Amazonas State, sometimes called "the Hernán Cortés syndrome") imbued with a radical attitude of "we come to change it all." The extensive turnover of personnel facilitated this (young resident doctors finish their field year and leave to study their specialization, others migrate, head officials at different levels are fired) in a context of increased subordination of the power of technical actors to new political actors. Thirdly, on a larger scale, regionalization efforts clashed everywhere (not just in Amazonas) with centralization. This constitutes a general trend within the Venezuelan state in the last two decades. What happens at the national level replicates at lower levels, including the regional and community level. Against the formation of an intercultural and local context of expertise and reference, nationalizing forces operate to erase difference and downsize local empowerment. These forces seek to normalize the initiatives of local institutions within existing channels and secular logics. Inertia is then ensured. A traditional interventionist dynamic starts to repeat itself in the resource-rich hinterland areas of Amazonia. These territories are subject to special administrative regimes as reserves under environmental protection and they are highly dependent on government funding. Military control of transport and fuel resources is dominant (in this case), and their citizenship networks are feeble.

In contrast to that of health policy, the register of social mobilization set in motion by the PSY initiative makes clear that Yanomami health agents and the communities they belong to operate in the midst of this inertial landscape and actively try to extract the best outcome for themselves from the competing interests at play. Even if the declared social welfare goals of the program have largely been stalled, it affords them another rich and contentious interface between indigenous and national society. The outreach of the state to promote its social welfare policies created a fertile field of productive misunderstandings (Kelly 2011, Ch.8; Viveiros de Castro 2004). For doctors and health officers, training a community agent and setting up a

remote health post meant a logistically demanding extension of their duties and an expansion of the National Health System. For the upper echelons of the state administration, securing control of these new administrative units through predictable and centralized protocols probably conflicted with the complexities of monitoring local indigenous management of primary health which resisted the governmental drive to administer welfare "from above." The fact that community health workers manage to become agents of social change despite bureaucratic resistance to local empowerment has been registered in many contexts (Maes 2015). Different kinds of results may have been achieved by the public administration side of this relationship, ranging from healthcare results (no matter how uneven) to reshaping/reinforcing power categorizations and structures. For the locals the extension of the state healthcare network had multiple practical and symbolic implications. Contrary to the governmental logic and discourse of social inclusion through the provision of healthcare that traversed ethnic frontiers, the political ecology of this experience shows that the fundamental feature does not consist in the bridging of a boundary between the state and hinterland peoples. Rather, it consists of drawing a boundary or adding landmarks to an existing one. As Kelly has put it: "the maintenance of the self/other distinction, at whatever scale, is a matter of political autonomy" (2016:75).

The boundary built here, however, is not a frontier but an interface of transformations. Similar to a cell membrane, it not only bounds an inside but also catalyzes communication with the outside, working as a milieu of transformation. As such, this interface operates as a lively membrane, bustling with novel situations of becoming, that links two worlds in new ways. Instead of an intercultural situation (a framework that fortifies the idea of discrete cultures coming into contact), this should be looked at as a frictional medium of sociality with "alters": a novel setting for mutual predation or ambivalent cooption of alterities (Fausto 2001; Viveiros de Castro 2011).

From the perspective of what happened in the hinterland *Shitari* villages, what I wish to highlight as a particularly socially productive dimension is this frictive medium, this membrane of communications channelling, incorporating, digesting and maintaining difference between worlds in contact, by means of several practices. This interface is configured as a milieu of exchanges which selects and incorporates potentially transformational happenings and agencies, and also sustains a vigilant—yet dynamic, if not fluid—categorization of differences. Within the breadth of this interface milieu health agents are both objects and operators of a transformation that re-edits and contextualizes pre-existing practices of care within an Amazonian ethos of continuous engagement and incorporation of the other. At close range they make kin out of the other (Vilaça 2002) through new bodily techniques and language provided by their health training and immersion in the outside world. At midrange, and as would be expected in an Amazonian setting, their transformation ensures the emergence of societal difference as the young men extracted from the villages become "Peseyés" installing a categorical gap with other people of their wider ethnic realm. Researchers who were central operators of the initial PSY (José A. Kelly, Johanna Gonçalves, Javier Carrera) have noted (personal communication) that the emergence of *Horonami,* the first Yanomami organization in Venezuela born out of indigenous initiative (and not of a religious organization, a state institution, or an NGO), was partly motivated by the emergence of the PSY group of students who then became healthcare agents. This suggests that clusters of societal difference multiply in contexts of transformation.

The interface setting enacted by the Yanomami health agents became partially autonomous from community control of the transformational dynamics, as their mobility and their insertion in the "peseyé" group allowed for contacts of a different kind and in different places. Their insertion also enabled a different kind of interlocution with doctors and health authorities that, even if failing to ensure proper medicine supply and support for their work in the

villages, installed them as a necessary presence with whose demands the health system needed to permanently negotiate. If we assess the health agents from the practical angle of their role as operators of well-being, it appears that their actions seek a range of improvements, from those of individual and family wellbeing and life-projects to community health and wider ethnic affirmation. In this they express an appropriation and translation of the healthcare package delivered from the outside into indigenous understandings of community welfare and the good life. And they also embody a drive towards local empowerment and autonomy with the potential to expand wellbeing at a community level, crafting their own project within the context created by a well-conceived and initiated, but ultimately failed, state initiative. By managing its membrane of transformations, the agents and the communities become agents of a different kind of change than the one prescripted by the state in terms of health indicators or national integration.

In a wider scale, this could be understood within the context of indigenous mobilizations that started to shape their own goals after defying an initial governmental co-option of their leadership (Mansutti 2006), particularly in the resistance to the neo-extractivist turn of the Venezuelan government (Horonami 2014; COIAM 2014; Gudynas 2011). But during a moment of worsening health indicators, scarce medical presence, and a deep national crisis (Hotez, Basañez et al 2017), community capacities of health management by indigenous agents (and thus their possibilities to manage the improvement of wellbeing) are weaker than ever. Healthcare approaches at this level of sociocultural and communitarian resolution have been surpassed by the operational logics of emergency imposed by outbreaks of re-emerging infectious diseases such as smallpox. These had been historically controlled in the continent but, despite the official cover-up of the figures, it is clear that they have reappeared in the Venezuela Amazon as an outcome of wildcat mining and the abandonment of immunization campaigns with a resulting high mortality (Grillet et al 2018; Paniz et al 2019).

Emergency aid –immediate relief, vaccination, and urgent medical attention— compels a logic of urgent healthcare delivery that works as a powerful device to maintain the inertia of the existing approach. Continuous helicopter support for healthcare in remote areas had ended during the years reviewed here, but its intermittent resuscitation for emergency campaigns confirms the insights offered by Paula Vásquez (2013) on the "compassionate militarism" governmentality that emerged after 1999 as a foundational move of the new Venezuelan republic[9]. Instead of facing the challenges of increasing participatory healthcare, "operativos" (emergency operations) punctuate an irregular pattern of healthcare in remote communities. When the efforts of a slow build-up of community welfare by and with the people is argued as the necessary course of action, these are categorized as a luxury by the supporters of the traditional interventionist approaches, a type of policy to be postponed until better times. The continuity of a top-down operational logic in an area where a more inclusive and participatory program was once implemented reminds us that indigenous health has always been part of a historic power struggle between unequal contenders (Zent & Freire 2011:374). The chances of reviving the Yanomami health agent initiative, in which the communities were actively engaged in improving health in the Upper Orinoco, are difficult to assess. But community health agents are still on the move.

9. This salvationist ethos of compassionate militarism was reinforced during those years by the routine airlifting of Indians from a frontier of citizenship and civilization to a center of public health, a subject I explore further elsewhere (Reig, in preparation).

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